Rose Cottage (Middlesex) Ltd

Rose Cottage

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 28 September 2017 and was unannounced. The last inspection took place on 24 February 2016, when we identified breaches of Regulations relating to staffing and good governance. We rated the service 'Requires Improvement' in three of the key questions we ask providers and overall. During the 28 September 2017 inspection, we saw the provider had not made enough improvements to the service to meet the Regulations.

Rose Cottage is a family run business registered to provide accommodation and personal care for up to five adults. The service supports people with learning disabilities, including autism, and people who may also have a physical disability. At the time of the inspection there were five men using the service.

The service had not had a registered manager since December 2015. The company director and the deputy manager were sharing the duties of the registered manager. On the day of the inspection we met the deputy manager but not the company director. 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.

During the inspection, staff could not always provide a good account of the types of abuse and how to keep people safe from potential harm. Risk management plans were not always robust and we could not be sure they reflected people's current needs. There were no lone working risk assessments, despite one member of staff being on duty at night. Completed incident and accident forms did not have a record of the action to take to minimise the risk in the future and not all incidents had been recorded. People using the service did not have personal emergency evacuation plans to minimise identified risks and help ensure people were not exposed to the risk of harm in the event of an emergency.

The premises were not always safe or fit for purpose for the people using the service, staff or visitors. Nor were the premises always clean, secure or properly maintained.

Medicines were not always managed in a safe manner as we found one person had an excess of two tablets indicating they had not received the medicine as prescribed. There were no medicines protocols or plans in people's care files where medicines had been prescribed to be given as required and the weekly medicines reconciliation was not recorded.

The provider had not ensured there were sufficient staff on duty to meet the needs of the people using the service and the provider did not always follow safe recruitment procedures to take sufficient steps to ensure staff were suitable to work with people using the service.

The deputy manager said training was up to date but did not show us any evidence to confirm this, so we could not be sure staff had all the required support to help them to develop their professional skills.

However, we did see staff received regular supervision.

The principles of the Mental Capacity Act 2005 were not being followed as authorisations under the Deprivation of Liberty Safeguards were not applied for in a timely manner and care plans did not record consent or identify how people were supported to make decisions.

We saw little evidence of positive interaction between staff and the people using the service and on the day of the inspection there was no activity.

We did not see evidence that the provider involved people in their care planning and care plans were mainly task orientated and were not person centred.

The provider did not have effective quality assurance procedures. They did not ensure record keeping was always complete or contemporaneous and there was no analysis of information to develop and improve service delivery.

People's dietary requirements were met and we saw evidence that relevant health care professionals were involved to maintain people's health and wellbeing.

People were supported to have choice and staff knew people using the service well. Relatives' surveys were positive about the level of care provided. Staff told us the deputy manager was approachable. We saw the provider followed their complaint procedures.

We found seven breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing and fit and proper persons employed.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Not all staff could identify the types of abuse and respond to keep people safe from harm.

Risk management plans were not always robust enough to provide the necessary information to help staff maintain people's safety.

The provider did not carry out appropriate risk assessments where staff were lone working and did not analyse incident and accident forms to identify trends and patterns to help prevent reoccurrence.

People did not have personal emergency evacuation plans to address their safety in the event of an emergency.

Medicines were not always managed safely.

There was not always a sufficient number of staff deployed in the home to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider could not evidence staff had appropriate support through training and yearly appraisals, but they were able to show us staff had regular supervision.

The provider did not always follow the principles of the Mental Capacity Act 2005 to help protect people's rights.

People's nutritional needs were met and people had access to relevant healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always maintain caring relationships with people

using the service. We observed very little interaction between staff and people using the service on the day of the inspection.

We did not see evidence of people being involved in their care planning or being supported to make decisions about their care but people's likes and dislikes were recorded in care plans and they were offered some choice.

The service did not have easy read documents and the files provided minimal information about the best way to communicate with individual people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Reviews were held monthly but there was no evidence care plans reflected people's changing needs.

The provider did not ensure people in the home were engaged in meaningful and stimulating activities.

The service had a complaints procedure and relatives knew how to make a complaint if they wished to.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor the quality and safety of the service and to ensure people's needs were being met were not always effective.

The provider did not have proper systems to assess and monitor risks at the service. They did not analyse incidents and accidents to identify the cause so as to prevent reoccurrence.

The deputy manager was accessible and available to people and staff if they wanted to raise any issues.

Rose Cottage

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 28 September 2017 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection, we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We viewed the action plan the provider sent us following the last inspection and we contacted the local authority's locality team and safeguarding team for their feedback about the service.

We spoke with one person using the service. The majority of people using the service were not able to share their experiences about living at the service with us. However, we spent time observing the way staff engaged and interacted with people. The company director was not available on the day of the inspection but we spoke with the deputy manager and three care assistants.

We looked at the care plans for four people who used the service. We saw personnel files for five staff which included their recruitment, supervision and some training records. We reviewed medicines management for three people and we also looked at records for monitoring and auditing the quality of the service.

After the inspection we spoke with one relative to gather feedback on their experiences of the service.

Inadequate

Is the service safe?

Our findings

During the inspection on 28 September 2017, we saw the provider had safeguarding and whistleblowing policies in place to safeguard people using the service. However, we were not confident all the staff had received the training they needed around safeguarding adults as not all staff were able to give a good account of the types of abuse possible and how to manage safeguarding concerns appropriately. In addition, only one out of three members of staff understood about whistleblowing. Most staff said they would tell the deputy manager about any concerns and if necessary the local authority and the Care Quality Commission.

The provider did not always assess the risks to the health and safety of people using the service. Risk assessments we viewed were not robust as the evidence of the review taking place was a record of the date the risk assessment was reviewed instead of an updated evaluation of the risks people faced and the effectiveness of the management plans to mitigate the risks. This meant we could not be sure risk management plans reflected people's current needs. For example, one person's care plan from 2015 said they no longer displayed challenging behaviour but they had risk assessments dated February and September 2016 and March 2017 to manage a behaviour that they were no longer showing.

The lone working policy stated suitable and appropriate risk assessments would be completed when staff were lone working. However, the service did not have lone working risk assessments even though staff always worked alone from 10pm until 7am, were left alone at times during the day with people using the service and the deputy manager told us staff went out with more than one person alone. The lack of risk assessments to assess how a lone worker could manage the care and support of more than one person if there was an emergency, meant there were inadequate systems in place to manage risks to staff, people using the service and others. Emergencies could include real scenarios such as a person having an epileptic fit during the night with one person on duty or if they were in the car with other people and one staff member driving.

The provider did not always do all that was practical to mitigate risks to people using the service. The incident and accident policy stated a form should be filled out for each incident and accident and submitted to the manager to take steps to minimise the risk. However, the incident and accident form did not have an outcome or action section to indicate how the risk was minimised and that the provider was satisfied the risks were being managed appropriately to prevent similar incidents and accidents from happening again.

When we asked the deputy manager to show us the incident and accident records for the service, they showed us an accident form dated 2 October 2016 and told us there has been no other incidents. However, we later saw a record in one person's file of an incident on 23 June 2017, which described an incident between two people using the service while out in the community. The record also indicated that although tension had been building up between the two people during the day, the decision had been made to take them out together. There was no recorded action or outcome to prevent the incident from happening again. The care plan to manage the person's behaviour was not reviewed or updated and the incident was not recorded in the incidents and accidents records in a systematic way. This meant the provider was not doing

all that was reasonably practicable to assess, monitor and mitigate risks to people to help ensure they were not exposed to the risk of harm.

Furthermore, in the same person's file we saw recorded on a Deprivation of Liberty Safeguards application that between January and August 2016 they had six incidents of challenging behaviour and 11 incidents of restraint. These were not recorded as incidents and accidents and the deputy manager said there had been no further incidents since August 2016 but provided no explanation as to why the behaviour ended so abruptly.

The service had a fire strategy document that said all five people living at the service could walk out the door independently if there was a fire, however there were no individual personal emergency evacuation plans (PEEPs) to indicate what specific support each person may need. When we discussed this with the deputy manager, they considered the fire strategy document sufficient because people could independently mobilise. The lack of PEEPs meant there were insufficient measures in place to minimise identified risks and help ensure service users were not exposed to the risk of harm. A staff member said, "Fire drills are every two weeks and all residents can evacuate by themselves if you tell them."

The premises were not always safe for the people using the service, staff or visitors. We looked at the windows in people's bedrooms and saw that the top windows opened without window restrictors and it was straightforward to override the restrictors on the bottom window, but there were no risk assessments addressing people's health and safety regarding the environment, such as the risks of falling from a height.

There was a freezer chest in the kitchen with a lid on it that was not attached. The kitchen door was no longer fit for purpose as a fire door to protect the lounge from fire. The auto guard that would close the door in the event of fire had been removed and the fire seals had been painted over so the door was no longer smoke tight. We observed cleaning products in the laundry room and kitchen were not kept in a safe and secure way. The cupboards in both rooms were open and we saw detergents and cleaning products such as drain cleaner and bleach easily accessible to people using the service. One of the bleach bottles had been transferred to another bottle and was leaking. The fridge had a number of opened, outdated condiments in it, for example applesauce with a use by date of October 2016. We also saw cooked food in Tupperware without a date of when it was made and some foods were not stored with the correct lids on them so they were not airtight.

The garden was neither secure nor safe. The fence in the back right hand corner was not secure and it was possible to go through it. That corner also had plastic rubbish, bits of wood and bricks in it. We saw the lawn mower was kept in an open shed and two metal poles against a fence. There were pieces of metal and wood lying around the garden including a piece of wood sticking up with three nails in it. This was made more concerning by the fact we observed one person go out into the garden with bare feet. The failure to assess, identify and mitigate risks in relation to the premises and environment meant service users were exposed to the risk of harm.

Medicines were not always managed in a safe manner. The medicines policy stated observations of medicines administration by staff should be carried out three months after training and annually thereafter. However, there was no evidence of this. The medicines policy had PRN (as required) guidelines that stated, 'to ensure PRN medicines were given as intended a specific plan must be recorded in people's care plan which should be kept with the medicines administration records (MAR)'. There were no PRN medicines plans in people's care files and we saw one incomplete PRN form at the back of the MAR charts.

We looked at the medicines for all three people using the service who required medicines and reconciled the

MAR charts with a stock check. We found one person had an excess of two tablets indicating medicines were not being taken as prescribed. One person was administered controlled drugs. We saw these were not kept separately from the other medicines and the record in the controlled drugs book sometimes only had one signature instead of two as required. The deputy manager told us they completed a weekly reconciliation of medicines stock against the MAR chart, however they did not record this.

The above paragraphs show that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not ensure that the premises and equipment used were always clean, secure and properly maintained. The service did not have a record of cleaning tasks. The deputy manager told us they or the provider visually checked the home each day for cleanliness. However, we saw an overflowing bin in an en-suite bathroom and toilets that were not cleaned properly. In the upstairs communal bathroom there was no toilet paper, soap or towel and there was mould around the bath. In the kitchen we saw one shared towel for everyone. The floor in the lounge area was coming apart and a trip hazard which was unsafe for people with mobility issues and bare feet. The hood on the cooker was coated with grease and therefore a fire hazard. One oven was missing a dial on the outside and had dirty baking trays in it. The other oven had the remains of a pizza from lunch three hours earlier. This meant the provider did not always deliver services in a clean and well maintained environment that was suitable for the intended purpose of care.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always follow safe recruitment procedures. A new member of staff who had previously worked permanently with the service eighteen months ago had moved from the agency they were working for, to permanent staff in July 2017 but the deputy manager was unaware of this. The member of staff had not completed a new application form and we saw that although they had previously worked in social care, only one work reference was sought and there was no employment history. Their criminal record check was from a previous social care provider and dated April 2015. We also did not see any updated induction forms or training since they had recommenced employment with the service. This meant there had not been checks on what had happened in the eighteen months since the staff member had left the service and the provider had not taken sufficient steps to ensure staff were suitable to work with people using the service.

The newest member of staff was shadowing another staff member on the day of the inspection. The provider was waiting for character references to come through and the member of staff had not previously worked in social care. Their training record stated they were given a care certificate workbook in August 2017 but there was no indication of an induction or what training they had done prior to shadowing to prepare them to provide appropriate care and support to people using the service. Therefore we could not be sure fit and proper staff were employed to work with people using the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was a family run business staffed by the company director, four family members and two other staff members. A fifth family member was in the process of becoming a member of staff and the deputy manager said another person was also in the process of being employed by the service. Sometimes the service used agency staff but there was not a profile held for agency staff. We observed the provider did not have sufficient staff on duty. One person's care plan indicated that they required one to one support due to a medical condition, another person's risk document said they could become agitated during activities and

a third person's care plan said they required the support of two people in the community. However, the rotas did not always indicate there were enough staff to support people's needs in this way as there were generally only two to three staff on shift at a time. For example, we saw on a Monday morning one person walked independently to their day activity. Another person attended college and when one staff member drove them to college at 9:30am, they took two of the other people using the service with them for the drive. However, one of these people was the person who required the one to one because of their medical condition. This meant if there was a medical emergency the one staff member would need to be available to address the emergency and also keep the other two people safe.

On the day of the inspection, a member of staff told us they were required to provide one to one support to a person but we saw them support another person to change their clothes leaving the first person without staff support. At a later time in the morning, an inspector alerted the same member of staff that the same person they had taken upstairs earlier required support with personal care and the staff member said they could not leave the person they had left earlier because they were providing one to one support.

The deputy manager said the service could not do the planned activity on the day of the inspection because they (the deputy manager) were busy with the inspectors. There were two staff supporting people, but one staff member was not yet inducted and could not be left alone with people. This effectively meant there was one member of staff supporting five people, including the person who required one to one, while the deputy manager was talking to us. Due to our concerns about people being left alone and the lack of staff interaction, we asked the deputy manager whether there should be another member staff to support people. Another member of staff came in at lunchtime. However, this indicated to us that had there been an emergency, there would not be enough staff to cope with it. This also showed that people were not getting the support they required to meet their needs. As most people relied on staff for support with activities, the lack of staff impacted on people's quality of life and meant they could not engage in the activities they enjoyed.

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

The provider had some arrangements to deal with a fire emergency. The fire alarm system was tested weekly and the emergency fire equipment monthly. The last fire drill was undertaken on 8 August 207. The provider also maintained equipment and ensured gas safety, legionella and electrical testing were carried out in the last year.

Requires Improvement

Is the service effective?

Our findings

At the inspection on 24 February 2016, we identified a breach of Regulation relating to staffing because the files we viewed did not have training records and there was not a development plan for staff training. Following the inspection, the provider sent us an action plan dated June 2016, which indicated how they would address the identified breach.

During the inspection on 28 September 2017, we saw the provider had not fully met the Regulation. The deputy manager told us two staff were enrolled to start their care certificate and that all staff had either completed or were undertaking their NVQ2 level 2 which included the required training such as safeguarding. The care certificate is a qualification that identifies specific learning outcomes, competencies and standards in relation to people new to health and social care. However, the deputy manager not able to show us a database to indicate for each staff member when they had completed a course and when the next one was due. The deputy manager said completed course certificates were kept in staff's individual files and further training was discussed in supervision but the information we saw in the files was not up to date.

For example, the staff member who was providing support to the person with a medical condition had not had training for that medical condition since 2015. One person's risk assessment said only trained staff could employ restraint procedures but we did not see the relevant training in staff records. We looked at six staff files and only one staff member had a record of completed safeguarding which was done in 2016 and only two staff members had a record of medicines training, also completed in 2016.

The deputy manager was unable to provide supervision, appraisal or training records on the day of the inspection. Eight days after the inspection the company director emailed us staff supervision records but did not oblige our request to email appraisals or a training data base to indicate the dates staff had completed specific training such as adult safeguarding and when training was next due. We saw supervision records from 2017 for five members of staff. Supervision covered areas such as performance and indicated all staff were undertaking NVQ training.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The principles of the MCA were not being followed as DoLS were not applied for in a timely manner and care plans did not record whether people had consented to their care or identify how people were supported to make decisions. The DoLS authorisations for two people using the service expired in August 2017, but the service waited until that time to apply for new DoLS authorisations as they thought people were being moved by the local authority imminently. Consequently, although DoLS applications had been submitted they had not been authorised meaning two people had their liberty restricted without the necessary authorisation.

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

People's dietary requirements and food likes and dislikes were recorded in their support plans. Staff cooked for people using the service and we were told people had a choice of vegetarian or non-vegetarian meals. People had enough to eat and staff said people could have a snack whenever they wanted.

The staff provided appropriate support to meet people's day-to-day health needs. People had health action plans however these were not all up to date. We also noted that the person who required full time supervision for their epilepsy did not have an up to date record of seizures. This meant people's files did not always have accurate information about people's needs to enable appropriate support. We saw some people had monthly weight chart records and the GP visited the service every weekend. Each person had a medical appointments record and there was evidence of people being supported to access the GP and community psychiatric nurse.

Requires Improvement

Is the service caring?

Our findings

During the inspection we saw little evidence of positive interaction between staff and the people using the service. Only one staff member was available to support people while the deputy manager was talking to the inspectors. The second staff member was shadowing and could not be left alone with people. People and staff were watching television most of the morning.

One person was left alone with one of the inspectors for the morning with no activity. The equipment for their preferred activity was broken and when we asked the deputy manager about it, they said it was up to the family to repair the equipment. However, in the meantime no alternative activity had been identified. Furthermore, the inspector had to alert the staff member to the person requiring support with personal care, as staff were not interacting with the person and checking if they needed any care.

We did not see evidence of people being involved in their care planning or being supported to make decisions about their care. However, we did see some likes and dislikes recorded in care plans and staff told us, "When I come here, I read their profile to know what they want or need. Most of them can speak for themselves and by that communication, you know their needs" and "I read care plans and go through folders [to know people's individual needs]."

The provider did not have proper arrangements to help people understand information so they were able to make informed decisions. The provider did not have easy read documents and policies and procedures that people might wish to have access to. People's care and the files also provided minimal information on how to communicate with them, particularly if they did not communicate verbally.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us people's independence was promoted by offering people choice. Comments included, "I ask what they want to eat, and they choose" and "Have a conversation and ask questions, for example, you need their consent to go into their room or to deal with finances. Check out with them before doing anything involving them. They have to give their consent." Regarding how to support people with personal care staff said, "I approach them in a way they can understand personal care. Before you start you have to tell them what you're about to do to them."

Requires Improvement

Is the service responsive?

Our findings

At the time of the inspection, we found that care plans for two people using the service were dated 2014 and 2015. Reviews were held every six months but the only evidence of a review was a date recorded when the review took place. There was no indication that care plans were updated to reflect people's progress or changing needs, nor was there any evaluation to demonstrate the care plans were effective in meeting people's needs. The deputy manager said this was because there was not any changes to people's needs. We were told by the deputy manager that families were not invited to the reviews to provide feedback, although a relative told us recently they had been involved in care planning because people at the service were moving to another service and the local authority had become involved with the planning. Care plans were not written in a format, such as easy read to be more accessible to people using the service. Consequently, we did not see evidence that people were supported by Rose Cottage staff to be involved in planning their care. This meant we were not assured people were receiving care that was in line with their needs, preferences, likes and dislikes.

The inspection team was at the service from 9am until 6pm and we observed little interaction between staff and people using the service. During the nine hours we were present, staff supported people to leave the building once for less than an hour to go to the shops, otherwise for the most part of the day, they watched television with people. The deputy manager said they had all planned to go out bike riding that day but could not go because the deputy manager was involved in the inspection. However, they did not offer an alternative activity to people or call more staff in to support people with the planned activity. As a result there was no meaningful activity that day for people using the service.

Care plans were mainly task orientated instead of person centred, and did not give much background information about people's preferred activities and how people were being supported to develop independent living skills. People had activities schedules in their files but we saw these were not all up to date. For example on the day of the inspection, one person's schedule indicated a community activity but they were in the house all day. The care records showed people participated in a number of regular community activities including college, day service attendance, a gardening club and youth club. A staff member said, "Activities depend on people's needs. Persons A, B and C go to the cinema and for walks. Person C attends a day service three times a week. Person D attends youth club and D and E participate in a weekly gardening club. Everybody goes cycling at the park." Daily record were also task focussed and had not been completed by staff for two weeks prior to the inspection.

The above paragraphs were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure and the last complaint recorded was in May 2007. We saw one relative had raised a concern in their survey feedback and the deputy manager had responded to the concern appropriately by email and provided a copy of the complaints procedure which the relative opted not to use.

Inadequate

Is the service well-led?

Our findings

At the inspection on 24 February 2016, we identified a breach of regulation relating to good governance because the provider did not effectively assess, monitor and improve the quality and safety of the service. Following the inspection, the provider sent us an action plan dated June 2016, which indicated how they would address the identified breach.

During the inspection on 28 September 2017, we saw the service had not met the Regulation. Our findings during the inspection showed the service was not managed in a way that promoted safe care and that the systems in place to monitor the quality of the service so the provider could identify areas for improvements and address these, were not robust or effective. The management structure, systems and oversight of the provision of service and the care people received were also lacking and did not provide assurance that improvements could be made within the service and that these would be sustained.

The quality assurance checklist indicated that a number of audits with dates had been completed, such as for medicines. These however did not indicate how the audits had been carried out, the findings of the audits and whether any remedial actions were required to address areas for improvement, where these were identified. There were, therefore, no clear outcomes and what action was being taken to make any improvements.

The systems in place did not identify concerns raised during the inspection and therefore the quality and safety of the service was not monitored effectively or risks adequately minimised to keep people safe from harm. The deputy manager told us they completed a weekly reconciliation of medicines stock against the MAR chart, however they did not record this and our reconciliation of medicines evidenced the medicines stock did not balance with what was recorded on the MAR charts. The arrangements in place to check and provide assurance that people's money was being managed appropriately were not effective. We looked at three people's cash sheets and reconciled them against their money. The reconciliations were out by 3, 20 and 47 pence each.

The deputy manager said they audited daily records weekly but we saw the daily records for the five people using the service had not been completed since 15 September 2017, which was two weeks prior to the inspection. This meant the provider failed to maintain accurate, complete and contemporaneous records in respect of each person that could be used to assess monitor and improve the quality and safety of the services provided. In addition, neither staff records nor people's care records were audited which meant areas lacking documents such as risk assessments, were not identified and monitored and there were no audits in place to monitor the incidents and accidents that happened in the home to prevent reoccurrence.

Furthermore, the service had not had a registered manager since December 2015. The company director and deputy manager were sharing the responsibility of the registered manager's duties. This resulted in a lack of consistency and clear leadership of the service.

The deputy manager told us the provider did not have residents' meetings but did have house meetings that

families could attend with people using the service. However, the only record of a house meeting was minutes in May 2017 by the local authority regarding transition plans to move people from the home. We did not see any minutes for any other house meetings. This meant people's views about the service were not sought through house meetings.

These paragraphs show that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw relatives' surveys from August 2017. The provider received mixed comments from the surveys. These included, 'Excellent care for [person] and other residents by skilled workers' and 'All good so far'. One relative said toiletries and personal care were not always as they would expect to have it. Another said when they returned with their relative to the home, the sleep in staff did not hear the doorbell. The relative told us they did not want to make a formal complaint and the deputy manager dealt with the issue appropriately. Relatives also helped people using the service to complete surveys and the responses on these were 'very satisfied' and 'satisfied'.

Staff told us the deputy manager was approachable. Comments included, "First I come to [the deputy manager]. If it is something I know [the deputy manager] can't sort, I go to [the provider]", "[Deputy manager] is approachable", "[The deputy manager] gets involved in care plans and reviews" and "[The deputy manager] is an accessible manager. He's always willing to listen and he is always noticing things."

We saw minutes for staff meetings held in May and August 2017 with a standing agenda of staffing, service user updates, health and safety, training and suggestions to improve the service.

The deputy manager was supported in their role by the company director and had just completed their NVQ level 5. They kept up to date with developments in the sector through emails from the company that provided the service's policies and procedures.

The provider knew when to report incidents to the local authority and the Care Quality Commission. There had been no safeguarding alerts in the last year.