Living Ambitions Limited

Living Ambitions - Newcastle

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection carried out on 22 March and 3 May 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to arrange the visit to their office.

Living Ambitions provides care and support to individuals with learning disabilities, challenging behaviour, physical disabilities as well as dual diagnosis conditions. Dual diagnosis means people who have two health conditions at the same time, for example; learning and physical disabilities. At the time of the inspection there were 35 people receiving a service. The majority of people received 24 hour support within their own homes or in shared facilities, although the provider supported two people in their own homes with staffing hours as required.

At the time of our inspection the service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We considered people were not fully protected against the risks associated with medicines because information was not always in place and safe procedures were not always followed to manage medicines safely.

Risk assessments were not always fully detailed to protect people, were sometimes not in place and were not always reviewed regularly. Accidents were not always reported by staff to the provider from the individual people's homes. The new quality monitoring system analysed accidents to check for trends forming.

Training records confirmed that staff had received training but the provider needed to help them support people effectively and protect themselves by providing additional training in a timely manner.

Individual care plans were in place for people, but we found that these sometimes lacked detail and had not always been reviewed in suitable timescales.

The people we spoke with told us they felt safe receiving care and support from staff at the service. Their family members confirmed people were safe. Staff received safeguarding training and were able to recognise and respond to signs of abuse. The provider took appropriate action in response to safeguarding concerns we looked at.

Recruitment practices were safe as background checks were carried out to ensure staff were suitable to work with vulnerable adults.

Staff received an induction. Staff were supported with supervision and appraisals being carried out, although a small number of staff did not feel they were supported and we brought this to the attention of senior management.

People were supported to enjoy a balanced diet and they were encouraged to make choices around meals, although we spoke with the registered manager about one person who we thought may have needed additional encouragement. The service worked with a range of health professionals to ensure people received support which met their healthcare needs.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. In this type of service, the court of protection makes decisions and appoints deputies to act on behalf of people who are unable to make decisions about their personal health, finance or welfare. We found the provider was complying with their legal requirements. We saw staff had received training in the Mental Capacity Act (2005) decision making processes. We saw people had information on mental capacity in their care plans and staff had been supported to make best interests decisions with the involvement of others, including healthcare professionals and relatives.

People thought that the staff team were caring individuals and relatives spoke positively about the staff who worked with their family members. Staff spoke to people with kindness and patience and found they knew the people they supported well. Staff knew what action to take to protect people's privacy and dignity.

People were supported to participate in community life through a range of activities.

Relatives knew how to complain and those who had made complaints told us they were satisfied with the response they received. Staff demonstrated how they provided people with choice and encouraged people to make decisions.

People and relatives spoke positively about the management team, although some staff members were less positive. We passed these concerns over to senior management.

Quality management processes were in place. The provider had recently implemented new audit process's which the service was now following. We found a number of issues during our inspection, which had not always been highlighted by any of the quality monitoring checks in place.

We found three breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, staffing and good governance. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Risk assessment and accidents procedures were not always safely followed.

People were protected from harm as staff were trained in recognising and responding to abuse.

Staffing levels were maintained by timely and safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was effective.

Staff training needed to be improved.

Staff received support through their induction and on-going supervision and appraisal.

People were supported with their health and nutritional needs well, although we discussed with the registered manager how they could improve this for one person who used the service.

People were supported to make their own decisions and where they lacked capacity to do so care staff ensured the legal requirements of the Mental Capacity Act 2005 were met.

Staff worked with other professionals to ensure people received adequate support which met their healthcare needs.

Is the service caring?

Good

The service was caring.

Care was provided by staff who knew the people they were supporting and was delivered in a kind and respectful manner.

Staff were able to demonstrate the different ways in which they

helped to protect people's privacy and dignity.

Staff told us they would support people to use advocacy services where additional help was required.

Is the service responsive?

Good

The service was responsive.

Care plans were in place and reviews had taken place.

People were supported to engage in activities in the local community and to maintain social links with families and friends.

People and their relatives knew how to complain and were satisfied with the response they had received from the provider when they had. Actions were followed up in response to complaints received.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were positive comments about the management team by people and relatives, but not always staff.

A range of new audits and checks were in place to monitor the quality of the service provided but these had not identified some of the issues that we had found during the inspection.

People and relatives confirmed they had completed surveys in order to gain their feedback. People had attended meetings in order to meet others and give them a chance to give their views.

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Detailed findings

Background to this inspection

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

This inspection took place on 22 March and 3 May 2016 and was announced. The provider was given 48 hours' notice because the location provides care services within people's homes and we needed to be sure that someone would be in when we called to visit.

The inspection was carried out by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information that the provider had sent us. This included the provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider about safeguarding concerns. Prior to the inspection we contacted the local authority contracts teams and safeguarding officers from across the areas where the service operated. We also contacted the local Healthwatch by email to obtain their opinion of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used any responses to support the inspection.

We contacted health and social care professionals by telephone before and following the inspection to seek their opinion of the service. These included two social workers and one community nurse. We used any responses to support the inspection.

We visited and spoke with five people in their own homes and spoke with four by telephone. We also spoke with five relatives.

We spoke with a number of staff during the inspection, including the registered manager, three locality leads, one team leader, the administrator and twelve care staff. The twelve care staff were a sample from each locality lead area.

We looked at a range of records which included the care records of the people we visited in their homes (five) and a further three at the office. We also checked the personnel files of six staff members and looked at a range of records regarding the management of the service.

Requires Improvement

Is the service safe?

Our findings

One person confirmed staff supported them with their medicines and said, "Yeah, staff help me with the tablets." Another person told us that staff reminded them and supported them to take their medicines on time. They also said, "I would not remember and that is no good." We looked at the medicine records for five people.

Staff maintained up to date records of medicines dosage and stocks and had completed people's medicines administration records (MAR). However, when we checked the MARs of three people we noted that the 'code' used for noting the reason for a missed dose, did not match with the code guidance on the actual MAR. For example, one person had code N marked against an entry and this did not exist on the listed possibilities e.g.. A for Absent, P for prepared and R for refused etc. This meant we were not clear on why the person had not received their medicines.

Many of the people using the service were supported by staff to take their 'as required' medicines. 'As required' medicines are medicines that are taken from time to time, for example, for a headache. These medicines were listed on people's MARs. However, we found that there was no protocol or procedure in place to support staff. This meant that staff were not equipped with full details and may not have given this medicine when it was needed, particularly for people unable to communicate fully.

We noted while visiting people in their homes that one staff member dispensed a person's medicines into a pot and then administered to them. The staff member then went to sign the medicines administration record (MAR) for the person which was kept separately. This meant that they were not checking that the medicines on the MAR matched what was administered. We also noted that there were hand written MAR entries which had not been countersigned by two staff as per the providers own policy guidance.

Staff documented one person regularly refused to take their medicine. In such cases they said they contacted the out of hours manager or the person's GP. However, staff did not routinely document that the person did not have any effects with refusing their medicines and the full outcome of any action taken. This meant there was an inconsistent approach to tracking the person's medicines. A member of staff completed a risk assessment for the person's refusal to take medicine. However, this was not fit for purpose because it instructed staff only to prompt the person and did not include other details to mitigate against all the risks of not taking their medicines. There was also no support plan in place to help staff meet the needs of this person with regard to their refusal to take their medicines.

We looked at the provider's training list and noted that not all staff had up to date training or competencies in the management of medicines.

Risk assessments we looked at were frequently out of date and not fit for purpose. For example, a risk assessment for one person who demonstrated violent and aggressive behaviour to staff was not adequate to support staff. We saw that the person's behaviour and emotional plan did not include guidance for staff or any information that could help them understand triggers to the person's complex behaviour. Staff

identified there was a risk of "serious harm" to them. However, the person did not have a risk management plan or support strategy in place. We spoke to the registered manager about this and when we returned on the second day of the inspection, a 'positive behaviour plan' was in place and staff showed us the updated staff security measures in place at the property.

We looked at the daily notes of two people and found staff documented challenging behaviours. For one person, staff noted they struggled to cope with this person's behaviour. For example, one note stated, "… don't know why [person] is behaving like this." Staff documented they told the person they would call the police if they did not modify their behaviour. There was no evidence staff were supported by adequate guidance or leadership from managers.

Accidents and incidents were not always reported by staff in the way they should be. We found one person where accidents and incidents had been recorded in their daily diary and in their communication book but they had not always been reported to the provider. In the providers accident and incident register, we found the person had two entries against their name from 25 January 2016 to 22 March 2016. However, when we visited the person, we found nine entries in their records which should have been reported.

Staff maintained a falls and balance record for one person who experienced eight separate falls between December 2015 and February 2016. Although the falls were documented, there was no evidence of an investigation or mitigating actions. Staff had requested a health screen by a mental health specialist but there was a significant delay in arranging this and there was no evidence interim measures were in place to protect staff and support the person.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Medicines were stored safely and staff knew how to dispose of any that were not required. We saw that daily checks on medicines were completed in people's homes and shared living arrangements. One staff member told us that any medicine errors would be investigated, and further commented, "They would not be brushed under the carpet." This meant that when issues had been identified that these were investigated.

People told us they felt safe receiving care and support from staff at the service. The relatives we spoke with confirmed people's feelings. Comments from people included; "Not worried about that [safety]. My carer is brilliant"; "Oh yes, feel safe with her [staff]. She is brilliant" and "Good; they [staff] look after me. They keep me safe all the time." Comments from relatives included; "I think [person] is very safe with the staff" and "If they weren't safe, they wouldn't be here. I'd move them out."

We spoke with staff who were able to demonstrate an awareness of different types of abuse and the signs they would look for which could indicate if a person was being harmed. When we asked one staff member if they thought people were safe, they said, "Oh my God, I would not have it any other way." Staff knew how to report abuse and felt confident the management team would take appropriate action. Training records we looked at showed staff had received training in safeguarding procedures. We reviewed the safeguarding records and saw investigations had taken place and referrals were made to the appropriate agencies. Staff were also familiar with whistleblowing procedures and each one we spoke with said they would report any concerns regarding poor practice they had to the registered manager or their line manager.

When we asked relatives if they thought there were enough staff, they told us they thought there was. One relative said, "I think it's [staffing] quite adequate." Another relative said, "I am not aware of any problems, and I think I would know." The provider tried to ensure people received continuity of care from the same

staff members, although they recognised this was not always possible due to sickness and staff vacancies. The management team were in the process of recruiting to vacant posts and hoped to have them filled soon, but recognised that this was an area that was constantly on-going.

There was an emergency on call number and procedures that both people and staff could activate. One relative told us, "I've the phone numbers of all the staff who are supporting [person's name]." Another relative said, "I've the contact numbers of staff in the house and the office."

Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Staff records confirmed potential employees had to complete an application form from which their employment history had been checked. Suitable references had been provided and taken up in order to confirm this. Eligibility checks had been carried out and proof of identification had been provided. This meant that appropriate checks had been undertaken to ensure staff were suitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

One person told us, "They [staff] help me a lot. They take me out. They make me tea." Relative's comments included, "Yes. [Person] looks good and well"; "They [staff] seem to be qualified to look after [person]" and "I would like to say that the staff team seem good at what they do, cannot ask for any more than that really."

Staff completed an induction based around the Care Certificate standards. The Care Certificate was officially launched in March 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards. New staff also shadowed established staff and completed a record to confirm this had taken place. One staff member told us, "The induction is good, it covers all the things I have needed."

There was a range of mandatory training completed by staff at the service to build upon the induction training they had received, including emergency first aid, health and safety, moving and positioning and mental capacity. One care worker said, "We used to have de-escalation training including non-violent intervention training. But we haven't had this or an update for a long time." Another care-worker said, "I've asked for training on challenging behaviour but [registered manager] hasn't arranged this yet. We're not at all equipped to deal with the violence and escalating behaviour we're seeing from [person]. We checked the training records of staff and found that 14 staff had received challenging behaviour training out of a possible 115 but that most of the training was from over three years ago and one over eight. We noted that some training was out of date, although the registered manager assured us that this would be brought up to date over the next few months. Staff had received a range of other training which was not registered on the providers training matrix, however, we saw certificates to confirm this in staff personnel files, including for Dysphasia, depression, food hygiene and diabetes. Dysphasia is a communication disorder which occurs due to brain damage. During the inspection training for staff was taking place in the service's main office and was in connection with person centred planning. We spoke with the registered manager about challenging behaviour training and they told us this was to be updated for relevant staff in the next few months. We were able to confirm that other additional training which was required had been booked to take place. However, due to the length of time lapsed between training we were not confident that the provider had managed this as well as they should have.

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

Staff received supervision and annual appraisals from the management team. The majority of staff thought they were well supported, although there were a number who did not feel that way and we brought that to the attention of senior management.

People had health action plans, which detailed their on-going health needs. The information in the plans was detailed and included guidance for staff. For example, what to do if one person refused their medicine or needed to see a podiatrist for their feet or a doctor for ear care. Where staff were concerned about the

health of a person, they had contacted appropriate professionals for support. We saw documented in one person's care record that an occupational therapist had been involved with them and specialist advice was recorded to enable the person to be moved and handled by staff safely. Another person had been seen by a dentist for their regular check-up.

One relative confirmed that staff checked it was alright to provide any type of support before they 'just do it'. One relative said, "Staff give directions first, before doing it. You cannot ask [person] because she will say yes to everything." We heard one member of care staff asking a person if it was alright that they provided them with personal care and it was only when the person agreed that they were heard to continue.

Where there was any doubt over a person's ability to make a decision, we saw decision making agreements documented in their records. This showed what the decision was, who was involved and who would make the final decision. For example, the person, family or social services.

Staff had an awareness of procedures involving people who may lack capacity. The registered manager was able to explain what involvement the court of protection may have with people. The Court of Protection in English law is a superior court of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves. There were procedures in place to support staff in their understanding of depriving people of their liberty and what action they must follow. A number of relatives we spoke with were power of attorney or deputies through the court of protection and staff were aware of this and what it meant, although the provider had not applied to the Court of Protection to have anyone deprived of their liberty.

Relatives told us that their family members received a good choice of meals, which were nutritious and met people's needs. They thought the food was served at the right time, was at the correct temperature and that people received enough to eat. One relative told us that their family member received refreshments throughout the day and night and said, "Yes, staff do put a lot of drinks in front of [person] for [person] to drink."

When we visited one person, we looked at their records around nutrition because we noted they were at risk of a poor diet due to their eating habits. Records confirmed that the person was encouraged to eat home cooked meals. We, however, saw little evidence of this when we looked in the cupboards and the refrigerator as there appeared to be few ingredients to enable staff and the person to work with. We noted that the person had no breakfast and refused any lunch while we were at their home. Although staff were heard asking the person if they wanted anything to eat, this was not followed up with words of encouragement after the person said that they did not want anything. We noted that the person had been previously referred to healthcare professionals and staff told us their weight was not a concern. We brought this to the attention of the registered manager who said she would look into the matter.

Staff confirmed people with particular dietary needs were monitored. Staff told us that one person who was at risk of choking had been referred to the speech and language therapy team (SALT). After a meeting with the team the person was commenced on a blended diet to minimise the risk of choking.

Good

Is the service caring?

Our findings

People said staff were caring. Comments from people included, "Very friendly, polite and nice"; "She [staff] has a nice manner. She is like a family to me" and "Nice friendly manner." Comments from relatives included, "Polite, friendly, caring and considerate"; "They have been fantastic. They have been great"; "Very nice, very helpful" and "All of them [staff], brilliant."

We observed staff interacted with people in a kind and compassionate manner. We saw they responded promptly to people who were requesting assistance and they did so in a patient and attentive way and we noted some warm and friendly exchanges between staff and people. A member of care staff helped one person sit next to us in order for them to be able to have a private conversation with us. Staff spoke with people while they were providing care and support in ways that were respectful.

Staff had good knowledge of individuals and knew what their likes and dislikes were. One person had a particular interest that staff understood and engaged with them over. Staff used people's chosen names when they spoke with them.

A number of people told us that they were able to attend religious services when they wanted. One person told us they went to church every month when they wanted to. One relative told us, "Yes, staff take [person] to church every week." Another relative explained that staff went out of their way to support their family member with their particular religion and culture, which included taking them to particular community centres and shopping at particular stores. This meant that staff had taken into account people different cultural and spiritual needs and supported people to maintain them.

One person confirmed that they were involved with their care planning. They said staff used alternative methods to explain and said, "Pictures to look at. I can't read." When we asked relatives if they were involved in the care planning process, they confirmed they were. One relative confirmed they were present and said, "Yes, [person's name] was present as well."

One relative told us, "I am involved in all of it. I interviewed new staff for [person]. I talked to all staff about [person]. I also talked about respect for service users to new staff."

One person told us they were provided with updates on the service from the staff who supported them. They said, "They [staff] give information whenever there is new information." We heard one staff member read out an appointment letter which had just arrived to one person to keep them informed. This was followed by a discussion regarding arrangements to get there.

People told us that staff respected their privacy. One person confirmed that staff provided them with privacy and said staff, "Leave me to get on to do things on my own." Another person explained that they were able to have privacy in their own space should they need it. One relative said, "Staff knock on the door before going in [person's] room. Very respectful." Another said, "Staff ask before doing anything even though [person] cannot speak."

People were encouraged to do things for themselves. One person confirmed they looked after their own money and was independent in that respect and said, "I do shopping with the carer. I can pay the cashier and keep the receipts myself." Another person explained how staff had encouraged them to become independent and said, "I am now able to go to college on my own on the bus; before I couldn't do it. My carer used to take me to college but I do it myself now." One relative told us staff supported their family member to remain independent and said, "They try as much as they can." This meant people were encouraged to be as independent as possible.

From people's records, we noted information was recorded about the use of advocates if necessary, although we did not find anyone that was currently using these services. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. This meant staff were aware of the need to involve advocates when a person had no one to represent them and needed additional support.

Good

Is the service responsive?

Our findings

From the comments that people made, they gave us the impression they thought the service was responsive to their needs. One person said, "If I wanted [staff name] to do something they would" Another person told us, "[Staff name] will take me out if I want to go." A relative told us, "They [staff] will do anything for [person]; they are part of the family now." A member of care staff told us, "Everyone is different, so we work on how best to meet people's needs."

People's needs had been assessed with additional information from the local authority, and care plans produced with risk assessments put in place. Evidence on people's care records showed the provider aimed to tailor support in a person centred way. For example, the one page profiles, described outcomes and information such as 'what people like and admire about me'. One person had recorded that other people liked their smile. People's likes and dislikes were listed and what involvement people wanted from their family. Information was recorded on how people liked to have various information/choices presented to them. For example, on one person's record it stated that they liked information, "Put in front of them." Another person's record explained that they did not like too many choices and preferred two and recorded, "I don't like too many." People's records included pictures of food and other items that were important to them and these were used as a tool to better communicate with people.

We saw good examples of person-centred care during our visits to people in their homes. For example, care workers had a good understanding of the needs, personality and temperament of one person they cared for. For example, they understood direct questions made the person anxious so they had developed a communication style to include more discussions than questions. In addition, the person had a restricted diet due to health concerns and the care workers had developed a special diet for them to include their favourite tastes. For example, they enjoyed milk but could not drink dairy products. To accommodate their taste, the staff had sourced non-dairy chocolate milk. They had also found a brand of non-alcoholic beer the person liked, which enabled them to enjoy the taste of beer while adhering to health advice from their GP.

Staff documented daily activities for people. Activities included supported visits to friends and family, day centres and to local coffee shops and bars. One relative told us their family member had a varied social calendar and said they had a, "Full programme for [person] for example, musical places to go to, walks, holidays and trips." One person told us that staff helped them to listen to music which was one of their hobbies. They said, "Yes, I like music. Staff switched on the radio for me as I couldn't do it." A staff member told us that they organised rides on adapted bicycles at a local activity centre. They said, "[Person] loves it. It's good exercise too." People were able to take holidays with support from the staff teams. One staff member told us, "[Person] had a few days in Kielder and [Person] went to Heartbeat [TV programme] country." One person told us they had been to Blackpool and wanted to go back there again in the future. This meant people were able to participate in activities and pastimes that they preferred to do with the support of staff if needed.

One person said, "I always go where I want to go and she [staff] will take me there." Another person said, "Yes I can make my own choices." One relative told us, "[Person's name] has limited ability to make choices,"

and continued, "Staff support [name] to make them as much as they can." Another relative said, "They would ask [person], 'do you want this or that', as they cannot ask." This meant that people had choice and were able to exercise their right to decide for themselves where ever possible.

People told us they knew how to complain. One person said, "I just tell them [staff] that I am not happy with them." They continued to tell us they had complained before and staff had dealt with the matter to their satisfaction. Another person explained that they had complained about two care staff before and continued, "Yes, they stopped sending these two particular carers to me." It was noted that in the care plan of one person the complaints policy was not in an accessible format appropriate to their communication needs. We brought this to the attention of staff. A relative told us, "I have got no complaints. They [staff] are good in all areas." There had been no complaints in 2016 and the six received in 2015 had been dealt with effectively by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. She told us she had worked with a range of people who had complex needs, including learning disabilities for over 18 years and had managed this service for a number of years, including transferring to the new provider when they took over in 2015.

People and relatives generally spoke positively about the management team. However, staff were not all positive and sighted some instances where they felt "isolated", "lacked management support", "spoken to abruptly" and that the "management was not responsive." We discussed this with senior management and they told us they were aware of some issues in the past but felt they had been addressed. They said they would look into these comments.

There were a number of areas regarding the management of the service in which we found shortfalls:-

People's needs had been assessed with additional information from the local authority, and care plans produced with risk assessments put in place. However we found that not everyone's care records and risk assessments were fully completed with relevant information. For example, dates were not always documented in full and care plans were not always reviewed in a timely manner. During the first day of inspection we spoke to the registered manager about documentation that was not in place at one person's home where we had identified significant risk to the staff and to the person. Just after our first visit the registered manager emailed us to confirm this information had been updated and safety measures put in place for the staff. However, we noted on the 8 March 2016 that a provider representative had visited the person and recommended actions, which had included additional safety measures for the staff. This meant that management had not acted in a timely manner to protect staff and the people at the service and had only responded when we raised the issues with them.

We also found that one person had out of date information regarding their appointee. An appointee has the legal right to deal with the benefits of someone who can't manage their own affairs because they lack capacity or are severely disabled.

We saw that dates and signatures were not always fully completed on people's care records. For example, one person had 'Jan 16' or 'Jan' recorded on their records. This meant we were not able to fully establish if the record related to the current year or which day of January.

The quality assurance checks completed had not always found the issues we had identified during our inspection, including those regarding people's medicines.

Staff told us that updates from people's care records were taken to the office on a memory stick in order that centrally held records could be updated. We asked if the memory stick was encrypted and we were told it was not. One staff member told us, "We have done it this way for ages. I think other staff do the same as well." This meant that there was potential for confidential information to be lost in transit.

At one shared accommodation we visited was in need of replacement furniture and some redecoration work for the people who lived there. A meeting had been held in November 2015 with people to decide what they wanted to buy and this was agreed. We saw an entry in the daily diary that one staff member had made to confirm a conversation that had taken place with management to authorise staff to go ahead and complete the work. When we asked staff why the work had not been completed, they told us that they did not want to buy anything until they had received the confirmation in writing, as per the organisation's policy and said that there had been occasions where management had denied giving authorisation to complete a particular piece of work and they did not want to be caught out again. We noted that written authorisation had not been received. We brought this to the attention of the registered manager who said they would look into the matter. This meant people were kept waiting avoidable extended periods of time for staff to replace furniture on their behalf and management had not followed this up.

The provider had not updated all policies or formal documentation, which included changes to the organisation's logo. This included records of mandatory training, risk assessments and the complaints policy. Staff were not able to tell us if the documents in people's care plans were still valid and confirmed they were not sure which paperwork they should be using. We saw, on the 1 May 2016, that staff had started to use a 'daily record' for one person which was based on the documentation of the previous provider. We discussed this with the registered manager and she told us that staff should know which paperwork to use.

We noted the management team completed audits on staff personnel files. This included checks to ensure that supervision had been completed. The form that was being used stated that staff should receive supervision six monthly and was on the previous providers paperwork. When we asked locality leads about the timescales of supervision, they agreed with this. However, when we looked at the provider's supervision policy, it stated that care staff should receive supervision six times a year. This meant there was a conflict in management policies or understanding by senior staff at the service.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

A new quality assurance system had been implemented by the provider from January 2016, including health and safety checks and monitoring in all areas in which the CQC checks during an inspection including, for example, safe, effective and well led. The checks had highlighted some of the areas that we had found during our inspection and the management team were in the process of working their way through these issues. Staff at the service completed checks of people's finances on a regular basis. One staff member told us, "We count their (people's) money at every shift to check it is ok and it's signed off." This meant that the provider had safety measures in place to ensure people's personal money was protected.

Accidents and incidents were now being monitored more thoroughly with the aim of identifying trends sooner and protecting people or staff from the possibility of further incidents in the future.

The provider had a management team in place to oversee the operation of the service. This included a regional manager, registered manager (operations manager), locality leads and team leaders. The service was in the process of recruiting to the posts of team leader as a number had either left or decided to take a less demanding role and had taken up posts as care staff. Staff knew what their responsibilities were. One member of care staff said, "I am here to make sure [person] can do things that they want and make their life mean more." Another member of care staff said, "We take [person] out and give them the opportunities they would not otherwise have," and, "It's our job to look after them and keep them safe."

We discussed the pressure that the locality leads told us they felt, with the registered manager. She told us

that this was due to a number of team leaders either leaving or changing roles. She said that the provider was discussing the possibility of employing a 'rota coordinator'. She told us this would take the pressure off team leaders and enable them to better support the locality leads. The registered manager also explained that two team leaders were due to start soon.

People and their relatives said they had received surveys to complete, asking them their opinions on the service and how they felt it was working for them. One person said, "Yes, completed one [survey]." One relative said, "I've filled out forms in the past." One relative felt that the staff were responsive to any comments they made about changes to improve the service offered and said, "Everything I asked of them, they carried out." We saw that from a recent survey that the registered manager had gathered 12 returned surveys from people. Comments were positive with one form being completed by a relative and the others by people with staff supporting them.

The provider had set up a 'Listen to me' group which was held at the provider's office. The group was attended by approximately nine people using the service and staff told us that they wanted to encourage more to go along as it was a chance to meet new people, talk about items that mattered to them and it was also an opportunity to discuss any concerns they might have had.

Many of the individuals who used the service lived in shared accommodation with other people. Staff told us that individual house meetings were held where people attended if they wanted to and this was encouraged. One staff member said, "It's important to include them [people] as much as possible."

We were made aware of a number of HR related issues from the staff that we spoke with. Although out of our remit, the registered manager assured us that these issues were in hand and being dealt with.

The registered manager had ensured all notifications to the Care Quality Commission (CQC) were made. Notifications are changes, events or incidents that the provider is legally obliged to send us within required timescales.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not followed safe practices in the management of medicines. They had also not ensured that staff mitigated against risk by completing appropriate documentation and had not always reported accidents or incidents to the provider. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were operated effectively to assess, monitor and mitigate against risk to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider had not always maintained accurate, complete and contemporaneous records in respect of each service user. Regulation 17 (1) (2) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured they had suitably qualified, competent, skilled and experienced staff working at the service.

Regulation 18 (1) (2) (a) (b)