Voyage 1 Limited

Voyage (DCA) Wiltshire

Inspection report

Ground Floor, Newbury House
Aintree Avenue, White House Business Park
Trowbridge
Wiltshire
BA14 0XB

Tel: 01225618032
Website: www.voyagecare.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This was the first inspection since the service made changes to their registration. Voyage DCA Wiltshire offers a supported living service to people within shared houses. People who use the service have learning disabilities, autism and/or physical disabilities. They are supported with personal care, medicines, cooking, shopping, activities and other day to day tasks. At the time of this inspection, 29 people were using the service.

This inspection took place on 12 and 18 July 2017.

A registered manager was 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 2008 and associated Regulations about how the service is run.

People's capacity to make decisions such as medicine administration, finance and personal care was assessed. We saw for people with Court of Protection orders in place the appointed deputies had not been consulted for specific decision. We saw for one person, their relative was managing the finances where there was no Court Appointed deputy in place. The registered manager had not made the Court of Protection aware that they were caring for a person who were deprived of their liberty. Members of staff knew how to support people to make day to day decisions

Copies of records were not kept at the service office which included copies of Healthcare action plans and hospital passports were not kept at the service. Copies of medicine administration records (MAR) and when required (PRN) protocols were not kept at the service. This meant office staff did not have access to people's information and were not able to give staff guidance over the phone. In addition office staff were not able to monitor records and the effectiveness of the delivery of care and treatment.

Care plans and risk assessments were combined. A traffic light system was used to identify the level of risk. Members of staff knew the actions needed to minimise risks. For example, aggressive and physically challenging behaviour. While some information about people's preferences was included, the care plans were not always person centred. They lacked detail on how staff were to encourage people to meet their needs. Where healthcare professionals had made recommendations on how to support people these guidelines were not always used to develop care plans. Care plans were not monitored and there was no evidence to show that the care plans were effective.

Some people at times used verbal and physical aggression to show they were distressed or frustrated. A record of these incidents were in place but there was no evidence that all the recommended were followed to prevent the challenging incidents from escalating. Reports of challenging incidents were analysed to see if staff had followed guidance in people's care plans, or to determine whether care plans needed to be updated.

People told us they received kind and compassionate care from staff. The staff told us how they developed relationships with people and they knew why this was important. The staff comments indicated staff knew people well and knew their preferences.

People told us they felt safe with staff. The staff told us they had attended safeguarding of vulnerable adults training. These staff were aware of the types of abuse and the expectations placed on them to report allegations of abuse.

Recruitment procedures were safe. Where staff had convictions, risk assessments were completed. However, action plans needed to be in place on how these staff were to be supported going forward.

Staff said the training was good and they had attended all mandatory training required by the provider. A combination of face to face and online training was provided. The staff we spoke with said they had regular one to one supervision with their line manager to discuss issues, their performance and training needs.

People's views were gathered and used to inform the development of the service. Review meetings were used to improve communications between relatives and staff.

Quality Assurance systems were in place to monitor and assess the standards of care, but these were not always effective. Action plans were in place where shortfalls were identified. Although there were similar findings with this inspection, care planning and mental capacity assessments had not been identified by the provider as an area requiring improvement.

The registered manager was aware of their role and challenges of developing a supporting living scheme. Staff told us the registered manager was approachable. They said the team worked well together. They knew their leadership style and challenges with managing a service from a distance.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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?

Good

The service was safe.

People we spoke with told us they felt safe. Staff had attended training on how to protect people from avoidable abuse and harm.

Members of staff knew the actions needed to minimise risk to people. Risk assessments were combined with the care plan.

There was a system in place to determine the number of staff required and agency staff were used where shortfalls were identified or to cover planned absences.

Recruitment procedures ensured people were supported by staff with the appropriate experience and character. Some members of staff had previously received a conviction on their DBS. Risk assessment was then put into place to support the new member of staff and mitigate potential risks.

Care plans or procedures for administering when required medicines (PRN) were not always detailed within people's care plans or identified separately as a protocol.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not following the principles of the Mental Capacity Act (MCA). Application for Court of Protection orders were not made for people whose care regimes deprived them of their liberty. The documentation showed staff were not always clear on the people to be involved when assessing people's capacity for specific decisions

New staff had an induction to prepare them for the role they were employed to perform. Staff were clear about their roles and responsibilities and benefitted from one to one supervision with their line manager.

People had access to ongoing healthcare. Relatives knew the arrangements in place to support their family member with their

ongoing health.

Is the service caring?

Good

The service was caring.

People told us the staff that assisted them were kind and caring.

People said they were treated with kindness and compassion by the staff. Staff respected people's rights and gave us examples on how they respected people's privacy, dignity and decisions.

Individual profiles on what was important to the person were in place for example, family, socialising and sensory stimulation. A typical day of the person was also gave information to staff on the person's preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive,

Care plans were not always specific on the plan of care, they were not monitored to show if the care plan was effective and did not include how staff were to support the person to develop skills. We found some action plans were not person centred and did not give staff guidance on people's preferences.

Overall people knew staff kept records about them and one person told us review meetings were held about their care was with their keyworker. Relatives told us they were invited to care planning review meetings.

People participated in social activities and where appropriate education. At weekends they joined in clubs and visits to the garden centre and cinemas were organised.

Is the service well-led?

Requires Improvement

The service was not always well led

A range of audits were completed by the registered manager and by senior managers in other departments. Action plans which included timescales and the staff responsible for the task were then developed on how the shortfalls identified were to be met.

However, care plans and mental capacity assessment had not been identified as an area for improvement.

The views of people were gained during house meetings and from surveys. Surveys were sent to people, using the service, relatives and staff. Issues identified for improvement were to be addressed through house meetings and during care plan review meetings.

Staff said they felt well supported and valued by the registered manager.

Voyage (DCA) Wiltshire

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 12 and 18 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service.

Before the inspection we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector and an Expert by Experience. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

We spoke on the telephone with three people and five relatives about their views on the quality of care. We spoke with the registered manager, regional manager and four staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included four care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe and their comments included "yes I do," "sometimes-some days-They do a good job-see them quite often," "I am quite happy here" and "alright-yes".

Staff said they had attended training on how to protect people from avoidable abuse and harm. These staff were knowledgeable about the signs of abuse and the expectations that they report allegations of abuse. Staff also understood the phrase whistleblowing. All staff said they felt confident to raise concerns and felt that they would be taken seriously.

Relatives of people using the service told us overall their family member was safe with the staff. Their comments included "We have a good working relationship-There have been a few issues where staff haven't considered the resident [person]". "I'm very happy-They are all very caring toward her" and "I think so-haven't had any concerns". Another relative told us there were issues with a housemate at one location. The registered manager was aware of these issues and was working with the local authority to review more appropriate placements.

Members of staff knew the actions needed to minimise risk to people. A member of staff said that "everything was risk assessed". They gave examples of how staff ensured people's safety, which included the medicines prescribed for the various types of seizure. Another member of staff said that risks were measured and actions were in place on how to ensure risks were taken safely. For example, aids and equipment were used for people at risk of falls. They said some people at times showed their frustration and anxiety through verbal and physically challenging behaviour. They said diversion techniques were used and some people were offered medicines to decrease their levels of anxiety.

The third member of staff said risk assessments for people with sensory needs were in place and staff were given guidance on how to support these people. For example, encouraging staff to listen and when supporting people in the community, staff were to position themselves on the outside of the pavement. There were risk assessments for trampolines and staff were to supervise the activity. Where there were people with mobility impairments, advice was gained from Occupational Therapists to develop pictorial risk assessments for staff. Other risks related to conflict, as some people were not always compatible with living in a supported living environment. The registered manager told us how compatibility was being addressed.

Risk assessments were combined with the care plan. A traffic light system was used by staff to assess the level of action needed for risks identified. For example, green for go and no action was needed, amber for think about the actions to minimise the risk and red for stop action plans were to be introduced. The registered manager said the aim was to develop an action plan that improves the risk level to "think or go". At the time of the inspection all risks identified were between "think and go."

The epilepsy care plan for one person was completed by a community healthcare professional. The plan included the equipment needed to alert staff the person was having a seizure during the night and the actions needed for each type of seizure. An emergency intervention plan accompanied the profile and

included a protocol for administering rescue medicines. The community healthcare professional and prescribing GP had signed this.

A member of staff said where incidents and accidents occurred reports were completed which the registered manager reviewed. They said where accidents occurred a body map to indicate the site of the injury in the body was attached to the reports

People said they had continuity from a core group of staff. They told us "yes -the same people [staff] and they are here [on duty]", "they see me at specific times," "I see different people [staff]. My key worker I see all day" and "Yes my keyworker." Members of staff assigned to work with specific people, were known as keyworkers.

There was a system in place to determine the number of staff required and agency staff were used where shortfalls were identified or to cover planned absences. A member of staff told us the staffing levels depended on the assess needs of people and some people needed 24 hour support by a minimum of one agency staff. Another member of staff said that in the Salisbury services, there was some lone working during the day and always at night. They said at times, agency workers was used to cover absences. This member of staff also stated that recruitment of staff was in progress and explained "we need our own staff. Service users [people] need familiar faces for continuity."

Recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Where staff had convictions the provider ensured this information was checked with the applicant prior to taking up their post. A risk assessment was then put into place to support the new member of staff and mitigate potential risks. While the risk assessment included the circumstances that led to the conviction, it did not include the learning from the events and how the staff identified potential triggers to ensure these events would not be repeated.

With the exception of one person, people said the staff administered their medicines. One person said "I do that-Yes they [staff] check."

Staff said they had competency based training before administering medicines. Medication care plans gave staff brief guidance on administering and recording of medicines. However, they did not include the medicines to be administered, the purpose of the medicines and the directions for administration. This meant staff did not have clear guidance on the support needs of people.

Care plans or procedures for administering when required (PRN) medicines were not always detailed within people's care plans or identified separately as a protocol. A member of staff said that one person was administered with medicines prescribed to be given as required. The registered manager told us this information was held in the home of the person. They told us the organisation's quality assurance system had accepted this system. However, there was no information held at the provider's office in the event guidance was needed by staff or if office staff had to contact healthcare professionals to discuss people's healthcare needs.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The records for this person showed they were having some foods excluded from their diet. However, there was no evidence the diet was recommended by healthcare professionals. Mental capacity assessments to determine the person's capacity to make this decision and best interest meetings had not taken place. A mental capacity assessment for finance was undertaken for one person and it was agreed for a relative to manage this person's finances. However, this relative did not have the legal power to manage their family member's finances. The documentation showed staff were not always clear on the people to be involved when assessing people's capacity for specific decisions. For example, there was a court appointed deputy to make decisions about one person's care, welfare and finance, but they had not been involved in these decisions.

Court of Protection orders were not requested where the care regime mounts to a deprivation of liberty. 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 deprivation of liberty safeguards do not apply to supported living services, therefore any deprivation of liberty requires authorisation by the Court of Protection. The action plan for one person with epilepsy gave staff guidance to supervise the person in all areas of the home and in the community. However, the Court of Protection was not made aware that regimes in place restricted the person's liberty. The registered manager told us the social worker for the person was going to be asked to make appropriate applications.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

Since the inspection the registered manager has taken action to make the Court of Protection aware that the care regime for one person mounts to a deprivation of liberty.

Decision making care plans detailed how staff were to support one person with specific decisions. Some people were offered two visual choices to help them make decisions. Mental capacity assessments were completed for personal care and for finance and best interest decisions were taken for people assessed as lacking capacity.

Some people we spoke with said they made their own decisions while other people said they needed some

support. Relatives told us about their involvement with decision making and the legal powers they had to support their family member with making decisions. Relatives with legal powers knew the decisions they were able to make for their family member regarding health and welfare or finance.

Staff understood some of the principles of the Mental Capacity Act regarding day to day decisions. A member of staff said "everybody had capacity" and people were given choices. They said people made day to day decisions such as the clothes they wore and activities. It was further stated that "people are not forced. We try and prompt and we [staff] know the difference. For example, one person may be too tired for activities after a day at college and they are not forced. Where people refuse medicines, staff keep trying to gain agreement from the person to take their medicines". Another member of staff gave us examples on how some people made staff aware of the decisions which included giving verbal responses and pointing while others made decisions through the use of "play". They said there were people in some premises that were able to make more complex decisions which included meals and activities.

People told us they had support from staff that were skilled and experienced. One person said "my keyworker [staff assigned to work with specific individuals] is very helpful."

Relatives gave us their feedback about the skills of the staff and their comments included "they are quite able-just don't always see things as important," "Seem to be well trained- There are a few staff changes- Mainly younger people who work well together" and "Absolutely- for about fifteen years he has had a team of two staff- One aged 30 and another aged 60- Both ends of the spectrum and both giving a different perspective- Excellent two people [staff]".

New staff had an induction to prepare them for the role they were employed to perform. Two members of staff said they had undertaken the Care Certificate designed to improve consistency in the training for new staff in social care settings. They said there was also an internal induction which covered shadowing more experienced staff to become familiar with the people in supported living environments. Another member of staff told us they had no previous experience of working in a caring environment and that their decision to change career was "the best decision" they had made. This member of staff told us their induction covered face to face training at the service office where they completed the mandatory training set by the provider. This included safeguarding people from abuse, basic life support and medicine training. They shadowed more experienced staff on all supported living environments for people using the service. It was also stated that during their induction they read the care plans that related to the people they were to support. This meant that before staff were working at locations they were able to gain some understanding of the people they were to support.

Staff were clear about their roles and responsibilities. Staff said the training provided ensured they had the knowledge and skills to carry out their roles. They spoke positively about the quality and quantity of training they had access to. A member of staff said the training provided was a combination of face to face and online training. They said there were opportunities for vocational qualification such as Social Care level two. The training attended recently included Mental Capacity Act, Health and Safety, epilepsy awareness, safeguarding of vulnerable adults from abuse and medicine competency.

The records of mandatory training set by the provider were online and we were told the information had recently migrated [the process of moving information from one online system to another] and errors had appeared with the information recorded which were being addressed. Other mandatory training included equality and diversity, fire safety, infection control, introduction to care and medicines. The registered manager said new courses were to be introduced, including moving and assisting and communication. The analysis of training attended showed 84% of staff had attended the mandatory training and the registered

manager said the expected attendance was 78%.

Staff said they benefitted from one to one supervision with their line manager. The analysis showed that not all staff had regular one to one supervision. The registered manager said the 59% ratio of staff having supervision, would improve with the supervision of new staff once their probationary period ended. A member of staff said there was a two way discussion. Feedback about their performance, their personal development goals and training needs were also part of the discussion. This member of staff also told us line managers were available to discuss issues of concern as they arose. The two personnel files we looked at showed one to one supervision and annual appraisals had taken place.

People told us about the arrangements for planning and preparing meals. Their comments included "I have my own stuff- I help them with snacks", "We have healthy stuff- I do my own cooking and shopping- I have house money", "They [staff] help me with meals- and shopping" and "We eat together- we cook together [supervised]".

Menu planners were in place to help staff with menu planning. A member of staff told us staff prepared meals and they catered for people's dietary requirements for example, gluten free. They said some people used certain behaviours to show their preference was for an alternative meal. For example, pushing the meals away from them. Another member of staff said menus were planned with people and each person was able to select their preferred meal from the menu. It was stated "people are encouraged to say their preferences. We still ask even if we know people's favourite meal." This member of staff said people were asked "what is your favourite meal".

People had access to ongoing healthcare. Some people said they went to GP appointments without the staff, while other people were accompanied by their keyworker. Staff confirmed this. Staff said Health action plans were kept in people's living environments but copies of these documents were not kept at the service's office. The registered manager said copies were to be held in the service's office.

Relatives knew the arrangements in place to support their family member with their ongoing health. Relative's comments included "staff arrange it [appointments] - They also take her out shopping", "He would go with support staff-he has regular checks ups- He has a core staff of three", "One of the team would take him-they are amazing- very kind and caring" and "He would be supported by a staff member."

Good

Is the service caring?

Our findings

People told us the staff that assisted them were kind and caring. The comments made by the people we spoke with included "They [staff] are very good- yes I feel that I matter" and "Very nice people [staff]- very pleased." One person told us the staff knew about their preferences.

People were treated with kindness and compassion. A member of staff explained how they showed to people they mattered and respected their rights. This member of staff said "I try to support people the way I would like. [I] treat people with respect". Examples were given on the communication methods people used to interact which included using sensory objects and movement. Another member of staff said "I have a good relationship with people at one location. I am thoughtful, courteous, I ask their [people's] opinion to make them feel valued [I] involve them in all decisions. What they think and what shall we do." This member of staff said they were able to identify signs of distress and stated that "it's in their expression. I listen. [I] say don't worry we will sort it. They [people] know I am going to do something about it". The third member of staff said people living in the supported living environments were known in the community and if there were concerns, people approached staff with these.

People told us their relatives were involved in the planning of their care while others were not sure if they were involved in the development of their care plan. People were not sure if their views about the service was gathered and their comments confirmed this. For example, "I don't know-I think so."

Profiles on what was important to the person were in place for example, family, socialising and sensory stimulation. A typical day of the person also gave information to staff on the person's preferences. Staff had recorded important information about people including personal history and important relationships. Support was provided for people to maintain these relationships, including support to keep in contact with family and friends. People's preferences regarding their daily support were recorded.

The rights of people were respected by the staff. One person told us the staff knocked on their bedroom door before entering. The comments from people included "I look after myself- they make sure I'm ok". "The [staff] just help me if I need them to." A member of staff said they respected people's decision to have space alone. They said one person asked staff to leave their bedroom and another closed the door to indicate they needed time alone. Another member of staff said when they were on duty in people's home's "I never enter bedrooms without an invitation to enter" and "sometimes they [people] say no leave me alone and that is respected".

Requires Improvement

Is the service responsive?

Our findings

Daily routine plans were not always detailed on people's preferences. Daily life routine for one person lacked guidance to staff on how they were to encourage the person to manage their personal care. For other people the daily life routines were in place included the times people liked to rise, meals and activities. The daily living tasks the person was able to undertake, the support people needed from staff and how staff were to assist them, were identified in the care plan.

Care plans were not always developed using guidance provided by social and healthcare professionals. The Eating and Drinking care plan for one person said they were able to prepare refreshments, purchase foods and plan menus. The action plan stated that staff were to support the person to maintain a healthy diet, to prepare refreshments and to encourage the person to develop new skills. Detailed guidance was not included on how staff were to support this person with meal preparation. The comprehensive assessment from the social worker for this person advised the staff to monitor the person's fluid intake and to monitor the person's weight. There was no evidence the advice from the social worker was used to develop the care plan. The registered manager confirmed the social worker's advice had not been actioned because the person's medical condition had improved. This means staff were not given clear guidance on helping people develop skills and their healthcare needs were not monitored.

The emotional and behaviour care plan for one person listed the triggers that may be presented and the appropriate responses from staff for each trigger. This included administering when required medicines to reduce anxiety and agitation. The action plan stated that staff were to complete "Antecedents Behaviour and Consequences (ABC) charts following each incident. We saw the guidance in the positive behaviour management (PBM) plans provided by a community healthcare professional was not used to develop emotional and behaviour care plans. For example, female staff, noise and bright lights were triggers for some behaviours. Documents of incidents did not show staff had followed the guidance within the PBM plans. This meant staff were not always managing potentially aggressive situation with detailed guidance on preventing situations from escalating.

Care plans for people who at times showed their distress using verbal and physical aggression were not always updated following aggressive incidents. Care plans instructed staff to complete "Antecedents, Behaviours and Consequences (ABC) charts" for incidents which detailed the behaviours observed before an incident, the behaviours shown during the incident and the actions taken. The ABC charts completed by the staff included the behaviours exhibited by one person and care plan of triggers the person may present. For example, noise had caused the incident. The behaviours that followed were described and the actions taken by the staff to de-escalate the behaviour was documented. This included games, giving the person time and offering refreshments. Despite staff being given guidance to offer PRN medicine to reduce anxiety and agitation there was no evidence that this was considered or offered. The registered manager told us that copies of ABC charts were being sent to the involved social worker to help them gather information on the behaviours exhibited. This meant ABC charts were not analysed to establish the events surrounding the incident and to determine if the care plans were followed or needed to be amended.

The comprehensive assessment from social workers for one person included the actions needed to support this person with communication. Staff were advised to develop communication care plans, use pictorial cards and introduce boards of "now and next" activities. The communication care plans although making reference to using pictorial cards to communicate did not include how staff were to support the person to understand the sequence of activities to take place. The registered manager was not aware that staff had followed this advice.

The emotional and behavioural care plan for one person stated the diet to be followed to reduce hyperactivity and pain, which may have an impact on the person's behaviour. The care plan in place gave staff guidance to follow a specific diet that a relative had provided. This guidance focussed on a medical condition that required specific foods to be excluded from this person's diet. The triggers that may lead to aggressive and challenging behaviours were listed. For example over stimulation, boredom and pain. The behaviours that may be exhibited when there were identified triggers for example, disturbed sleeping patterns for over stimulation and excessive laughing. It was also documented that medicines were prescribed as needed were to be offered for pain in the event this was the cause of the behaviour exhibited. The registered manager confirmed this guidance was from the relatives of the person. We were provided with correspondence dated 2016 from the Community Children's dietician to the Community Paediatrician which expressed the relatives views about the diet followed. There was advice with the relative's knowledge from the Community Children's dietician to reintroduce some foods into the person's diet. This meant staff were only following the guidance provided by the relative

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

Overall people knew staff kept records about them. One person told us review meetings were held about their care with their keyworker. Some people were not aware that a care plan was in place.

Relatives told us they were invited to care planning review meetings. We were told review meetings were annual which included where appropriate a review of medicines. They told us their suggestions on how their family member was to be supported were taken seriously. A relative said "yes- they [staff] are very pro-active" and "yes they are very good- they always listen to any suggestions."

People's social history was gathered and documented. People's relationships with family and friends and their interests were recorded.

Staff were kept informed about people's currents needs and welfare. Staff told us care plans were devised by the team leaders and they had access to them. They said daily reports were completed by the staff on duty and related to events, observations, activities and meals served. It was also stated that handovers when staff came on duty provided an overview of "what was going on" and if medicines were administered. Staff documented where people had appointments, the time people woke and the meals prepared. A member of staff said handover kept them informed about the previous shift. They said "everything is documented." The copies of daily reports included a description of the activities undertaken which included the household chores, meals prepared and organised trips.

Care plans were in place on how some people expressed their emotions. For example, happiness was expressed through vocal sounds which included singing and humming and for agitation, self-injury behaviours. There was supplementary information on specific behaviours exhibited with guidance to staff on how to respond appropriately. For example, when the person appeared tiered staff were to check if the person was in pain.

People participated in social activities and where appropriate education. One person told us they had just returned from an overseas holiday to visit family. They said staff supported them with shopping. A member of staff said some people in the supported living environment attended college, joined clubs and there were outings organised to coffee shops. Another member of staff said that at one supported living environment "the people never stopped". They said people went to cinemas, football matches, attended outings, museums, joined clubs and attended college and day centres.

Copies of the activities plans were kept in care files. The activities care plan for one person showed they attended college during the week and at weekends joined in clubs and visits to the garden centre and cinemas were organised.

One person told us it was their preference to approach their relative with issues. Relatives were not always clear on the procedures for making complaints but felt able to approach the registered manager with concerns. One relative said where they had raised concerns the registered manager "dealt with them immediately." Another relative said "there has been no need to complain- He is doing fantastically well-it has changed his life completely." We looked at the log of complaints and none were received recently.

Requires Improvement

Is the service well-led?

Our findings

A range of audits were completed by the registered manager and by senior managers in other departments. Action plans which included timescales and the staff responsible for the task were then developed on how the shortfalls identified were to be met.

Quarterly audits to assess standards against CQC Key Lines of Enquiry (KLOE) were undertaken by the registered manager. Where the KLOE was met, a pass was given and where there were shortfalls a fail or not fully met was awarded. For example, we saw a sample check of records were reviewed and for mental capacity assessments a fail was given. Social histories were identified as missing in some care plans. The audit undertaken by the regional manager showed medicine systems were assessed and when required (PRN) protocols were identified as missing for some people. The Quality assurance team had assessed the standards at the service and an 84% rating was given.

Whilst quality assurance systems were in place, these were not always effective. The provider and registered manager had not identified the concerns around care plans that we highlighted during the course of this inspection.

The registered manager maintained a log of safeguarding referrals, accidents and incidents which included a description of the event and the actions taken. They said while they read the reports, the team leaders were currently analysing incidents and accidents reports. It was agreed that smarter analysis from the registered manager was needed which included reports of challenging behaviour.

The views of people were gained during meetings and from surveys. Surveys were sent to people using the service, relatives and staff. The analysis of surveys was recently undertaken and from the 20 surveys sent to people17 responded and from the 20 surveys sent to relatives six relatives responded. The 20 staff surveys sent five staff responded. People had identified arguments between housemates and more choices, as an area for development. Better communication between staff and relatives were areas for improvement. The registered manager said the issues identified for improvement were to be addressed through house meetings and during care plan review meetings.

The values of the organisation were known by the staff. A member of staff said the organisation was "caring and supported people to live independent life as possible and the emphasis was on support." Another member of staff said the visions of the organisation included person centred care, empowering people to make choices, develop people's skills to lead independent lives and inclusion into the community. The third member of staff said "I am lucky, I am proud of the team. I am passionate and caring. They said the registered manager was good and "he will do his best to support staff".

People said they had contact with the registered manager. When we asked people if their views about the service were gathered, the comments people made included "Yes I am very happy with them" and "I'm happy [with the care] Happy [with the staff]".

Staff said they felt well supported and valued by the registered manager. A member of staff said while the team worked well there were some staff that were "lazy". We passed this information to the registered manager. They said the registered manager was "ok". Another member of staff said the team was "great all helpful and supportive. We help each other out." They said the registered manager and team leader were "great I like them both easy going, extremely helpful and easy to approach." Staff said they attended regular staff meetings. Staff received a compliment from a relative about staff engagement with their family member.

The registered manager discussed with us their management style and the challenges with managing a service. They said the role of service manager included responding to issues promptly to ensure people felt valued and interacting with people and staff to support them. They said to achieve this role they were approachable and open for feedback. This manager said the service benefitted from having strong team leaders and maintaining recruitment of staff. Challenges included distance management which some people and staff was perceived as remote.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always specific on the plan of care, they were not monitored to show if the care plan was effective and did not include how staff were to support the person to develop skills. We found some action plans were not person centred and did not give staff guidance on people's preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had not followed the principles of the Mental Capacity Act. DoLS authorisation was not requested for people subject to continuous supervisions. Mental capacity assessments were not undertaken to assess people were able to make specific decisions. Where people had lasting powers of attorney decisions were not made with the involvement of the decision maker with power to support the person with decision making. Staff had given relatives power to manage some decisions without having authority to make these decision.