Westwood Homecare (North West) Limited

Sedgeborough House

Inspection report

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13 March 2018

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

Summary of findings

Overall summary

This inspection took place over two days on 12 March 2018 and 13 March 2018. The first day was unannounced which meant the service did not know we were coming. The second day was by mutual arrangement.

Sedgeborough House is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older people, people living with dementia, and people with physical disabilities. Not everyone using Sedgeborough House receives regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection the service was providing personal care to 10 people.

The purpose of this inspection was to ascertain the effectiveness of the service improvement plan submitted to CQC in February 2018 and to determine if all the regulatory breaches identified at previous inspections had been met. However, at this inspection, we found continued multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of; safe care and treatment; person-centred care; need for consent; good governance; staffing; and fit and proper persons employed.

The overall rating for this service continues to be 'Inadequate' and therefore the service remains in 'special measures'. We are currently considering our enforcement options in response to the regulatory breaches identified. Full information about CQC's regulatory response to any serious concerns found during inspections are added to the report after any representations and appeals have been concluded.

We reviewed how the service sought to ensure people's medicines were managed safely. At the last inspection this had been an area of concern. During this inspection we found improvements had not been sustained and medicines were not always managed safely. Issues identified included Medicines Administration Records (MARs) not always being available in a person's own home and medicines risk assessments not always being completed when support with medicines was part of an assessed care need.

We looked at how the service sought to ensure newly recruited staff were suitable to work with vulnerable people. We looked at a sample of recruitment records and found a variety of issues including unaccounted gaps in employment history; failure to carry out a risk assessment when an employee was known to have criminal convictions; and, a failure to ensure the validity of employment references. This meant the service was not able to consistently demonstrate the suitability of candidates to work with vulnerable groups before an offer of employment was made.

In order for care to be delivered safely it is fundamental that staff receive an appropriate level of training and their skills and competency are checked. However, the service used unsupported online e-learning as the primary source of training for staff. This raised serious concerns regarding the ability of staff to process, retain and reflect upon training completed as some staff spoken with lacked awareness of the training courses they had completed and course content. Furthermore, we found serious issues in respect of moving and handling training. This training was not fit for purpose and was also delivered solely via a one hour, unsupported online e-learning and did not involve any practical sessions.

We checked to ensure staff were receiving regular supervision sessions. Staff supervision provides a framework for managers and staff to share key information, promote good practice and challenge poor practice. We found the completion of supervision sessions to be ineffective, inconsistent and not in line with company policy.

Since our last inspection the provider had introduced a mental capacity assessment tool. However, a blanket approach had been taken and the application of the assessment tool was not decision specific. This meant the service was not acting in accordance with the Mental Capacity Act (2005).

We checked to ensure people's privacy and confidentiality was protected through the safe management and storage of records. We found care files and staff personnel records were simply stored on a shelving unit in an office that we observed to be unlocked throughout the duration of our inspection visit. This was despite the fact there were frequent visitors to Sedgeborough House in connection with the provider's other business interests which operated out of the same building.

We found some improvements had been made to the overall format of care plans and the quality of information being recorded, which included the completion of an assessment before a new package of care was accepted. However, we found care planning documentation had not been provided in an 'easy to read' format for people who used the service who were living with a learning disability.

We found continued systemic failures in systems and processes which provided no quality assurance of this service from the leadership, management and governance, through to its delivery. Systems such as regular audits, which seek to assess, monitor and improve the quality and safety of the service were not carried out. Furthermore, systems and processes such as recruitment, training and recording of medication which seek to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk and which arise from the carrying on of the regulated activity, remained inadequate.

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.

The provider had failed to ensure safe and effective systems in place for the management of people's medicines.

The provider had failed to ensure that person's providing care had the qualifications, competence, skills and experience to do so safely.

The provider had failed to ensure that staff employed are of a good character and suitable to work with vulnerable people. In particular, given that personal care is provided to people in their own homes.

Is the service effective?

Inadequate

The service was not effective.

The provider had failed to ensure suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.

The provider had failed to ensure the service was acting in accordance with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had failed to maintain records securely which posed a risk to people's privacy.

The ethos and culture of the service did not provide assurance that people would receive care and support that was non-discriminatory and that took account of a protected characteristic.

Feedback from people who used the service was positive in respect of the caring nature of individual staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

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

People were not supported to express their views and to participate in decisions relating to their care and support.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager.

Continued systemic failures in systems and processes which provided no quality assurance of the service from the leadership, management and governance, through to its delivery.

Poor recruitment and selection decisions made by the registered provider raised serious concerns about the operational management and effectiveness of the service.

Sedgeborough House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The CQC last inspected Sedgeborough House in July 2017. At that time we found continued multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service received an overall rating of 'Inadequate' and was placed in special measures. Full information about CQC's regulatory response to the serious concerns found during the inspection in July 2017 will be added to that report after a legal appeal by the registered provider has concluded.

Prior to this inspection, we received information of concern in respect of three people who used the service. We shared these concerns with the relevant local authority by raising safeguarding alerts. We also used this information to inform our inspection plan.

The inspection team consisted of two inspectors from the Care Quality Commission and site visit activity started on 12 March 2018 and ended on 13 March 2018. It included reviews of records including care plans and associated documentation, staff recruitment files, staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

On the second day of inspection we visited four people in their own homes and spoke with them and/or their family member, to gather their views on the service. We obtained people's consent to look at paperwork in people's homes relating to their care. On 14 March 2018 we also attempted to contact eight members of staff by telephone but we were only successful in speaking with five staff members.

Inadequate

Is the service safe?

Our findings

In order for care to be delivered safely, it is fundamental that staff receive an appropriate level of training and that their skills and competency are checked. However, at this inspection we found serious issues in respect of moving and handling training. This training was not fit for purpose and was delivered solely via a one hour, unsupported online e-learning and did not involve of any practical sessions.

We carried out a review of one person who used the service and we established they had experienced a medical event which had resulted in a significant physical disability. This meant they required a track hoist and two staff, four times a day to support transfers. By reviewing the staff rota and through discussions with the company director, we identified the four members of staff who primarily attended to this person. We were also provided with evidence of training certificates these staff members had received in respect of the online e-learning for moving and handling training. We found two of the four staff had completed practical moving and handling training but this was back in 2014 and no refresher moving and handling training had been provided since. During telephone interviews with staff, one carer told us they had previously raised concerns with management about their own competency in moving and handling due to a lack of practical training. Despite this, the member of staff continued to be deployed to this person which exposed the person to the significant risk of harm.

This meant the four care assistants who were actively involved in the moving and handling of the person, were not suitably qualified and could not been deemed competent due to a lack of practical moving and handling training. This placed this person at a risk of harm due to risks associated with the operation of track hoists and associated body slings.

This was a breach of Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that person's providing care had the qualifications, competence, skills and experience to do so safely.

At our last inspection we found the provider could not ensure that care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable employment references had not been obtained. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was still in breach of this regulation.

At this inspection we reviewed three staff records for staff recently recruited. We found one applicant's recruitment records had been completed correctly, although we noted their employment history had not clearly been recorded between 2012 and 2016. In the other two staff files we found there was an inconsistent approach to safe recruitment. For example, we found their employment history was not fully completed, which meant there were unexplained gaps. We also found this person had multiple criminal convictions relating to theft of monies/property. This information had not been risk assessed by the provider before they commenced employment or to date, to establish if this person was safe to work in the community, alone with the vulnerable people the service supports. We also questioned the validity of one employment reference this person had provided due to lack of details provided in respect of the company. We found

there was no follow up completed by the management team to ensure they checked the reference was official.

In the second staff members file, we found dates of their employment history was not completed on the application from, no interview notes were on file and one reference obtained was a character reference which did not detail who this person was. This is of particular concern in light of staff working independently without oversight in people's own homes.

This was a continued breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure that staff employed are of a good character and suitable to work with vulnerable people. In particular, given that personal care is provided to people in their own homes.

At our last inspection in July 2017 we found the provider failed to have safe and effective systems in place for the management of people's medicines. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was still in breach of this regulation.

We reviewed one person's Medication Administration Records (MARs) with their permission during our home visits. The MARs we viewed had been signed correctly by the care workers to confirm the person had received their medicines as prescribed. However, we found this person's MARs did not always detail the month or year and had not been checked and signed by two staff members to confirm the person's medicines matched the MARs, as this provided an additional safety check to ensure the medicines prescribed were correct. Furthermore, following discussion with the company director, we established the management team were not auditing MARs once they were returned to the office. This meant the provider did not have the appropriate overview of medicines staff administered to ensure any errors were detected and resolved in a timely manner.

Since our last inspection the provider introduced a medicines dependency risk assessment that assessed people's level of ability in respect of managing their medicines. During the inspection we were informed by the company director these risk assessments had been completed for all people receiving a service. However, at another home visit, we found a person's care plan contained conflicting information and suggested their medicines were to be prompted by staff. We discussed this with the person and we were told staff administered their medicines and we found evidence staff were completing MAR charts. We also found the information in this person's care plan had not been updated since November 2016 and no medicines dependency risk assessment had been completed. In discussion with the company director, we were shown an updated care plan that had been produced but this was stored in the office and a version was not available in this person's home. The company director was unaware this information was not in the person's home. This meant staff did not have access to the up to date information in respect of this person's care and support.

This was a continued breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have safe and effective systems in place for the management of people's medicines.

Inadequate

Is the service effective?

Our findings

At our last inspection in July 2017 we found the provider had not ensured staff received an appropriate induction and relevant training to undertake their roles. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was still in breach of this regulation.

We reviewed documentation relating to training and development of staff; this included a review of the training matrix, training records and certificates. As previously mentioned in this report, a programme of unsupported training was in place delivered solely via online e-learning. Examination of training records and certificates showed staff had completed a large number of e-learning modules within a short period of time. For example, one member of staff had completed e-learning in basic life support; moving and handling; safeguarding; food hygiene; infection control; fire safety; health and safety; COSHH; mental capacity act; and challenging behaviour within one day which if completed appropriately is claimed to amount to 16 hours of training.

Another member of staff had completed E-learning in basic life support; the safe handling and administration of medicines; moving and handling; safeguarding children (levels 1 and 2); food hygiene; infection control; health and safety; COSHH; and mental capacity act, within one day which was claimed to amount to 13 hours of training. Furthermore, no assessments of competency had been completed which meant there was no assurance that staff were actually sufficiently skilled and competent to provide care safely.

Through discussions with the company director, and following a review of care planning documentation, we also found the service provided support to people living with a learning disability and behaviours that challenge. However, no specific training was provided to staff in respect of learning disabilities and the E-learning module for challenging behaviour module was not fit for purpose.

The over reliance on e-learning as the primary source of training raised serious concerns regarding the learning and development systems in place at Sedgeborough House. Furthermore, it raised serious concerns regarding the ability of staff to process, retain and reflect upon training completed. Staff spoken with lacked awareness of the training courses they had completed and course content to demonstrate the training translated to practice.

We reviewed the providers approach to staff induction and found an induction policy was in place but this had not been followed correctly. We found the provider did not have systems in place for new staff to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. This was also brought to the provider's attention at our last inspection.

The provider had not ensured that training was in place and attended in a timely manner to make sure staff were appropriately trained and competent to meet people's needs. When training was out of date or staff failed to attend there was no system in place to show how this had been addressed, or that any analysis of training had been completed regularly by the provider to address any shortfalls. This meant the provider could not evidence how they ensured staff were appropriately trained to carry out the role.

At the last inspection we found supervision sessions were undertaken by the registered manager employed at that time, every three months and staff confirmed these were happening, but this did not include an annual appraisal. At this inspection we asked to view staff supervisions and we were provided with a file that had all the current staff members' details, but did not contain any completed supervisions records. We asked the company director if supervisions had taken place and we were informed they were not sure. Throughout the inspection, no evidence was presented that assured us staff had received four supervisions as outlined in the provider's own supervision policy and procedure dated January 2017.

Comments from staff in respect of training and development included, "I think the training is basic, but I know the [company director] is trying to improve it"; "To be honest I haven't done all my module training. I need to find time to get in the office to do it. I have told [company director] I am not comfortable to use hoists until I have a refresher moving and handling training. I have not done MCA training, so I am not comfortable in this area"; and, "Training is okay, I have not completed moving and handling yet and many of the new e-learning training."

This was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Sedgeborough House provides a service to people in their own home, therefore any decision to deprive a person of their liberty within a community setting must be legally authorised by the Court of Protection. At the time of our inspection, 10 people used the service and none were subject to a court order.

At the last inspection we found a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not operating in accordance with the Mental Capacity Act 2005. At this inspection we found the provider was still not compliant and insufficient improvements had been made.

Since our last inspection the provider had introduced a new MCA assessment tool. However, a blanket approach had been taken and the application of the assessment tool was not decision specific. Similarly to the issues found at the last inspection, we reviewed one person's care file and found this contained the signature of a family member however, it was not clear if the person using the service had capacity or not. In other care plans, members of the family had been involved in making decisions regarding the care for the individual and had signed their consent, but there was no evidence on file to suggest that people using the service lacked mental capacity.

Family members must have 'lasting power of attorney' for health and welfare decisions before they can consent on behalf of the person. In the absence of an LPA, there must be a best interest's decision. The care records we viewed contained no evidence to show this authority was in place or that best interest decisions had been taken. This information is essential to ensure that decisions made on behalf of people are lawful.

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

At the last inspection we found the provider did not have sufficient guidance for staff to follow to show how risks relating to people's health and nutrition were mitigated. During this inspection, we reviewed those people who required support with eating and drinking as part of an assessed care need; this included one person who was deemed at high risk due to swallowing difficulties which placed them at a risk of choking. We saw improvements had been made in the quality of information recorded in care records. For example, the Speech and Language Therapy (SaLT) swallowing assessment and guidance was available to staff in respect of how this person's food and drink should be prepared. On this basis, we were satisfied that the provider was no longer in breach Regulation 12 specifically for the risks associated with eating and drinking.

Requires Improvement

Is the service caring?

Our findings

Whilst at the provider's office location of Sedgeborough House, we checked to ensure people's privacy and confidentiality was protected through the safe management and storage of records. We found care files and staff personnel records were simply stored on a shelving unit in an office that we observed to be unlocked throughout the duration of our inspection visit. This was despite the fact there were frequent visitors to Sedgeborough House in connection with the provider's other business interests which operated out of the same building.

This was a breach of Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to maintain records securely.

Prior to the inspection of Sedgeborough House, we received information of concern in relation to alterations that had been made by the provider to the call times for one person due to the service being short staffed. During this inspection we reviewed this person's care records, spoke with the company director and visited this person and their family at home. We established the night time care call had been brought forward by one hour which now meant this person received their last call at 8.30pm. However, the next care call would not be until around 10.00am the next morning. This meant this person remained in bed for fourteen and a half hours in between care calls.

By reviewing daily records completed by staff, we found written entries that described this person as being 'soaked' and the bed 'wet through' in reference to the fact they were incontinent of urine. Through discussions with the company director, we confirmed this change to the last call was in response to staff shortages. However, we saw no documentary evidence that this had triggered a review of this person's package of care to ensure the service could continue to meet their needs. When we visited this person at home, due to their health issues they were unable to communicate their wishes to us, but we spoke with this person's relative who was also the main carer. The relative did not express a view either way in respect of this change, but we were of the view this had simply been accepted by the family as an inevitable part of receiving care at home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not take sufficient steps to ensure people using the service were not left in undignified situations.

During the inspection we visited four people who used the service in their own homes. Feedback from individuals and their families was positive in respect of the caring nature of staff. Comments included, "I don't know what's going on in the office but as far as the staff that come here are concerned, I think the staff are caring."; "They do tend to call if they're running late and I've no concerns about the staff." and, "The staff are OK, they come in, do their job and go. Nothing special but no concerns really."

Sedgeborough House served a diverse and multi-cultural community and the client base was reflective of this. We therefore looked at the service's approach to equality, diversity and human rights (EDHR) and how people from different backgrounds were supported. Whilst we saw the service had an equality and diversity policy we saw no tangible examples of how this was applied in practice. Furthermore, it was not clear to us how the ethos and culture of the service sought to ensure people received care and support that was non-discriminatory. In particular, how the needs of people with a protected characteristic were considered. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination on the basis of age, disability, race, religion or belief and sexuality.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the provider had failed to ensure care plans reflected people's assessed needs, personal preferences and current support needs so that people received person centred care.

During this inspection, we found some improvements had been made to the overall format of care plans and the quality of information being recorded, which included the completion of an assessment before a new package of care was accepted. However, two people who used the service were living with a learning disability, and care planning documentation had not been provided in an 'easy to read' format.

One person told us the staff would sometimes read out aloud the information contained in the care plan but they would have preferred to have had the information in an accessible format for them to read at any time. However, this person told us this was not possible because they could not understand the care plan in its current format.

In respect of the second person who used the service, as previously mentioned in this report, the care planning documentation in their own home was out of date which meant it had not been reviewed and updated timely and thus was not reflective of their current needs. This was in addition to no information being provided to this person in an easy to read format.

We looked at how people were supported to express their views and participate in decisions relating to their care and support. Despite the service only having 10 people who were in receipt of a package of care, we found the involvement of people was sporadic with no systematic approach.

We were told that three monthly reviews were completed with people but we only found documentary evidence to support that two people had been involved in a review and these were both completed in November 2017. More widely, similarly to our findings at the last inspection, it wasn't clear from these reviews whether the member of staff completing the review had discussed aspects of the care plan with people or the staff team, due to the limited information recorded. We found these reviews continued to be focused on the general quality of the service and whether people were happy with the care that was provided, rather than a meaningful person-centred review regarding whether the care being provided was meeting their needs.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure care plans reflected people's needs, personal preferences and current support needs so that people received person centred care.

Due to the time constraints of packages of care provided by Sedgeborough House, there were little or no opportunities for staff to engage with people who used the service to enable them to access community based activities.

At the time of our inspection, Sedgeborough House did not provide end of life care. Within the City of Manchester, the expectation would be that if a person in receipt of a care at home service required end of life care, the care package would be transferred to another provider.

Inadequate

Is the service well-led?

Our findings

We last inspected Sedgeborough House in July 2017. At that time we found continued multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service received an overall rating of 'Inadequate' and was placed in special measures. Full information about CQC's regulatory response to the serious concerns found during the inspection in July 2017 will be added to that report after a legal appeal by the registered provider has concluded.

In response to the regulatory breaches found at the last inspection, the registered provider had sought the services of an external social care consultant. An improvement plan had been developed and was implemented on 18 September 2017 and included updates of actions up until 18 January 2018. In February 2018, the registered provider gave written assurances to CQC through the improvement plan, that the risks identified to people would be mitigated and the regulations would be met. However at this inspection we found very few improvements have been made. Additionally, we are further concerned by the evidence obtained during this inspection and the service's inspection history that the registered provider does not have the knowledge and capability of taking appropriate remedial action.

Since the departure of the previous management team, the company director had again assumed day to day operational management of the service since February 2018. However, following the last inspection of Sedgeborough House, it was accepted by the company director that despite their involvement in the management of the service, they lacked the necessary skills and experience within the adult social sector and lacked knowledge and understanding of the regulatory framework in which the sector operates. Verbal assurances were previously given to CQC that they would seek to gain a formal qualification in social care and gain a broader understanding of the regulatory framework. However, since the last inspection, no positive action has been taken by the company director in this regard.

Along with the company director, we reviewed the improvement plan to ascertain progress. We asked the company director whether or not they considered all of the actions as detailed in the improvement plan to have been completed. The company director told us the previous service manager, deputy manager and training manager were responsible for the improvement plan but as they were no longer employed, the company director was unable to confirm if all the actions had been completed. This meant they had not provided any oversight to ensure this was achieved or that actions identified were being completed.

We also reviewed what appeared to be a working copy of the improvement plan that was located in the back office of Sedgeborough House. This copy contained hand written notes and indicated whether or not an action had been completed, was ongoing or not completed. For the areas of the improvement plan that indicated actions had been completed, we asked the company director to provide us with evidence of tangible examples that would offer assurance about the quality and safety of service but none could be produced. This demonstrated there was insufficient understanding and oversight of the improvement plan. Furthermore, the regulatory breaches identified during the inspection demonstrated the improvement plan had not been effective despite previous assurances given to CQC that it had.

We reviewed what systems and processes were in place by means of formal audit and quality monitoring to ensure the safety and quality of services being provided and to demonstrate good governance. We reviewed a file entitled 'audit' which contained an index sheet detailing the frequency in which audits would be completed, it stated: Training audits – monthly; Surveys – quarterly; Health & Safety – quarterly; Personnel files – monthly; Care plans – monthly; Infection control – monthly; and, Medication/MAR – 2 weekly. However, documentation contained within the audit file was not reflective of the index sheet and was either of a poor quality, incomplete or missing.

We therefore found continued systemic failures in systems and processes which provided no quality assurance of this service from the leadership, management and governance, through to its delivery. Systems such as regular audits, which seek to assess, monitor and improve the quality and safety of the service were not carried out. Furthermore, systems and processes such as recruitment, training and recording of medication which seek to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk and which arise from the carrying on of the regulated activity, remain inadequate.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to ensure systems and processes were established and operated effectively to ensure compliance.

Since our last inspection of Sedgeborough House, the service had been without a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.