RNIB Charity

RNIB Domiciliary Community Living and Support Services

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

Summary of findings

Overall summary

RNIB Domiciliary Community Living and Support Services (RNIB DCLSS) provides personal care to people either living in their own independent accommodation or in one of the service's supported living properties. The service seeks to provide specialist support to adults who are blind or partially sighted. People may also have additional learning disabilities, emotional or mental health needs. RNIB DCLSS supports people across a range of locations; at the time of our inspection, the service was providing the regulated activity of personal care to 12 people across seven locations.

The inspection took place on 10 May 2016 and 17 May 2016. The provider was given twenty-four hours' notice of the first inspection day.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility
for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left the organisation in January 2016. The provider has appointed another manager within the service to oversee the RNIB DCLSS and this person is in the process of applying for registration.

Due to some wider changes within the RNIB Charity, this service has recently experienced some significant changes. The RNIB previously operated a community living service to people living on a site owned by the provider in Redhill. Due to a large scale redevelopment project, this site ceased operating in October 2015. This meant that the existing community living service moved location and re-registered at the current address. As a result a number of people who previously had accommodation on this site, of which six received a personal care service, transferred to either two independent flats or one of the shared houses on the new site of the RNIB DCLSS, Swail House.

At the same time, two houses on the Redhill site which provided residential care to people also closed and these people also had to move. As such, six people were now in receipt of a personal care service at supported living properties, one in Leatherhead and the other in Ashstead.

The above process has been widely referred to across the RNIB Charity and all stakeholder as the "decant". We have therefore retained this terminology for ease throughout this report. The impact of this decant has been varied according to whether people moved simply from one supported living location to another or from residential care to supported living. The former achieved a relatively smooth transition with people quickly settling into their new homes and adjusting to a different location. For those individuals who moved from residential care however, the decant process was poorly managed and resulted in a period of significant instability which failed to place people at the centre.

People and their representatives had been let down by a lack of communication about what was happening

at provider level. As a result people some people moved into accommodation that did not initially meet their needs in a safe way.

The provider had also not taken sufficiently proactive steps to ensure people's legal rights were protected. The management team had failed to work collaboratively with people, their relatives, funding authorities and the staff that knew them best. As a consequence decisions were made outside the Mental Capacity Act 2005 and best interests processes which exist to safeguard them.

The provider was not fully delivering the services set out in its Statement of Purpose. This was because some of its locations had not fully transitioned to the supported living model. These services were operating as care homes and were not offering people the same level of skill development and independence as those who were receiving a service from the Swail House site.

Insufficient planning had been undertaken in order to minimise the disruption of people's daily lives and activities. The geographical move of location across towns meant that people had less contact with their friends and their activity plans were disrupted. For some people, the move also reduced their independence. This was because they could no longer access their local community on their own as they had done previously.

Staff had not been prepared or supported to adapt to their change in roles. Aside from the location change which for many staff was personally disruptive, some staff had never worked within a supporting living service before. The lack of training and transition for these staff left them vulnerable and exposed to mistakes.

The provider had however recently listened to the concerns raised by us, commissioners, relatives and staff and reflected on the lessons learnt. As such, the management team were now looking at the Swail House part of the service that was experienced at providing supported living to see how the service as a whole could grow and develop together.

Staff told us that there had recently been a greater management presence across the services and more opportunities for information sharing had been held. People told us that they were starting to feel more settled. Feedback from most relatives and care managers also indicated that improvements were now being made.

All people who had moved locations were at varying stages of formal re-assessment and their care plans and risk assessments were now up to date. The recent recruitment of a driver had increased people's opportunities to access activities without the additional cost of taxis or public transport.

People had been supported to access new doctor's surgeries and their healthcare needs were being met. Medicines were managed safely and there were good processes in place to ensure people received the right medicines at the right time.

Appropriate checks were undertaken to ensure only suitable staff were employed. The management team were reviewing staffing models to ensure that locations across the service could function as intended and meet people's needs effectively.

People were protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in protecting them. All staff were trained in supporting people with visual impairment. Staff were passionate about protecting people and had recently acted as strong advocates for

their needs.

People told us that staff were kind and caring towards them and promoted their privacy and dignity at all times. Relationships between people and staff across the service were positive and lots of fun and laughter were observed.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 safely delivered.

The lack of an appropriate transition for some people to their new accommodation meant that risks to their safety had not always been appropriately assessed and managed.

In some locations, staffing levels were based on the needs of the group and not people's individual support requirements. Appropriate checks were undertaken to ensure only suitable staff were employed.

People were protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in protecting them.

Medicines were managed safely and there were good processes in place to ensure people received the right medicines at the right time.

Is the service effective?

Requires Improvement

The service was not wholly effective.

The provider had not ensured people's legal rights were always protected. They had not followed the principles of the Mental Capacity Act when assessing people's suitability to move from residential care to a supported living service.

Staff completed appropriate training to enable them to support people with visual impairment. The provider had not however ensured that staff had access to other training and support to allow them to deliver their roles effectively.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

People were supported to maintain good health. The service had good links with other health care professionals to ensure people kept healthy and well.

Is the service caring?

Good

The service was caring.

People had good relationships with the staff that supported them. People were clearly relaxed with staff and felt happy and confident in their company.

Staff respected people's privacy and took appropriate steps to ensure their dignity was upheld.

Staff understood the importance of respecting people's choices and advocating strongly on their behalf.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not always received a service that that was personalised to their needs.

People's daily routines and access to activities had been negatively impacted by the decant. It was however evident that recent improvements to this area had been made.

People were confident about expressing their views to staff, but relatives felt that the provider had taken too long to listen to and address their concerns.

Is the service well-led?

Requires Improvement

The service was not wholly well-led.

People had been let down by the poor management of change across the service.

The service was still in transition and was not wholly effective in delivering its stated purpose.

The provider had recently reflected on the decant process and was making changes to improve. Feedback indicated that the management culture was starting become more open.

Systems for monitoring quality and auditing the service had recently improved and were being now used to develop the service.

RNIB Domiciliary Community Living and Support Services

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 over two days on 10 May 2016 and 17 May 2016. The provider was given 24 hours' notice of the first inspection date in order to ensure representative of the provider were able to meet with us and provide access to records. On the second inspection date we arranged to visit two of the new supported living locations in Ashstead and Leatherhead. This inspection was carried out by one inspector with background experience of this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider also completed a Provider Information Return (PIR) before our inspection. This 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.

Across the two inspection days we met with seven of the 12 people who currently received the regulated activity of personal care from RNIB DCLSS. We also joined people at their day service where we had a group discussion about their experience of receiving support from RNIB DCLSS.

We interviewed seven staff, which included two of the managers responsible for the overall running of the

service. Following the inspection we gathered feedback from three relatives, and three social care practitioners. We also reviewed a variety of documents which included the care plans for four people, three staff files, medicines records and various other documentation relevant to the management of the service.

Due to the re-location of this service which resulted in a new registration, this is the first inspection of the RNIB DCLSS.

Requires Improvement

Is the service safe?

Our findings

People told us that the service they received made them feel "Safe" because they trusted staff to look after them. Relatives of people who had moved from residential care to the supported living houses said that they did not believe people's safety had always been considered when the new properties were first secured. For example, one relative told us how when people first moved into their new home there were no handrails to facilitate safe access on the stairs. This has now been resolved, however due to the visual impairment of people who use the service this was a vital and basic requirement that had been overlooked.

Environmental risks to people had not been appropriately assessed and controlled prior to people moving into their new accommodation. We saw that whilst risk assessments relating to people in their new environment had now been updated, there had been a delay in these being completed for the people who had moved from residential care. Staff confirmed that risks to people had not been properly assessed and managed when they first moved. Staff cited the impact that the lack of a handrail had had for people at one of the houses. Similarly, they expressed concern that one person had been given a downstairs room when the bathroom was located upstairs and it was known that they accessed the toilet during most nights. It was evident that staff and team leaders had worked hard to make these risks safe, but they should have been identified prior to allowing people to move in.

Each person had a Personal Emergency Evacuation Plan (PEEP) which provided guidance to staff to assist them to evacuate people safely from their accommodation in the event of an emergency, such as fire. For the people that had previously received a supported living service that these had been updated swiftly following their move. A monitoring report completed by an external consultant in February 2016 highlighted at that time that the PEEPS for people in the shared houses in Leatherhead and Ashstead had still not been reviewed. These people had therefore been living in the properties since October 2015 without appropriate evacuation guidelines. The provider had since taken corrective action and the fire service confirmed that appropriate fire safety measures were now in place.

The principle behind the supported living and the service's stated purpose is that staff are allocated on the basis of people's individual needs. In two of the supported living houses staffing levels were based on the needs of the group and not people's individual support requirements. The Leatherhead and Ashstead houses were running a collective staff rota which provided 24 hour cover at the service. Some people living at the service now had supported living contracts with their funding authority, whilst others did not. Staff were unable to tell us how many hours of care people were contracted to receive. Staff told us that they were allocated to shifts at the houses and not hours to people.

Whilst staffing levels at the above two house ensured people's safety they did not effectively meet people's care and support needs. For example, on both inspection days one staff member took people from the Ashstead House to their day service and then spent three and a half hours waiting for them to return home. Similarly, on the first inspection day, another member of staff was rostered to work in the Ashstead House from 10am-4pm despite there being no people in the house in the afternoon. By staff being rostered to work in this way, meant that at other times when people could have benefitted from additional staffing, the staff

were not available. For example, people told us that they had been unable to go out in the evenings or at weekends on some occasions because only one staff member was working alone. Similarly, a team leader confirmed that at the Leatherhead house outings for people were sometimes restricted because of the allocation of one staff member to three people.

The allocation of staff based at the Swail House site however was based on a supported living basis. As such, we saw that people were supported by named staff in accordance with their support needs. People who used this part of the service told us that staff support worked well and that they always received the assistance they needed at the times agreed. We also found that people worked in collaboration with the service to be able to attend bespoke outings or holidays. For example, the team leader showed us that the service was flexible in enabling people to 'bank' their support hours in order to use them at times of their choosing.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history written references and job descriptions in staff files to show that staff were suitable to work in the service.

People were protected from the risk of abuse. Staff were confident about their role in keeping people safe from avoidable harm and demonstrated that they knew what to do if they thought someone was at risk of abuse. Training records showed that staff had received training in safeguarding and policies and procedures were in place for staff to follow if they suspected abuse. All staff confirmed that they felt able to share any concerns they may have in confidence with either a team leader or one of the management team. Staff were also clear about how to correctly report abuse to the outside agencies if necessary.

Medicines across the service were managed safely and there were good processes in place to ensure people received their medicines appropriately. Each person had a locked medicines cupboard in their own accommodation and this facilitated medicines being given in a person centred way.

At the Swail House site people were encouraged to be involved in managing their medicines and where appropriate, people had been risk assessed to enable them to take responsibility for the administration of their own medicines. We discussed with staff at the Ashstead and Leatherhead locations how they could be more proactive in supporting people to deliver greater independence in this area. During feedback the management team reflected that this was an area for improvement.

Where staff supported people with their medicines, they completed Medication Administration Records (MAR) following the administration of medicines. These records were found to have been accurately completed which ensured the service had a record of the medicines people had received. .
Staff understood how to support people safely with their medicines. Only staff that had completed training and competency assessments were permitted to give medicines. Policies and procedures provided staff with appropriate guidance to support people with their medicines in accordance with safe practices. There was also a policy for the use of "homely" or "domestic" remedies, such as those for minor ailments. This helped to ensure that people could have swift access to treatment if they had a cough or cold. Where people were prescribed occasional (or PRN) medicines, such as pain relief, there were appropriate protocols to inform staff how and when these medicines should be administered. Staff were knowledgeable about the medicines they were giving.
Medicines were stored and disposed of in a safe way. Medicines were audited and accounted for regularly to ensure they had been given as prescribed. There was a system for recording the receipt and disposal of

medicines to ensure that staff knew what medicine was in the home at any one time.

Requires Improvement

Is the service effective?

Our findings

People told us that staff asked for their consent about their care and we observed that staff routinely checked they were happy before providing support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that through the decant process, the provider had not ensured people's legal rights were fully protected. This was because in making decisions about people moving from residential care to supported living, the provider had not ensured appropriate assessments were completed in line with the MCA for those people who lacked capacity to make this decision for themselves. As a consequence some people moved to their new locations without the legal authority to do so and at the time of our inspection, for some people, this was still the case.

When we spoke with people's care managers on behalf of their funding authorities, we found that the provider had not informed them of their proposals in a timely way so as to allow them time to complete capacity assessments in advance of the move. One care manager told us "I don't have confidence in the provider's understanding of best interests and capacity." We found that whilst staff understood the importance of obtaining consent from people on an everyday basis, the provider had not sought appropriate consent about their care.

The care records for one person highlighted that the provider had submitted both urgent and standard DoLS applications for them in July 2015. Neither had been reviewed nor updated following this person's move to a new location in October 2015. As such the provider had not only moved this person without obtaining valid consent, but was still failing to safeguard their legal rights.

The failure to provide care in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Both people and their relatives were complimentary about care staff and described them as "Good." It was evident that people had particularly good relationships with their keyworkers and one relative told us that their family member's key worker was "Just brilliant." All staff completed mandatory training in supporting people with visual impairment before they were permitted to support people. This training was extended to external agency staff.

Since the decant staff had not always been fully supported in their role. For those staff that had transferred from residential care to supported living, no additional training or support had been provided to help them understand the differences and what was expected of their new role. Training records showed that there was a programme for refresher training which included safeguarding, moving and handling and various health and safety topics. Staff across the service however told us that accessing this training had been delayed due to a temporary lack of access to facilities to undertake the courses.

New staff were appropriately inducted into the service. Newly recruited staff were in the process of completing a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. Those staff who had been recently recruited confirmed that their induction had helped provide them with the necessary skills and knowledge to support people effectively. One recently recruited member of staff had regularly met with their team leader to discuss their development and set performance objectives.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet. People told us that they enjoyed their food and that staff supported them to plan, shop for and cook their meals. One person talked to us about the goals they had in place to achieve a healthy weight and how staff supported them with this. The care records for this person included appropriate guidelines in respect of this along with evidence of regular weight monitoring of the person.

We found that people living on the Swail House site were supported to plan and cook meals as individuals, whilst those people who lived in the Leatherhead and Ashstead houses had chosen to cook for the group. We discussed with staff ways of developing people's skills and increasing their independence in this area in line with the supported living model. During our feedback to the management team they recognised this as an area for improvement.

People were supported to maintain good health. The service had good links with other health care professionals to ensure people kept healthy and well. Staff had liaised with the new GP surgeries and following their respective moves, people had been supported to register with a new doctor and attend a health review. Care records documented that people also attended regular health checks with their dentists, opticians and chiropodists. Each person had a 'Care Passport' which was a document that provided a summary of key information about people's health needs which could be shared with other healthcare professionals in the event of an admission to hospital.

Good

Is the service caring?

Our findings

People told is that staff "Are kind." When we asked people to explain why they thought this, they added "They listen to us." Relatives told us that on the whole staff were "Very nice" and that through the recent difficulties associated with the decant process, the consistency of staff who cared about their family members had provided some level of reassurance. Feedback from professionals also described staff as "Good" and "Caring."

The atmosphere between people and staff both at the day service and in people's homes were relaxed and friendly. There was a positive display of banter which highlighted that people were clearly confident and comfortable in the company of staff.

People's privacy and dignity were respected. People told us that staff always respected their private space. We observed that staff either knocked on people's bedroom doors or rang their doorbell to gain permission before entering. Some people were keen to show us that they had keys to their flats or houses and how they used them. When people required personal support we saw that this was provided discreetly and in a way that upheld people's dignity.

Staff were inclusive in the way they spoke with people and sensitively respected their visual impairment. For example, we observed one staff member spend a lot of time explaining to people exactly what biscuits they were being offered. During a personal news activity session people were encouraged to talk about what they had been doing, how they felt about that and what else they would like to do. We saw the staff member running the session took notes which they explained would then be used to support people to do more of the things they enjoyed and to highlight any areas where people expressed a worry.

Staff demonstrated the values of caring and empathy towards the people they supported. When we spoke with staff they were passionate about people and spoke up for their rights. It was clear that staff had been unhappy about the way the decant had been handled and were keen to ensure that steps were taken to enable people to receive better care. One staff member told us that whilst the process of moving had affected them personally, what they were most upset about was the impact on people. It was clear from our discussions with staff that they were strong advocates for the people they supported.

Since the decant, staff had spent a lot of time talking with people to reassure them about the future and involve them in making decisions about their care. Care records showed that each person had a monthly meeting with their keyworker in which they discussed areas that were going well and things they would like to change. As a result of these meetings we saw that staff across the Leatherhead and Ashstead houses had liaised with each other in order to facilitate more opportunities for people to spend time with their friends.

Staff had supported people to personalise and furnish their new accommodation according to their individual tastes and preferences. People proudly showed us around their homes and talked about how they were supported by staff to take ownership and responsibility for them.

Requires Improvement

Is the service responsive?

Our findings

People told us that they had found the last six months "Stressful" and "Upsetting." People described that whilst things were settling down and getting better now, the decant process had been a difficult time. People told us that they had been given a choice about who they wanted to live with and whilst it was clear this choice had been respected, people commented that they missed living close to each other and the missed being in Redhill.

Relatives from the people who had moved from residential care to supported living also expressed dissatisfaction at the way the decant had been managed and the effect that this had had on their family members. Relatives particularly highlighted the impact the move had had on people's activities and relationships with their peers. One relative told us "I'm concerned about the lack of female interaction my daughter now has and I'm concerned about the lack of activities." Another relative told us that the move had been "A backward step for independence." The location of the services when in Redhill had meant that people could walk to their activities or visit their friends, but since the move this was no longer possible.

For those people who had moved from residential care to supported living, their care and support had not always been planned in partnership with them. Feedback from people, their relatives, care managers and staff highlighted that the service people had received through the decant process had not been personalised to their needs. A comment made by one staff member summarised the views of others; "The decisions about who should move to supported living was based on the houses that needed to be emptied and not the people living in them." We found that the lack of assessment and planned transition for these people corroborated this view.

We read in the introduction to one person's support plan that the person had told staff "I want to be at the centre of planning my life." This person lacked the capacity to choose where to live and yet had moved house without any assessments or best interests discussions about whether this was the right move for them. Other people who had moved from the residential service also told us that they would have felt happier if they had been able to visit their new home in advance of moving in.

People told us that following their respective moves, their activities had been disrupted. People commented that they missed some of their old hobbies and they all told us that they missed the regular opportunities they had to meet with each other.

The failure to carry out a collaborative assessment of people's needs and preferences in order to provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person across the service had a detailed plan of care that outlined their individual needs and preferences. This included a pen portrait of the person that provided a summary of their needs, interests and care preferences. Staff told us that care plans provided a good level of information to support people effectively.

We found the Swail House part of the service had been more proactive in transitioning people's activities to their new location. For example we saw that one person had been supported by staff to attend a new local church which they now accessed independently.

Prior to the decant, we found that people had access to a wide range of activities that were meaningful to them. People told us that all activities had been suspended for two weeks after the move and some had since been re-introduced. Staff told us that the recent recruitment of a driver had improved people's access to activities and reduced the cost to them of attending activities such as horse riding by taxi. People commented that they had recently started spending more time meeting up with each other at weekends which they enjoyed.

We found that people who lived on the Swail House site were able to live independently and they received appropriate support that was tailored to their individual needs. At the other locations, staff were supporting people as a collective group. These people had some opportunities to develop their skills, for example one person had bespoke equipment in order to make their own breakfast. We discussed how these opportunities could be further extended to enable people to do more for themselves.

People told us that they felt comfortable expressing their views and feelings to staff and that they had lots of opportunities to do so. People said that they had confidence that their concerns would be listened to and taken seriously.

The service had a complaints policy which was accessible to people and their relatives. Relatives said that whilst they knew how to complain, they felt that their concerns about the decant process had taken too long to be heard. For some relatives they felt the provider was now more open and willing to listen, whilst others said that they had lost trust in the process.

Requires Improvement

Is the service well-led?

Our findings

We received a lot of negative criticism about the recent leadership of the service. Relatives, professionals and staff were all highly critical of the lack of effective communication about the decant process. This failing had significantly impacted on the lives of the people who used the service. One relative told us "The move was so badly handled, the RNIB just didn't listen to the concerns people were raising." Another talked to us about the emotional impact the situation had had on their family member.

The service was not operating in line with its stated purpose. When the provider de-registered the residential homes located on the Redhill site, they submitted a Statement of Purpose to us which stated that people would be receiving personal care within a supported living environment. The provider had however not provided any support, training or transitioning so as to enable this change to occur effectively. As a consequence, the services operating from the Leatherhead and Ashstead locations were continuing to operate as care homes.

The RNIB Charity promote their services as offering bespoke support for people with sight loss. Despite this, no assessments had been undertaken to ensure the new locations were safe and suitable for people living with a visual impairment. One relative commented that the recent situation had made them question the whole quality of care their family member received, telling us "I don't feel my family member is getting an RNIB service now, they could be living anywhere."

The lack of involvement of staff in the decant process and poor communication about the move of location for the services had negatively impacted on staff morale. One staff member told us "When we needed support the most, we received the least." Another commented "There was a lack of consultation and poor communication all round." A review of staff supervision records and staff meeting files showed significant gaps in both between July 2015 and February 2016. There had been an absence of any meaningful engagement with staff at a crucial time and as such they lacked clarity and certainty about their roles.

The provider was open with us about where they had gone wrong. They also shared with us the minutes of a management meeting that had been held following the decant which reflected on the lessons learnt. Staff told us that more recently they had been involved in discussions and plans for the renovation project which ultimately will see people with the opportunity to make back to the Redhill site. This demonstrated that the provider had now taken the concerns seriously and was committed to ensuring the previous mistakes were not repeated.

At the time of our inspection people presented as settled and most relatives told us that they thought that their family members were now adjusting to their new homes. The people living on the Swail House site were receiving a good quality of life and with the exception of location, their support had remained consistent.

Systems for monitoring quality and auditing the service had recently improved. Auditing on key areas such as health and safety, infection control and medication were completed regularly by designated leads across

the service.

A recent satisfaction survey completed by people who used the service showed that the majority of people received a service in which they felt happy, healthy and safe in. The provider also showed us that they were in the process of arranging a parent afternoon with a view to sharing information about their plans for the future and their visions for providing to a proper supported living service. As such we anticipate that the service will now move forward in the right direction.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to carry out a collaborative assessment of the needs and preferences of service users.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to provide care in accordance with the provisions of the Mental capacity Act 2005.