Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Old Rectory

45 Sandwich Road, Ash, Canterbury, CT3 2AF

Tel: 01304813128

Date of Inspections: 27 June 2014
26 June 2014

Date of Publication: August 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✗ Action needed
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Requirements relating to workers	✗ Enforcement action taken
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Enforcement action taken
Records	✗ Enforcement action taken

Details about this location

Registered Provider	R Cadman
Overview of the service	The Old Rectory provides accommodation and personal care for 40 people who have a learning disability.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	7
More information about the provider	7
Our judgements for each standard inspected:	
Respecting and involving people who use services	8
Consent to care and treatment	11
Care and welfare of people who use services	13
Safeguarding people who use services from abuse	16
Requirements relating to workers	18
Supporting workers	21
Assessing and monitoring the quality of service provision	23
Records	25
Information primarily for the provider:	
Action we have told the provider to take	27
Enforcement action we have taken	29
About CQC Inspections	31
How we define our judgements	32
Glossary of terms we use in this report	34
Contact us	36

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 26 June 2014 and 27 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other authorities. We talked with other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

The inspection team was made up of four inspectors. We visited the service over two days.

We spoke with the people who used the service, the provider, the deputy manager, the head of care and care staff. We also observed staff supporting people with their daily activities.

The Old Rectory can provide accommodation for up to 40 people who have a learning disability. There were 37 people using the service at the time of our inspection.

We considered our inspection findings to answer questions we always ask:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well-led?

This is a summary of what we found. This summary is based on our observations during the inspection, discussions with people using the service, staff supporting people and the management team:

Is the service safe?

The service was not safe. There were no systems in place to make sure that the staff

learned from accidents and incidents.

When people had accidents the most appropriate and safe action was taken to make sure they received the treatment they needed.

Assessments were not undertaken to ensure that people received safe and appropriate care.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The relevant people were consulted with regard to people's mental capacity and the deprivation of people's liberty was taken into account.

People using the service told us that they felt safe.

Care and support plans detailed each person's individual needs. When risks to a person were identified the home carried out a risk assessment. However, care plans relating to continence needs were not always followed by staff.

Recruitment processes were not safe. This was because there were not robust procedures in place. There was no evidence that potential risks had been assessed when people had criminal convictions or poor references. The provider had not taken action to protect people who used the service from risks posed by staff that were not honest or of good character.

Is the service effective?

The service was not effective. Some care and support plans referred to out of date information so were not current.

Staff had not filed some people's records correctly so they were not easily accessible. There were loose documents and paperwork which could get lost or damaged.

Some people were unable to communicate verbally and used signs and gestures. Staff were able to tell us what signs were displayed if someone was agitated and what they could do to reassure them. We observed staff communicating effectively with people throughout our inspection.

The provider did not operate an effective system to regularly assess and monitor the quality of the service provided. The service had a complaints process in place and information had been given to people about how to make a complaint. The easy read version of this process had recently been updated, but had not been shared with people using the service.

There were no structured systems in place to ask relatives and staff for their views about the service. There were no staff meetings. This meant that people's representatives and staff did not have opportunities to air their views and opinions.

Is the service was caring?

The service was caring. People were supported by kind and attentive staff. Staff showed patience and gave encouragement when supporting people. People we spoke with said

they felt staff respected their privacy and dignity and said that staff were polite and caring. People we spoke with said they liked the staff.

We found that people were supported to attend health appointments, such as, doctors or dentists. We saw records to show that the service worked closely with health and social care professionals to maintain and improve people's health and well-being. However, we found that action was not always taken when recommendations had been made by health professionals.

We saw positive interactions from staff when supporting people throughout our inspection.

Is the service responsive?

The service was responsive. People told us that they were happy with the service. It was clear from observations and from speaking with staff that they had a good understanding of the people's care and support needs.

We saw records to show that the service worked closely with health and social care professionals to maintain and improve people's health and well-being.

Staff were attentive to people using the service and responded promptly when needed.

Regular meetings were held with people who use the service to express their views on the day to day running of the service. However, there was limited participation with people who were less assertive or who had communication difficulties.

Is the service well-led?

The service was not well led. The provider was not in day to day control of the service.

There was a management structure in place. The provider and the management team knew about some of the shortfalls at the service but no action was taken to address these. They did not take responsibility for things that happened in the service and did not implement changes to address the shortfalls and concerns.

The provider did not operate an effective system to regularly assess and monitor the quality of the service provided. This meant that the people could not be confident that their health, safety and welfare would be protected.

Audits of the care plans and other systems used at the service had been not been completed to assess the quality of the care being provided. The service had not identified the shortfalls in the care plans found at the inspection. Therefore the systems in place to audit the care plans and risk assessments was not effective to make sure people were receiving the care they needed.

Staff told us they were clear about their roles and responsibilities and that they felt supported by the management team.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 03 September 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against The Old Rectory to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We spent time talking to people who used the service, observing their day to day activities and their interactions between staff and other people. We found that the routines in the home formed a structure for the day and people said they were happy with this. There was some flexibility to the routines because staff were responsive to people when they asked about their personal care, wanted refreshments and wanted outings to be arranged on an individual basis. The provider may wish to note that the numbers of people using the service compared to the staffing and the way the home was organised may restrict people's experience of individualised care.

People who used the service were provided with some opportunities to be independent and for community involvement. Some people were independent and able to manage road safety, used public transport and purchased items in shops with an awareness of money. Other people were able to go out with staff support to participate in these activities. There was some turn taking in individual activities that required staff support due to the number of people using the service. Some people told us they had lived in the home for a long time and had got to know people in the village, at the local shop and pub. One person said, "I go out quite a lot. I like it here."

The provider gave people opportunities to participate in community projects and events that were run by the provider. People talked about these projects with enthusiasm and told us about the jobs they did. One person spoke about gardening. They said they enjoyed it and together with other people they talked about the vegetables they had planted and watched grow. People said they were excited because some of the produce was ready and was being cooked in the meals that week. This meant that people were involved in activities that were meaningful and of value.

People who used the service were supported to say how they wanted their care to be given. Meetings were held with some people to enable them to discuss the routines in the

home and their care. Minutes were taken and action agreed in response to suggestions. People who had communication difficulties or who were less confident needed more support for their views to be heard separate to the meetings. There was no documentation to show that individual meetings with people who needed additional support took place.

People with communication difficulties had been referred to the speech and language therapist and had received advice and support. We saw communication assessments in care plan folders. These included descriptions of known gestures people used and their meanings, pictures of their own modified versions of Makaton sign language and ways that individuals usually communicated.

We observed staff talking with people using signs and gestures. For example, we saw one person discussed their care routine using signs and gestures and agreed who was going to assist them that evening with a member of staff. The staff member explained that the person liked to choose each day who was going to assist them with their personal care in the evening.

One person had a communication passport. This gave staff and other people guidance on how to communicate with the person and what each sign they used meant. The staff explained that they regularly printed new versions of the passport because the person tended to destroy it on occasions. We saw staff talk with this person and responding to the signs used. We requested to use the communication passport to help us to talk with this person. This was unavailable for both days of our inspection which meant that people who did not know the person well could not communicate with the person effectively.

We saw people being offered day to day choices. Staff explained that they supported people who were non-verbal with choices by showing them the options. For example, choosing between items of clothing held up and we saw people being shown the plates of dinner so they could choose. Staff gave an example, explaining how they had supported one of the people to make the choice of a wash or a bath by using objects and gestures. However the lack of use of some communication aids and the lack of up to date records meant that people's ability to participate in decisions about the home and make choices was at risk of being restricted.

The documentation in the service did not always reflect the way the care was given. For example, we saw that some care files contained information that was written in a way which had not respected people who used the service. We read several people's personal profiles. The profiles described each person's personality based on staff opinion. One person was described as 'opinionated and stubborn' and another person's described them as 'can be selfish and belligerent'.

People used the conservatory dining room for their meals and refreshments at routine times. They also sat outside at the tables and chairs and others stayed in their bedrooms. A cooked breakfast was provided on the first day of our visit. Two of the people we spoke with recited the breakfast menu for the week. They said they liked the food. One person said, "Nice breakfast." Staff said they had got to know people's likes and dislikes and activities and menus were arranged around this. The cook showed us the choices provided to people on the planned menus and said that alternatives could be made available on request. We did not see anyone ask for anything different from the menu. Staff told us and we saw that people could have refreshments at any time and could have their meals in different places if they preferred. This meant that people had some choice in where they ate their meals and when they had refreshments although we observed that

most people followed set times for both.

Some people helped with the meal preparation and cleaning afterwards. Some people were able to make their own drinks and snacks independently depending on their ability and risk assessments. Other people requested drinks from the staff and these were either made for them or they were assisted to make them. Opportunities for people who needed staff support were limited due to the number of people using the service compared to the number of staff available.

People were treated with respect. When carrying out personal care or administering medication, staff took time to explain what they were going to do and obtained the person's agreement.

Staff got to know individuals and responded to their needs for privacy in a way that suited them. One person needed to have bed rest but still wanted to see what was happening in the home and have some control over who came into their room. We saw staff had managed this need by using a gate across the person's door so that they were able to see and hear some of the activity in the home and could see people approaching and was able to prevent people wandering in without their permission.

People's bedrooms were personalised with their belongings and decorated in the way they liked. One person said, "My room is upstairs. I like it. I've got a big room. I've got photos and pictures there." Another person said, "I've got lots of photos and a balloon. I like balloons. It's nice".

People were able to keep their belongings safe and their privacy was respected. Some people had locked bedroom doors and others had lockable cupboards and drawers. Two people we spoke with showed us their bedroom door keys and said they liked to be able to lock their room. One person showed us their bedroom and said they did not have a key to their room but kept their wardrobe locked and said they liked this because "it keeps my stuff safe."

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Where some people needed support to make a big decision about their lifestyle or health, the service sought the support they needed to be able to make the decision in their best interests.

Out of the four staff we talked to about the Mental Capacity Act, three staff had a good understanding of how this related to the care of the people using the service. They were able to demonstrate how they enabled people to make informed choices and referred to assessments that had been completed in people's care plan folders.

For people who needed to make a decision about a health treatment or invasive intervention or procedure advice had been sought to help them weigh up the benefits and risks. One person had ongoing health conditions and had received support from the community learning disability nurse and staff in enabling them to understand the conditions and the treatment options available to them. We saw the Mental Capacity Assessment in the person's health action plan. The person had had discussions and support had been given including the use of picture cards and easy read statements. Other professionals were involved so that it was clear what the consequences of each decision would be and the person had been able to make the decision. The records showed the process and that this decision was kept under review. Another person needed medical intervention and this was explained to the person in a way they would understand. They made the decision with support and were assessed to have capacity to make this decision. The process and decision were clearly documented in the person's plan of care.

Two people needed dental treatment and both had been referred to the IMCA (Independent Mental Capacity Advocate) service.

People were given the information they needed to make an informed choice and consent to care and treatment. For example, one person was receiving ongoing treatment in hospital and had attended appointments for this. The person did not want to attend the next appointment despite staff encouragement and explaining the different options. The

person was sure they did not want to attend so staff respected this and made another appointment.

However for more day to day decisions there was a lack of systems in place to regularly assess and review people's capacity and ability to consent. People had formed relationships and some of these were physical relationships that were potentially sexual. There had been involvement with other professionals, including psychiatrists and care managers; for some people and staff were aware of which people using the service had physical relationships. Some of these relationships had been long standing as many people using the service had lived in the home for over 30 years. Staff gave examples where they felt people were consenting, although they acknowledged that people had not had Mental Capacity Assessments to make sure of this. Where risks had been identified of potential sexual relationships where one person may be vulnerable and not able to give consent staff explained the strategies that were in place to protect people. There were insufficient processes in place to make sure people were able to understand the risk, benefits and whether they had the capacity to consent.

There were Mental Capacity Assessments in three people's care plans that stated that the care plan had been discussed with the person and devised with them but that they were unable to sign to say they agreed with them. This was not the case for everyone.

We observed people being asked by staff for their permission before receiving care and before entering people's rooms.

Generally people were free to come and go in the home and outside. Some people went out to the local shops and surrounding areas independently. People who needed support to go out looked happy to wait for staff assistance and chose not to go out on their own. The front door and gates were unlocked.
One person's care plan we looked at stated that they were able to go out when they wished to but needed to let staff know so that they could be assisted. We spoke with the person who was able to indicate that they were able to go out when they wished. Staff told us and records confirmed that the person had been able to pursue their chosen activities outside the home.

A Deprivation of Liberty Safeguard authorisation had been applied for to protect one of the people using the service at times when they needed additional support and protection. This had been advised and discussed with the person's psychiatrist. The staff had supported the person's independence and had not needed to use this authorisation. Instead the person had been able to continue to go out and staff had been able to support the person by observing at a distance to make sure they were safe. This followed a strategy agreed with the care manager and it was recorded in the person's care plan.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People's needs were not consistently assessed and care and support was not always planned and delivered in line with their individual care plan.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People told us that they had lived at the Old Rectory for a long time. Some people had lived there for over 30 years. People told us "I like living here" and "I love it here". We watched people join in with activities such as arts, watching television, watching films, listening to music, karaoke and bowls. People also had trips out of the home. Two people had visited the local beach on one of the days we inspected. One person's activity plan in their care file showed that the activities the person had planned had taken place.

People who used the service told us about planned trips and activities. They said that nine people had planned to go to a steam festival at the weekend. People told us that they were looking forward to going to the war and peace show later in the year.

A hairdresser and barber visited the service, staff asked people if they wanted their hair cut and people choose to accept or not. A visiting optician also visited the service during our inspection.

We carried out a short observational framework for inspection (SOFI) during our inspection. During this observation, which took place in one of the lounge areas, we saw that staff provided discreet prompts and reminders to people who used the service. For example, as one person was watching a film with others; the staff member approached the person and quietly asked them whether they would like to use the toilet and then when the person said yes they helped them to leave the room. Staff asked each person in the room whether they would like a drink and gave them a choice of drinks to choose from. Each person communicated in their own way what drink they would like and the staff member returned with each drink.

We saw staff offer reassurance in a kind and caring manner. For example, one person told the staff they were worried about something and so the staff member talked through the person's concerns and offered reassurance. The person was reassured and hugged the member of staff.

Most of the interactions we observed were good. However, we did see that one staff member asked the head of care if one person who lived in the home wanted their hair cut rather than asking the person directly. Whilst the staff member chatted to the head of care about the person; they ran their fingers through the person's hair without asking them if this was alright.

Some of the support was inconsistent. We watched one person who used the service repeatedly punch the provider in the arm with force. The provider told us that this person was acting out a part in a film. The provider did not stop the person from doing this. Other staff tried to support the person to move away from the provider when this was happening. An inspector distracted the person from doing this by asking them a question.

Some staff used humour whist interacting with people using the service; sometimes this was not appropriate to the situation. For example, one staff member described a person who lived at the home as their 'girlfriend' when describing why the person knew their name which was not appropriate.

Staff told us about the needs of people who lived in the home. This included how they supported people's needs relating to continence management and equipment. However, we observed that staff did not follow a person's care plan in relation to promoting their continence. This led to a person indicting that they were in pain. Care plans relating to healthcare needs were not always followed by staff. There was minimal recording by staff in daily notes about site entry wound care with 'personal care given' recorded even though some wounds required washing and dressing daily. There was no evidence that wounds were being washed and dressed as required so a risk that wounds may become infected.

There was evidence in care and support plans that people had been referred on to specialists as their health deteriorated. People had support from district nurses, GP's, dentists, hospital consultants and a hospice. Some speech and language therapy (SALT) assessments had been carried out for a number of people by SALT. We looked at one person's health and social care record which detailed that nurses had attended to the person's health needs. This record showed that the home had made contact with the nurses to log concerns. Seven care and support plans we viewed had been updated and reviewed between January 2014 and June 2014.

We found that specialist advice had been sought for people that had a visual impairment. For example, an environment assessment report was in place that highlighted recommendations to improve the environment for people with a visual impairment. These recommendations included replacing carpets to stairs as they were worn. The carpets had been replaced and were in good condition. Other recommendations, however, had not been followed up such as providing contrasting colours to the edging of the metal fire escape stairs and reducing the glare in the conservatory.

Care and support plans detailed each person's individual needs. When risks to a person were identified the home carried out a risk assessment. We found assessments relating to people's mobility, behaviours that people might find challenging, road awareness, health conditions, communication, difficulties eating and swallowing, and infection control.

One person's risk assessment showed that they could become anxious and aggressive. It gave clear information to staff on how to support this person if they became anxious. This included information on possible triggers and how to distract the person. A person became anxious during our inspection. Staff supported them by offering reassurance and by

distracting them. We observed that this person had not been engaged with activities prior to becoming distressed. The person pointed to the car outside and a staff member recognised that the person wanted to go out and took them out for a drive.

Some people who used the service had a person centred plan which gave details about their life history and who and what was important in their lives. However, not everyone had a person centred plan. The person centred plans had not been kept up to date so did not contain information about each person's current goals, aspirations, likes and dislikes.

One person had a communication passport which gave staff and other people guidance on how to communicate with the person and what each sign that they used meant. The communication passport was not available. We spoke with the deputy manager who told us that a copy of the communication passport was stored on the computer in the office so was not accessible which meant that people that didn't know the person well could not communicate with them.

One relative told us that they visited the home regularly and that the 'Staff are brilliant'. They said they "See the same staff regularly"; "So glad I found the home" and their relative "Loves it [at the home]".

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not always protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening where a person may not have capacity.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Since our previous inspection the service had taken action to put suitable arrangements in place to ensure that people were protected against the risk of abuse.

At our last inspection we found that the provider had stopped staff members working at the service when the local authority safeguarding team had received safeguarding allegations which implicated individual staff members. During this inspection we found that staff had only returned to work following an investigation by the local authority safeguarding team. The provider had also completed their own investigation and met with the person prior to their return to work to address any concerns. For example, we saw that additional supervision and training had been put in place for one staff member. This meant that the provider had taken action to make sure safeguards were in place when a staff's practice had been questioned.

A few of the people using the service were involved in sexual behaviours or physical relationships. During our previous inspection we were concerned that no regard, by way of assessment, had been given to people's capacity to consent. During this inspection we saw evidence to demonstrate that the service had supported people, who had capacity, to work with health professionals around certain behaviours, to keep themselves and others safe. We also found that the service had worked with health professionals to understand if one person was happy with the affections another person was showing them. The provider had not taken action to assess, where a person may not have capacity, that they understood the consequences of their behaviour and were making an informed decision.

People using the service we spoke with told us that they felt safe and that staff supported them when they needed. People showed us how they kept their personal items safe. We also found that where people wanted to they held a key to their room and were able to lock their door. Appropriate arrangements were in place to enable staff to access people's rooms in an emergency.

Some people's care plans showed that there was a risk that they may take other people's things. We found that staff were aware of these risks and strategies were in place to support people to understand why they should not do this. We saw evidence that staff had supported people to return items to their rightful owner.

Some people had gates across their bedroom doorway to prevent other people from entering their rooms. We observed that people were happy for these gates to be in place and that they did not stop the person from leaving their room. People's care plans recorded why they gates were in place, for example, to prevent people walking in and taking the person's things. This meant that arrangements were in place to safeguard people's personal items.

When one person had informed staff of concerns they had, staff followed the services safeguarding policy to inform the person's care manager in a timely way. The deputy manager and the head of care for the service told us that they had met with the local authority safeguarding co-ordinator recently as the safeguarding coordinator wanted to go through safeguarding protocols. They both described how they would raise alerts from now on. This meant that the service had changed their safeguarding process to include information given to them by the local authority.

At our previous inspection we found that there was a risk that people were not protected against the risks of unlawful or excessive control or restraint because the provider had not made suitable arrangements to protect people. Since then, the service have informed us that all of the bedrails and lap straps used by people were assessed and provided by health care professionals and they have completed bedrail assessments for people where they were in use. They had also taken some assessments and other documents out of their archives to show why bedrails and laps straps were in use. As these had been archived there was a risk these may be out of date and not current. Two people had been referred to health professionals for an assessment of their needs and copies of assessments and other records had been requested from health professionals. This meant that the service had taken action since our last inspection to put an assessment and consent process in place which would prevent the risk of excessive or inappropriate restraint.

Requirements relating to workers ✖ Enforcement action taken

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were not cared for, or supported by, suitably skilled staff who were of good character.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

There were not effective recruitment and selection processes in place. The provider had a "Staff Recruitment & Selection Policy" in place but this had not been reviewed since February 2011.

We looked at seven staff files. Each of them contained an application form, proof of identity, job description and appointment letter.

The provider was not following its own policy in regard to the interview process. The provider's policy stated that "Job interviews provide an opportunity for the home to get the information it needs about the applicants to decide which is the most suitable for the position in question", "Gaps in the employment record are routinely explored" and "The assessments made by interviewers must be formally recorded on an interview assessment form". We found that one staff application had brief interview notes and that one had incomplete notes. There were no interview notes or assessment forms on the other five files. Since our inspection the service has told us that they are recruiting for a night carer and that they had conducted one interview. The deputy manager told us that they used interview questions and took notes and provided CQC with a copy.

One staff had completed the employment history section of their application form. One of their references was from a previous employer, but this employment was not on the employment history section of the application form. There was no evidence to demonstrate that the provider had queried this at interview as there was no record of any interview.

Appropriate checks were not always undertaken before staff began work. The provider's policy stated, in regard to references, "Two written references are obtained before an appointment is confirmed" and "All offers of employment are made on the condition that two satisfactory written references are obtained in respect of the applicant. If the

references prove to be unsatisfactory, the offer of employment may be withdrawn without the home being in breach of contract". We saw evidence that the provider wrote to referees and obtained, where possible, written references in accordance with their policy. However, one staff record had a written reference which stated that the person was "not suited" to the service and had been "asked to leave". The provider had taken reasonable steps to confirm the reasons their employment had ended by following up with a telephone call and the notes made at the time showed, "Doesn't think nights would suit them. Didn't like to be told what to do. Overpowering. Would not re-employ". The provider employed this person as a night carer. There was no evidence that the provider had discussed these concerns with the staff member and put safeguards in place to protect people using the service.

Another application showed that a staff member had worked with people with challenging behaviour but did not give the dates. This previous employer had been given by the staff member as a referee. Handwritten notes on the application stated, "Called - Unable to complete a reference as not permitted to give a bad reference". There were no notes on file to demonstrate that this had been discussed with the staff member who had been employed and no record of any safeguards in place by the provider to ensure people's safety.

We found that the provider had a "Criminal Records Policy" in place which stated that the home would, "Comply with the law and the criminal records bureau (CRB) disclosure service to obtain information to enable it to assess the suitability of applicants or employment in positions of trust". This policy was last reviewed on 24 February 2011 so had not been updated to reflect the changes in the way checks are obtained from the Disclosure and Barring Service (DBS).

This policy stated, "Where a conviction has been disclosed in an individual's application for a post with the home, a discussion will take place at the end of the interview regarding the offence and its relevance to the position. Failure to reveal information relating to unspent convictions could lead to withdrawal of an offer to employment". The policy also stated that because staff would be working with vulnerable adults and in a position of trust that both 'spent' and 'unspent' criminal convictions should be disclosed. We saw evidence that information about cautions and convictions was requested on application forms. Details of any criminal convictions or pending prosecutions and also if the applicant had ever been cautioned, received a police reprimand or warning were requested. The application form also stated that, due to the nature of the work, the post was exempt from the Rehabilitation of Offenders Act 1974. We found that the policy was not followed consistently. For example, on one application form we viewed, the applicant had left the criminal convictions / prosecutions pending section blank and had ticked the "no" box in relation to being cautioned. When we checked the DBS Enhanced Certificate for this person we found that they had criminal convictions. We were unable to find any evidence that the provider had discussed this lack of honesty and integrity with the staff member or that they had taken any action to safeguard the people who used the service. This meant that the provider had not taken action to protect people who used the service from risk posed by staff who were not honest or of good character.

We saw that each file contained a statement of employment which detailed things, such as, job title, sickness, disciplinary and grievance procedures and confidentiality and data protection. The job title on these did not always reflect the contents of the staff file. For example, one staff had the job title of "maintenance" and had completed training on "People handling including hoist instruction". We asked the deputy manager why this staff

had completed this training. We were told that they were maintenance / carer; however, there was no job description on file to evidence their role. We found that not all the statements of employment had been signed and dated by the staff. This meant that the provider did not operate an effective recruitment procedure which ensured that people were protected from the risks posed by staff who were not of good character or did not have the qualifications, skills and experience to fulfil the role.

The provider had a disciplinary process in place and had taken action when they considered that a staff member was no longer fit to work at the home. We saw evidence that a disciplinary had been followed up with the staff member and that this had been documented. The provider was able to show CQC evidence that plans had been put in place to minimise future risks.

The recruitment and selection process did not consistently ensure that staff were fit and physically and mentally able to perform their role. Only two of the seven files we looked at had a completed pre-employment health questionnaires. This meant that people who used the service could not be confident that their safety and health and welfare needs would be met by staff who were physically and mentally fit.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care and support safely and to an appropriate standard through development.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff were supported through training, supervision and appraisal to deliver care safely to people using the service. Staff did not receive further development.

The provider had an induction policy in place that required new staff to complete an induction. Staff told us that the Skills for Care induction was used. Skills for Care publish guidance on recognised standards for induction into the care sector. Staff training records showed the date that this had been completed; however, we only saw two "certificates of successful completion" in the seven files we checked. We asked the deputy manager if they were able to show us the content of the completed inductions and were told that "staff take them home when they have done it" so the records were unavailable for us to verify.

Staff told us that new staff shadowed experienced staff to begin with to enable them to get to know the people using the service and the routines of the home. Our observations showed that staff knew people and their routines well.

Staff we spoke with, the deputy manager and head of care told us that staff had completed mandatory training. However the training records were not up to date with at least six members of staff not recorded on the training matrix.

Staff training records showed what courses had been completed and when refresher training was due. Training certificates had been issued by different training companies but had not been filed in people's employment files. Most staff had completed basic mandatory training courses in subjects, such as, safeguarding vulnerable adults, moving and handling, first aid and fire awareness. Staff told us that they had undergone training on nail care and care plans showed that staff were carrying this out. However there were no records to support this. We did note that people's nails appeared well maintained. Some staff had received additional specialist training which helped them do their jobs in subjects including sexual health and learning disability, challenging behaviour and mental health but there was no recent training in any of these subjects. This meant that staff may not have had an appropriate level of knowledge, competencies and experience to meet the

changing needs of people using the service.

The service had a "Staff Appraisal Policy" in place which stated that appraisals would take place annually. This was also stated in staff's job descriptions. We found that appraisals had been completed in March 2014 and signed by both the employer and the employee. Part of the appraisal form was a tick box section for completion by both parties in order to compare them. None of the forms we sampled had been completed by staff so staff had not given their views or opinions of their own performance. This was not in line with the policy which read, "The appraisal makes use of reports from the job holder based on a self-assessment of their progress in their work".

Staff we spoke with said that they had appraisals and that they felt supported. The appraisals noted what had been achieved and set new agreed targets and performance objectives. We noted that these were sometimes brief, generic and did not encourage personal learning development. For example, one stated, "To continue training" and another said, "To continue to provide a high level of care and complete training". This meant that there was a risk that staff may not be being supported to assess and develop their skills and experience fully.

We found that the service provided regular supervision, on a three monthly basis, in accordance with their policy. Copies of the staff supervisions were held in staff employment record files and these were generally signed by both the supervisor and the employee. Supervisions were based on observations of either "Mealtime & Promoting Independence" or "Personal Hygiene & Promoting Independence". Part of the supervision was a tick box for the observation and part was for discussion. We found that, in some cases, the comments on both the employer feedback and employee feedback to be brief. For example, there was a section regarding verbal communication skills. Many of the supervision records noted, "Very good" or "Very good throughout", whereas a few were more detailed, such as, "Clear and users service users preferred communication at a pace they understand". We did not see any supervision records which detailed any actions needed. We spoke with the head of care who told us that additional one to one supervisions and small group supervisions also took place. There were diarised notes regarding topics discussed but there was no record of these meetings in staff employment files. This meant that the people using the service could not be confident that staff delivering their care were supervised and managed effectively.

We saw positive interactions from staff when supporting people throughout our inspection. Staff we spoke with told us that they were happy working at The Old Rectory. People who used the service told us, "I like the staff" and "The staff are nice".

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People who use the service and others who may be affected were not consistently protected from risk.

We found that the service had not assessed the risks to people of falls from windows, balconies or fire escapes. The provider had booked a contractor to complete some remedial work following a recent incident at the service. Environmental risks were evident at the service including an accessible pond. This, and other risks had not been assessed and an environmental risk assessment had not been completed. We could not be assured that all potential risks had been identified and action had been taken to put adequate arrangements in place to protect people.

The service had a current fire risk assessment in place. On the first day of our inspection fire maintenance contractors attended the service to complete scheduled checks on fire safety equipment such as smoke detectors and the alarm system. The local fire and rescue service had visited the service recently following a referral we made. The fire service had found blocked fire escape routes and locked fire exits as well as a lack of personal evacuation plans. The fire service advised that the fire risk assessment and fire safety procedures required improvement to ensure that all risks were identified and managed to keep people as safe as possible.

Following advice from the local authority the service had put a process in place to assess and manage the risks posed to people using the service from visiting contractors, such as decorators. We found that no contractors had visited the service since the introduction of the process, therefore we were unable to assess if the new process was effective.

There was no evidence that learning from incidents / investigations took place and appropriate changes were implemented. Staff told us that they noted when people had accidents, such as falls, and contacted the person's doctor. We found evidence that the service had responded appropriately to high risk incidents. The service did not have process in place to analysis and take action to learn from incidents and accidents that took place. This meant that appropriate changes could not be made to keep people safe.

The provider did not operate an effective system to regularly assess and monitor the quality of the service provided. Weekly housekeeping audits and monthly checks on medicines were carried out. However, no further checks and audits on the quality of the service were completed. This meant that the provider did not have adequate systems in place to regularly assess and monitor that the quality of the services so people could not be assured that their health, safety and welfare would be protected.

People who used the service, their representatives and staff were not regularly asked for their views about their care and treatment. There was a process in place to do this but this had not been completed since 2011. We saw that people and their relatives spoke to staff about the service they received on an informal basis but we could not be assured that the provider had robust processes in place to regularly ask people and their representatives for their views and act upon the feedback received to reduce the risks of people receiving inappropriate or unsafe care.

The service does not hold regular staff meetings. The last recorded meeting was October 2013. Staff had provided feedback at this meeting to the provider about areas of the service which required improvement, such as laundry equipment. We saw that the Head of Care held meetings with small groups of staff at the beginning of each shift. Staff had received information and guidance about areas that required improvement such as the wording of people's records and staff behaviour whilst on duty at these meetings. So, areas where the quality of the service did not meet the standards expected had been identified and action had been taken. However, the service did not have a formal, current process in place ask staff for their views on the quality of the service they provided. This meant that risks to people may not be identified and managed to ensure that people receive appropriate and consistent care and support.

The service had a complaints process in place and information had been given to people about how to make a complaint. The easy read version of this process had recently been updated, but had not been shared with people using the service. This meant that people using the service may not know how to raise any complaints they had formally. We reviewed the complaints the service had received and found that no complaints had been recorded since 2011. Staff told us they had addressed the minor complaints and comments that had received since this time informally. People's relatives that we spoke with told us they were confident to raise concerns and complaints with the service. They also told us that they were involved in planning their relative's care and the service kept them informed about their relative's needs and care.

Records

✖ Enforcement action taken

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People's personal records including medical records were not accurate and not fit for purpose.

The provider told us that, "Paperwork was not the home's forte but they [the home] were good at care". The provider added that they had "Not been good at paperwork for 32 years". No changes had been made by the provider to ensure 'paperwork' improved.

There were gaps in the daily care records one person's daily notes that had been written between April 2014 and June 2014. Several entries that were blank so there was no record of what care, choices and support had been given.

Staff had not filed some people's records correctly so they were not easily accessible. There were loose documents and paperwork which could get lost or damaged.

Some care and support plans referred to out of date information so were not current. For example, one care plan dated June 2014 referred to information about changes in the person's needs following an admission to hospital. The hospital admission had occurred in December 2011, so this information was no longer relevant.

We discussed the content of some of the plans with staff, who informed us that some people were not currently participating in recorded activities. Staff told us that they had included the information in the plan as there was a risk that it may occur again. The historic nature of the behaviour was not clear in the records and appeared to be current even though it was not current. This meant that there was a risk that people may not receive appropriate support as staff and other professionals referring to the plans did not always have up to date information.

Health professionals, such as specialist nurses and psychiatrists had written guidelines

and documents, which they stated "serve as care plan documentation", for staff to follow to make sure people had the right support. This information had not been referred to in the plans and risk assessments written by the service. For example, one person had a strategy in place for when they went out, written in consultation with their family, doctor and other health and social care professionals. This was not referred to in their care plan. All the staff we spoke with were able to tell us how they had followed the strategy but we could not be assured that new staff or staff returning to the service would have access to current guidance about people's needs and the care and support they required.

We reviewed records related to safeguarding concerns and found that the action taken had been recorded in daily records and other confidential records. However, these records did not contain the times that actions were completed and were not signed. This meant that the service had not maintained detailed records demonstrating the action they had taken in response to an allegation of harm or abuse.

The service had a process in place to ensure that records and other information were kept confidential. Records were stored in locked rooms and access was restricted to authorised staff and other professionals who required them. Staff were able to locate the information we requested promptly. Staff had recently been reminded of their responsibilities in relation to confidentiality. This meant the service had suitable processes in place to keep people's personal information safe.

Staff records and other records relevant to the management of the services were not accurate and fit for purpose. The service was unable to provide CQC with up to date lists people who used the service or staff. Policies had not been updated to reflect changes in legislation and best practice guidance. This meant that people who used the service and staff could not be confident that their personal records were up to date, reviewed and properly managed.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. Regulation 18(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care that is inappropriate or unsafe by means of completing assessments and planning and delivering care in such a way as to meet their individual needs. Regulation 9(1)(a)(b)(i)(ii)
Regulated activity	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service who may not have capacity were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Regulation 11(1)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff did not receive further development. Regulation 23(1)(a)(b)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 03 September 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 12 September 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: The provider did not operate an effective recruitment procedure which ensured that people were protected from the risks posed by staff who were not of good character or did not have the qualifications, skills and experience to fulfil the role. Regulation 21(a)(i)(ii)(iii)
We have served a warning notice to be met by 12 September 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met:

This section is primarily information for the provider

	The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. Regulation 10(1)(a)(b)
We have served a warning notice to be met by 12 September 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20(1)(a)(b)(I)(ii)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk