Inspection Report

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

The Maples

Tokers Green, Reading, RG4 9EY

Tel: 01189724553

Date of Inspections: 10 September 2013
06 September 2013
05 September 2013

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December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✖	Action needed
Care and welfare of people who use services	✖	Action needed
Requirements relating to workers	✖	Action needed
Staffing	✖	Action needed
Supporting workers	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Action needed

Details about this location

Registered Provider	Disabilities Trust
Overview of the service	The Maples is a residential care home for up to 15 people who have autism and accompanying learning disabilities.
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'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 5 September 2013, 6 September 2013 and 10 September 2013, 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 talked with other authorities.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We used a number of different methods to help us understand the experiences of people using the service, because the people using the service had complex needs which meant they were not able to tell us their experiences. We also spoke with three people who use the service, three relatives, and ten members of staff.

When we reviewed people's care plans we found evidence of some service users' involvement in making decisions about their care was absent. Relatives told us they were involved in annual reviews of care for their family members. However, one relative told us they were not involved in this year's review, because the date had been changed at short notice and they were unable to attend the new date offered. Although we observed occasions where staff treated people with respect, and involved people who use services, we also observed occasions where they did not.

One person who uses the service we spoke with said "I can assure you, the quality of care is very good". One relative told us "staff are caring" and another told us their family member was "well looked after and cared for". When we spoke with staff, they were able to describe how they would support people who use the service to meet their needs. However, we found one person had not seen the dentist or optician for two and a half years. We saw some risk assessments were in place, but others were out of date or had not been completed at all. Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

The provider did not have effective recruitment and selection procedures in place. Not all of the relevant checks had been completed before staff began work.

The provider did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. There was a risk they would not be able to safeguard the health, safety and welfare of people who use the service.

When we spoke with staff they told us they felt well supported by managers and they had enough training to enable them to meet the needs of the people they supported. However, when we looked at staff training records we found the provider did not ensure that staff were properly trained and supported to provide care and support to people who use the service. There was risk that staff would not be enabled to carry out their role effectively.

The provider did not regularly assess and monitor the quality of the services they provided. They did not identify risks relating to the welfare and safety of people who use the service. The provider did not have regard to the comments made, and views expressed, by people who use the service, and those acting on their behalf. The provider did not ensure that people's personal records were accurate. Records required to protect people's safety and wellbeing were not being maintained. Other records in relation to people employed by the service were not accurate.

We have made a referral to the local authority safeguarding adults team, due to the concerns raised from this inspection.

We spoke with the person managing the service on the day of our inspection. Throughout this report, we have referred to this person as the acting manager. The location did not have a registered manager at the time of our inspection.

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 10 January 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 Maples 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 ✖ Action needed

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 not meeting this standard.

People's privacy, dignity and independence were not always respected.

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

The Maples had recently been re-built as three separate bungalows. Two of the bungalows had self- contained flats where people who use the service were encouraged to live as independently as possible. We met with three people living in the bungalows and observed how staff helped promote people's independence. For example, staff supported a person to visit the shops in the local town and supported people with household tasks.

People who use the service had been involved in making choices about the décor of their rooms and deciding the names of the new bungalows. One person we spoke with told us they liked their flat "very much". However, we observed that doors to people's rooms did not have any information to identify who they belonged to. The acting manager told us they had been thinking about including door numbers or people's photographs on their doors, but had "not got around to it". The acting manager also stated that personalisation of people's bedroom doors would require their consent.

The home's door locks were operated by an electronic key fob. Care workers used a key fob that opened all of the doors, including people's private rooms. On most occasions, we observed staff protecting people's privacy by knocking on their doors before entering the rooms. However, we observed two occasions when staff used the key fob to enter people's rooms without knocking first. On one occasion the person was being supported with personal care in their room. The provider was not ensuring that people's privacy was respected at all times.

We observed staff speaking to people who use the service in a respectful way. One care worker was observed supporting a person to maintain their dignity. Another care worker was observed supporting a person to be involved in household tasks. However, we observed another person who required the support of a care worker in order to maintain their dignity. None of the staff noticed and we had to direct staff to the person so they

could provide appropriate assistance. As soon as the staff were made aware of the situation they acted appropriately and the person was provided with suitable support to maintain their dignity.

The Maples also had a learning centre where people who use the service could participate in activities of their choosing. Each person had a weekly activity plan and staff were aware of what people's activities were for the day. Care workers were able to identify if people did not want to participate in a planned activity and offered them alternative choices. Written plans were available on the wall of the learning centre although people who use the service did not have a personal copy of the timetable.. This meant that people might not have access to appropriate information in relation to their care and might not be able to make decisions about what activity they were to participate in.

We spoke with the relatives of three people who use the service. They all told us they were involved in annual reviews of care for their family members. However, one relative told us the provider did not always take their opinions about their family member's care needs into account. Another relative told us they were unable to attend their family member's most recent care review because it was moved to a different date at short notice, and the new date was not convenient for them to attend.

When we reviewed people's care plans we found little evidence of individual's involvement in making decisions about their care, where they were able. We saw the provider's internal quality assurance review completed in May 2013 which identified people's 'support plans and risk assessments have not been appropriately reviewed and updated. Attention needs to be paid to what reviewing the plans means….'. The provider was unable to demonstrate how people were enabled to make, or participate in making decisions relating to their care, where they were able.

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.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

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

One person we spoke with said "I can assure you, the quality of care is very good". Another person told us they liked living at the home. We spoke with three relatives of people who use the service. One of them said "staff are caring" and described how they were involved in reviews of their family members care needs. Another relative told us their family member was "well looked after and cared for".

When we spoke with staff, they were able to describe how to support people who use the service and meet their needs. Care workers were able to describe how they would manage people's challenging behaviour appropriately, as well as other care needs.

A person who uses the service invited us into their bedroom. They were unable to communicate verbally. The person's care worker accompanied us, and was able to explain to us what the person wanted to do in their room. The care worker supported the person to meet their needs in a caring manner.

We looked at the care records for two people who use the service. In one person's care record, it had been identified the person had a health condition which needed to be controlled by changes to their diet. Their weight needed to be monitored to ensure the change in diet was effective. The Malnutrition Universal Screening Tool (MUST) was included in the care plan but was not fully completed. MUST is a screening tool used to identify adults who are malnourished, at risk of malnutrition or obese. The person's change in weight had been noted and it had been identified that the changes had helped to manage their health condition. When we spoke with staff about the person's health condition and dietary requirements, they were able to explain what they needed to do to support the person's needs. There were also detailed behavioural support plans in place to help staff meet the care needs of the person.

However, we noted in the same person's care records details of a dentist's appointment that took place in June 2011. We asked the acting manager about this. They confirmed this was the last time the person had visited the dentist and no future appointment had

been made for the person. We also noted details of an optician's appointment from June 2011. The acting manager confirmed this was the last time the person had visited the optician and no future appointment had been made. There was a risk the person's health would deteriorate because they were not being supported to attend regular appointments with healthcare professionals.

Risk assessments and management plans were included in the person's care records, for example, travelling in the car. The home had recently been re-built and some of the risks assessments did not relate ensuring people's welfare and safety in the new buildings and environment. We also found there was no evidence of a recent review of the person's care needs with the commissioning authority. There was a risk the person might receive unsafe or inappropriate care because risk assessments and care plans had not been updated since the person had moved into the new buildings.

We looked at the second person's care records. We noted they moved to the home from another local authority area in July 2013. There was a detailed pre-admission assessment which included information about the person's health status, and psychological and behavioural support needs. The person had complex needs so a half day teaching session for staff was completed. A health care professional who was familiar with the person's needs visited the home. They talked with staff about the person and how best to support them. When we spoke with staff about the individual, they were familiar with their background and what their current support needs were.

The pre-admission assessment was completed by a clinical consultant psychologist. They recommended the person had the support of two members of staff at all times during the day. The recommendation was in place to ensure there were enough staff to support the person's challenging behaviour, and reduce the possible risk of harm to the person and others. This was for a period of three to six months after the person began living at the home. The person had a review of their care needs on 13 August 2013. It was noted the person should continue being supported on a two to one basis to ensure the safety of the person and staff was protected.

We spoke with the acting manager about this. They told us staff were supporting the person most of the time on a two to one basis, but they felt the person's behaviour was improving so they were trying one to one support to enable the person to become more independent. We asked what risk assessments or plans were in place to manage possible risk caused by a reduction in staff support. The acting manager told us there were none and they were "seeing how it goes." The provider was not carrying out a suitable assessment of need for the person, or identifying possible risks and how they should be managed. There was a risk the person would not be protected from unsafe care.

We saw there were detailed plans in place to guide staff on how to communicate with the person, managing physical aggression and travelling in the car. The assistant psychologist described to us how they assessed the person before the care plan was completed. This had included visiting the person before they came to the home, and discussions with other health care professionals who had experience of supporting the person. However, there were no written records of the assessment, where risk may have been identified, or evidence that the person had been involved in making decisions about their support plan.

We saw evidence that risk assessments and management plans were in place for some activities, for example, attending hospital appointments and going out. However, most of the person's care plan was based on assessments undertaken at the person's previous

home. There were no assessments or plans in place to enable staff to support the person with their care needs in the new home. While some of the information included in the care plan was still relevant to the person, some of it was not. Examples included out of date personal care plans and medication information. The provider had not carried out a suitable assessment of the needs of the person. They had not planned care in such a way as to meet the person's need. There was a risk that the safety would not be protected and their care and welfare needs would not be met.

The home had arrangements in place for dealing with emergencies and each person had their own personal emergency evacuation plan. We saw evidence that regular fire drills were completed. The home had an appropriate contingency plan in place to manage any emergencies, for example, a flood.

Requirements relating to workers ✖ Action needed

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.

The provider did not have effective recruitment and selection procedures in place.

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

We looked at the personnel records of seven members of staff. The records showed evidence some of the relevant checks had been undertaken before staff began work. All of the records contained proof of identity including a recent photograph, evidence of a disclosure and barring service check and satisfactory evidence about staff's physical and mental health.

However one record did not contain satisfactory evidence of the staff member's previous conduct when they were employed in a service that provided health and social care, or support for vulnerable adults. Three of the records did not contain details of why the person's employment had ended where their duties involved work with vulnerable adults. Six of the records did not contain a satisfactory written explanation of gaps in employment.

We spoke with the acting manager about the missing information. They confirmed that if it was not in the staff records we looked at, the information was not recorded anywhere else.

There was a risk that the provider would employ staff who were not honest, reliable and trustworthy, because they were not carrying out all of the relevant checks before they employed staff.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs. Where people required high levels of support, the provider had not ensured their needs were met by sufficient numbers of staff at all times.

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

When we arrived on the first day of our inspection on 5 September 2013, we were met by a support worker. They told us there was no senior support worker on site at that time. They said there were six members of staff present and two care workers had phoned in sick. When the acting manager arrived, they confirmed what the support worker had told us.

On the second day of our inspection on 6 September 2013, we attempted to speak with members of staff. It was difficult to speak with staff because staff were required to provide support to people who use the service while other staff would be away to speak with us. A senior care worker we spoke with confirmed a staff member was also absent on the late shift the same day, and they had been unable to get cover from a bank member of staff. However, another member of staff covered the shift instead.

On the third day of our inspection on 10 September 2013, we were able to speak with three members of staff about staffing levels. They all told us there were staff shortages at times, and it was not always possible to get bank or agency cover at short notice. One person who uses the service told us there were some times when there were staff shortages, but they told us "I don't mind because I don't need help very often". One relative told us "they are always short staffed when I visit". Another relative told us staffing levels had improved over the last year.

We asked the acting manager how many staff they needed to meet the needs of people of people who use the service. They told us they needed eight members of staff on duty in the day, and four at night to meet the needs of people using the service. The acting manager also told us five of the people required one to one support during the day, one person required two to one support and three people were supported by one care worker.

We asked the acting manager for copies of their staffing rotas to demonstrate how many staff were on duty on each day and night, in the last month. We reviewed the rotas after

our visit. One rota titled "The Maples Rolling Rota" covered a six week period. It was undated so it was not possible to establish what dates the rota referred to. There were 84 day and 42 night shifts listed on the rota. Day shift times were 7.30am to 3pm and 2.45pm to 10.15pm. Only two shifts showed eight care workers listed for duty. 10 of the shifts only had four care workers listed and three of the shifts had three care workers. On the night time shifts there were 16 shifts where only two members of staff were listed and two nights where only 1 member of staff was listed.

The provider also gave us copies of the 'Allocation Book' which detailed which member of staff supported which person on each day. There were no details of staff allocation in the book for the night shifts. The allocation book covered the dates 31 July 2013 to 01 September 2013 and covered 126 shifts.

We looked at the allocation book and found only 29 of the shifts showed the required numbers of staff had been allocated to support individuals. On one day, for one shift, three care workers were allocated to support two people each. However, both of the people they were supporting required one to one support. On another day, for both shifts, one care worker was allocated to support two people. Both of the people they were supporting required one to one support. This meant the member of staff would not be able to meet people's needs, because they could not support two people at the same time on a one to one basis.

On ten of the shifts, one member of staff had been allocated to support people one to one, but was also allocated to support one or two other people who were more independent. This meant staff would not be able to support people on a one to one basis at all times, because they were also allocated to support other people.

We also reviewed the staff allocation for a person who required two to one support. We noted there were seven morning shifts and nine afternoon shifts where only one member of staff was allocated to the person. One entry was not completed.

There were seven shifts when one person did not have a member of staff allocated to them, and two, where two people did not. On one morning shift, none of the people had a member of staff allocated to them, the entries were blank.

The provider was unable to demonstrate there were sufficient numbers of staff with the right qualifications, skills and experience to meet the needs of people who use the service at all times. They were unable to respond appropriately to unexpected changes in circumstances in the service, for example, to cover sickness. There was a risk they would not be able to safeguard the health, safety and welfare of people who use the service.

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 treatment safely and to an appropriate standard. Staff did not receive regular supervision of their practice or an annual review of their development to ensure they were able to meet people's needs. Staff did not receive regular training to enable them to meet people's needs.

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

When we spoke with staff they told us they felt well supported by managers and they had enough training to enable them to meet the needs of the people they support. Staff were also able, from time to time, to obtain further relevant qualifications. Some staff had national vocational qualifications (NVQ) and others were currently studying for diplomas in health and social care.

We spoke with three members of staff about supervision and appraisal. Only one member of staff told us they had participated in a recent supervision session. Another member of staff told us their last supervision session was a "couple of months ago" and that supervision sessions were not regular. The third member of staff said they had never had a supervision session. Two members of staff confirmed they had an appraisal in the last year.

We looked at the personnel records for seven members of staff. Only two of the records showed evidence of supervision in the last six months. Three of the records showed staff had not had a supervision session in the last 12 months. Six of the seven staff were required to have an appraisal as one person had only just started working at the service. All six records showed evidence of an appraisal in the last 12 months.

The acting manager explained that responsibility for staff supervision sessions at the location had changed over time. They told us they were initially responsible for supervisions but then two other members of staff were delegated responsibility for this task. We asked the acting manager to show us records of supervisions and appraisals for all staff. This included evidence of supervision and appraisals that had been completed, as well as a schedule for future supervision and appraisals. The acting manager told us "I did do one (when I was responsible), but I don't think we've kept to it". At the end of the third day of the inspection, we had not received the records we had requested. The acting manager told us they were not completed. We asked the manager to send us copies when

they were completed and we received the records the day after we concluded our inspection visit.

When we looked at the records we saw they listed 37 members of staff and covered the dates June 2013 to May 2014. There was no evidence to demonstrate that supervision or appraisals had been completed before June 2013. For the dates June 2013 to August 2013, there were only two appraisals recorded and six supervision sessions. One person was shown as having supervision sessions in June, but when we looked at their personnel file, we saw evidence that the last supervision they had was in February 2012. The provider was unable to demonstrate that staff were being properly supervised and appraised. Staff were not given the opportunity to discuss any issues about their role, or the people they provided care and support to. Staff development was not supported because there was not a regular system of appraisal in place.

We looked at the training records for seven members of staff on day two of our visit. None of the records showed evidence of induction training. We asked the acting manager about this. They told us they were not sure about the induction arrangements for staff prior to starting work for the provider in July 2012. We asked the acting manager to provide us with evidence of staff's induction training. At the end of day three of our visit, the assistant manager, who was responsible for inducting new staff, showed us induction records for four new members of staff. Two members of staff started work in June 2013 and two in July 2013. Only two of the four records were fully completed.

We asked to see induction records for staff who had been employed for a longer period of time. The assistant manager was unable to provide these to us. They said "there wasn't much induction going on". The assistant manager described the current induction process to us. They said all new full time permanent staff completed a three week induction period, when they would shadow experienced staff. After three weeks, if managers agreed the staff member had developed the appropriate skills, new staff would then be able to support people who use the service independently. However, the assistant manager also told us that bank and night staff did not complete the same induction process as the full time staff. The assistant manager said that the bank employees conducted a local induction only.

We looked at evidence for other training in staff members' personnel records. One of the records showed evidence of moving and handling training in the last year, two of the records did not contain evidence that this training had been completed at all. Only one record showed evidence training in safeguarding of vulnerable adults (SOVA) had been completed in the last year. One member of staff began working at the home at the beginning of June 2013. There was no evidence in their records that any induction or other mandatory training had been completed. Their name did not appear on the training records the provider kept for all staff.

We asked the acting manager how frequently mandatory training should be completed for staff. They confirmed it was annually. They also told us that some staff training was out of date or due to expire "soon". We looked at the mandatory training records the provider kept for all staff. There were 30 members of staff listed in the records. All of the fulltime members of staff who were required to do so, had completed training in medication administration. However, we saw six members of bank staff had not completed medication training. This was because these members of staff did not administer medications as part of their duties. We saw some of the staff had not completed training in SOVA, moving and handling, fire safety, health and safety and basic food hygiene in the last year. One person had completed infection prevention and control (IPC) training in the last year, and two

people first aid in the last two years.

We spoke with the acting manager about training for staff for managing people's behaviour that challenged the service. They told us they were in the process of completing training for all staff in de-escalation intervention. When we looked at the training records we saw eight members of staff had completed the training, and 13 were scheduled to complete the training by the end of October 2013. However, three members of staff did not have a date scheduled and three entries were blank.

When we looked in the personnel records of the seven members of staff, we noted four of them had received crisis, aggression, limitation and management (CALM) training. CALM is a way of managing challenging behaviour using a positive behavioural support approach. However, three members of staff's training had expired in 2012. This meant that only nine members of staff had up to date training in managing challenging behaviour. There was a risk that people who use the service would not receive care that was safe, because staff had not been appropriately supported to meet people's needs.

The provider did not ensure that staff were properly trained and supported to provide care and support to people who use the service. There was risk that staff would not be enabled to carry out their role effectively.

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 or identify, assess and manage risks to the health, safety and welfare of people who use the service and others. They did not identify risks relating to the welfare and safety of people who use the service, and others. The provider did not have regard to the comments made, and views expressed by people who use the service, and those acting on their behalf.

We have judged that this has a moderate 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

We asked the acting manager what systems were in place to seek the views of people about the quality of their service. The acting manager told us the provider completed an annual quality monitoring survey involving people who use the service, their relatives and other health professionals. They said the last one was completed in December 2012. This was confirmed by relatives we spoke with. We asked to see the completed survey, including feedback given by people who took part. We also asked to see an analysis of the results, any action points raised, and plans that were in place to manage any concerns identified. The acting manager told us they did not have a copy at the location and that it was kept at the provider's head office.

We asked the provider to send us a copy of the survey and the results after the inspection. The provider sent us a blank copy of questionnaires they had sent to external stakeholders and a spread sheet which contained results. The spread sheet was titled "copy of analysis of family and stakeholder questionnaires December 2012". The spread sheet included the questions asked in the survey. It showed one family member had responded to the questionnaire, but there was no further information or analysis included.

The provider was not able to demonstrate they had an appropriate system in place to gather information from people about the quality of service they provided. They were not able to demonstrate they were analysing the results of the quality survey, identifying any possible action points, or putting plans in place to manage any concerns which may have been identified.

During the inspection visit, we were able to look at the questionnaire used to gain the

views of people who use the service. These were written in an easy read format and all of the people had completed the questionnaire. However, when we reviewed the comments written on the questionnaire, it appeared that some of the comments did not express the views of people who use the service, but were those of the care worker who had completed the questionnaire.

We discussed this with the acting manager and they confirmed that some of the comments were those of staff. There was minimal evidence that steps had been taken to enable people to express their views, for example, use of sign language or photographs. People who use the service were not being supported to express their views about their experience of the care provided.

Staff we spoke with confirmed they were given the opportunity to give feedback to the provider in staff and multi-disciplinary team (MDT) meetings. They explained how they would note people's feedback in the person's daily records, and this would then be discussed in MDT meetings. We saw documentary evidence to support this.

We reviewed one person's care record. In the records we saw staff had noted two separate incidents where the person they were supporting displayed challenging behaviour. One of these incidents was serious, and staff had to take action to protect their own safety. The person required two to one support from care workers, but did not have a member of staff supporting them during the incident.

We asked the acting manager about the incidents, and what they had done to analyse the events, to reduce the risk of such an incident re-occurring. They told us they did not know the incidents had happened, so had not been able to analyse them. This meant the provider was unable to assess if changes to the care provided to the person were necessary. There was a risk the person, and others, would not be protected from harm.

In the same person's record we noted a clinical consultant psychologist had recommended the person had the support of two members of staff at all times during the day. This was for a period of three to six months after the person began living at the home. The person had a review of their care needs on 13 August 2013. It was noted the person should continue being supported on a two to one basis to ensure the safety of the person and others was protected.

We spoke with the acting manager about this. They told us staff were supporting the person most of the time on a two to one basis, but they felt the person's behaviour was improving so they were trying one to one support to enable the person to become more independent. We asked what risk assessments had been undertaken to identify and manage possible risks caused by a reduction in staff support. The acting manager told us there were none and they were "seeing how it goes."

Records ✖ Action needed

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 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

In one person's care record we noted that risk assessments had been completed for the person. Some of them were hand written but were not signed. The Malnutrition Universal Screening Tool (MUST) had been included, but not fully completed. MUST is a screening tool used to identify adults who are malnourished, at risk of malnutrition or obese. Behavioural monitoring charts were not fully completed, and did not include the person's details, for example, their surname or dates they were completed.

The person had a health action plan (HAP) included in their care records. A Health Action Plan details the actions that are required for each person, to maintain and improve their health and any help that might be needed to accomplish this. Details in the HAP should include the names and contact details for any health professionals that support the person, for example, the GP or dentist. The HAP included in the person's care record gave contact details for professionals for the home the person lived in previously. This meant the details were not accurate. We asked the acting manager about this and they told us who the person's new GP and dentist was, and how they would contact them.

In another person's care record it was documented the person was subject to a supervision order.. Their access to the community had been restricted to protect them and others from harm. We asked the acting manager about this. They told us the person no longer had this order but their records had not been updated. There was no documentary evidence confirming the order was no longer in place. Most of the support plans in place referred to the restrictions put in place from the supervision order. The provider had identified this in a quality assurance review completed in May 2013. An action point stated "ensure that the support plans and current risk assessments are reflective of the current status of the service user". This had not been completed. The records were not being accurately maintained. There was a risk that appropriate care would not be planned, because the information recorded about the person was not accurate.

The acting manager also told us the person had recently visited the GP but there were no records of the visit, or the outcome, in the person's care record. Outcomes of other

appointments the person had attended had not been recorded. Other information in the person's care record was not fully completed, for example, a MUST assessment. Some other risk assessments had been reviewed, but details such as date and staff names had not been included. Some risk assessments did not relate to the current living accommodation. The acting manager confirmed the records were inaccurate.

The provider completed an internal quality assurance review in May 2013. In the report they identified several areas where records were inaccurate or incomplete. These included people's HAPs detailing incorrect medication information, one HAP that had not been updated since 2011, and entries that did not include date, time and signature. The review also noted that outcomes of appointments and any follow visits required with the GP were not clearly documented. There was no evidence that concerns identified in the quality assurance report and been addressed.

We looked at the staff training records. When we compared the service's training matrix to the individual records for seven members of staff we saw most of the records did not correspond. Staff training records were not accurate. The provider was unable to locate the supervision and appraisal records for staff until after our visit. These records were not located promptly.

The provider was not ensuring that people's personal records were accurate. Records required to protect people's safety and wellbeing were not being maintained. Other records in relation to people employed by the service were not accurate.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The provider did not ensure the dignity and privacy of service users. Service users were not enabled to make, or participate in making, decisions relating to their care or treatment. The provider did not encourage service users or those acting on their behalf to express their views as to what is important to them in relation to the care or treatment. Regulation 17(1)(a)(b(c)(ii).
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 did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user, and the planning and delivery of care in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9(1)(a)(b)(i)(ii).

This section is primarily information for the provider

Regulated activity	Regulation
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 effective recruitment procedures in order to ensure that persons employed were of good character, or ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity. Regulation 21(a)(iii)(b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.
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: The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate

This section is primarily information for the provider

	standard, including by receiving appropriate training, supervision and appraisal. Regulation 23(1)(a).
Regulated activity	Regulation
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: The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user and records appropriate to person's employed by the provider. Records could not be located promptly. Regulation 20(1)(a)(b)(i)(2)(a).

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 10 January 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 22 January 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: The provider did not protect service users against the risks of inappropriate or unsafe care and treatment, because they did not regularly assess and monitor the quality of the services provided. They did not identify risks relating to the welfare and safety of service users. The provider did not have regard to the comments made, and views expressed, by service users, and those acting on their behalf. They did not analyse incidents that had the potential to harm service users. Regulation 10(1)(a)(b)(2)(b)(i)(c)(i).

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.

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