Krinvest Limited

Krinvest Head Office

Inspection report

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13 March 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 12 and 13 March 2018 and was announced.

This was the first inspection of Krinvest Head Office since the service was registered in January 2017.

This service provides care and support to people with complex mental health and social care needs living in eight 'supported living' settings, so that people can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

At the time of our inspection, the service was providing 'personal care' to nine people who were living in their own homes in Knowsley, Halton and Warrington.

The service is provided by Krinvest Limited and coordinated from an office in Warrington.

The service did not have a Registered Manager. 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.

The Chief Executive Officer and the Business Development Director (referred to collectively in this report as the Senior Management Team) had taken over the interim management of the service in the absence of a registered manager and a deputy manager for the service.

Prior to our inspection the Commission received information of concern from whistle-blowers who raised concerns regarding the operation of the service.

During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to: staffing; fit and proper persons employed; safeguarding service users from abuse and improper treatment; safe care and treatment; receiving and acting on complaints and governance arrangements. We also found that an offence had been committed under the Care Quality Commission (Registration) Regulations 2009 as the registered person had not notified the Commission of incidents or allegations of abuse.

We identified that there had been no proper scrutiny or monitoring of the service by the provider which had led to significant failings within the service.

There had also been inappropriate admissions into the service and people did not always receive a reliable person-centred service that was responsive to their needs.

Recruitment practices were not safe as staff had not always undergone the necessary checks required prior to commencing employment. Furthermore, staff had not been appropriately inducted, trained and supervised to undertake their roles and responsibilities. This placed the welfare of people using at risk.

Records relating to the people using the service had not always been accessible to staff and were in need of development and review - to ensure staff had access to up-to-date and accurate information on the people they cared for.

Systems to safeguard people from abuse, to notify CQC of reportable incidents and to respond to concerns and complaints were ineffective and not robust.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding systems and processes did not provide adequate protection to people using the service.

People were not adequately protected from the risks associated with unsafe medicines management.

Systems for deploying staff were disordered and were in need of review to ensure people received appropriate person centred care and support.

Recruitment practice was poor and records were incomplete and did not provide sufficient assurance that the necessary checks had been undertaken prior to staff commencing employment.

Is the service effective?

Inadequate

The service was not effective.

People's needs had not been adequately assessed to ensure they received care and support that was tailored toward their individual needs and within the eligibility criteria of the service.

Staff had not routinely completed satisfactory induction, mandatory and other service specific training to help them understand the needs of the people they supported.

Policies and procedures relating to the Mental Capacity Act and Deprivation of Liberty Safeguards had been developed however half of the staff team had not completed any training to help them understand this protective legislation.

Is the service caring?

Requires Improvement

The service was not always caring

Staff and whistle blowers raised numerous concerns regarding the management, safety, care and treatment of people using the service.

Staff interactions were warm however some staff lacked awareness of the need to maintain confidentiality.

Is the service responsive?

Inadequate

The service was not responsive.

Systems for managing and responding to complaints were in need of development and review. There was no evidence that concerns had been recorded, investigated and acted upon.

Care / support plan records, risk assessments and supporting documentation were missing or in need of review. This meant that staff did not always have access to up-to-date or key information necessary to assist in the delivery of person centred care.

The service did not specialise in the provision of end of life care.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager in place to provide leadership and direction.

Leadership and governance arrangements were not robust as they had not picked up on or addressed the failings within the service. This placed people at risk of harm and of receiving a service that did not meet their needs.

Krinvest Head Office

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 checked whether the provider was 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.

The inspection was prompted in part by information of concern received from four whistle blowers. The intelligence received by CQC covered a range of issues relating to: ineffective governance and poor records; inappropriate admissions to the service; fitness and conduct of the registered manager and deputy manager; poor recruitment practices; training, supervision and competency of staff; reliability of the service and to deploy appropriate staffing levels and failure to safeguard people using the service from abuse and to notify CQC of reportable incidents.

During the inspection we found evidence to support the information received from whistle blowers. The provider is therefore working with service commissioners to ensure reviews are undertaken for people currently using the service. The CQC has also placed this service in special measures and will continue to keep the service under review.

We gave the service 48 hours notice of the inspection visit in accordance with our methodology for this type of service. Inspection site visit activity started on 12 March 2018 and ended on 13 March 2018.

The inspection was carried out by two adult social care inspectors and an 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. In this case of people receiving the regulated activity 'personal care' in a supported living service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service provided by Krinvest Head Office.

We looked at all the information which the CQC already held on the provider. We also contacted

commissioners from Halton, Warrington and Knowsley local authorities during the inspection to obtain any information they held about the service. We took any information provided to us into account.

During the site visit, we spoke with the Chief Executive Officer / Nominated Individual and the Director of Business Development (the senior management team) who were managing the service at the time of the inspection.

We undertook home visits by invitation to six people receiving support from the supported living service in order to review records and undertake observations. During the home visits we also spoke with eight support workers. We also contacted a further two people who used the service by telephone. One person was unavailable to talk to us.

Furthermore, we spoke with 11 staff employed by the provider by telephone.

We looked at a range of records including eight care files belonging to people who used the service. This process is called pathway tracking and enables us to judge how well the service understand and plan to meet people's care needs and manage any risks to people's health and well-being.

Examples of other records viewed included; policies and procedures; four staff files; minutes of meetings; staff rotas; staff training; audits and other key documentation.

Inadequate

Is the service safe?

Our findings

We asked people who used the service and their relatives if they felt the service was safe.

Some people raised concerns regarding the reliability of the service and the consistency of the staff team. For example, one person told us: "I get scared with new people. Not a lot of stability. Generally the staff are alright. Although, I have had new staff turn up that I don't know." Likewise, another person said: "I don't feel confident that someone will come."

Comments received from staff included: "It's been really up and down. This service user has not had the support they should have had. For two days just before Christmas [name] didn't get any support. They should get four hours a day"; "Staff from the hospital have been helping out. It has been a real mess" and "The supported living has been dysfunctional and very poor. Low morale with staff and the service users have been worried, upset and anxious about not always knowing if they are going to get any or the correct support."

At the time of our inspection the service was providing personal care to 9 people who were living in their own homes within Knowsley, Halton or Warrington. Twenty staff were employed within the service who worked variable hours subject to the needs of the people using the service and individually commissioned packages of care.

The senior management team confirmed that wherever possible the service endeavoured to deploy the same staff to support people using the service to ensure continuity of care however this could sometimes change due to annual leave, sickness, staff training or when staff had moved on to new jobs.

Prior to and since our inspection, the CQC has received information of concern from whistle blowers who reported that some people using the service had not always received the support they required such as support from two carers for safety reasons.

We referred the information regarding missed calls to the chief executive officer / nominated individual prior to our inspection. Following an investigation by the chief executive officer the Commission was informed that there had been instances where only one staff member had been in attendance or that staff had not attended for the required amount of time. We did not receive details of the number of occasions that people had not received the required staffing levels.

We also received intelligence from a social worker within a local authority who had been contacted directly from a person using the service and a support worker who raised concerns regarding the reliability and standard of service provided to three people using the service.

During our inspection, we asked the senior management team to provide us with the reasons, details and times when people using the service had not received the required levels of support. The senior management team reported that they could not provide the inspection team with this information as the

details of any missed visits or changes to staffing levels had not been recorded on the rotas or via separate records. Rotas viewed presented as master copies and did not identify when people had not received the required staffing levels.

This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to demonstrate that the care and treatment provided to service users was appropriate to meet their needs

The senior management team informed us that they had met with a supplier to discuss the viability of purchasing a new electronic rota system to help the service to plan their rotas and capture real time information on the hours worked by staff.

Prior to our inspection, we received information of concern from whistle blowers who reported concerns about the standard of recruitment practice and associated records within the service. We were also informed that a senior member of staff was working in the supported living service despite being barred from working in a regulated activity.

We referred this information to the chief executive officer / nominated individual prior to our inspection and received confirmation that an employee had been barred from working in a regulated activity for a period of 10 years. This highlighted a lack of understanding within the organisation about what constituted a 'regulated activity' and the obligations of the provider in respect of such decisions by the Disclosure and Barring service.

The chief executive officer made arrangements to remove the employee from this role and they are no longer working for the organisation.

The registered provider had a recruitment policy in place that provided guidance for management and staff responsible for recruiting new employees. We looked at a sample of four staff files and noted that various records required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were not in place.

For example, in one employee's file we found no evidence of an interview; a blank application form with no employment history; a blank health and fitness questionnaire; no references and no evidence of a POVA (a pre-employment check to ensure that a prospective employee is suitable to work with vulnerable adults) or Disclosure Barring certificate (DBS). A DBS check aims to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We received confirmation of a DBS check for the employee following our inspection.

Likewise in another employee's file we found no evidence of references or evidence that gaps in employment had been explored.

Discussions with staff during home visits confirmed the recruitment process was very poor and overly informal. For example, one member of staff told us that they had a 'chat' with the registered manager and was asked to start work the next day, without any references being taken up and no probationary training. This employee told us that they had no experience of working in care and was observed to be working with a person who had complex mental health needs. This placed the service user at risk of harm and also placed the staff member in a potentially difficult position.

This is a breach of Regulation 19 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, in that, the registered person had not operated robust recruitment procedures or obtained the necessary information prior to staff commencing employment.

Prior to our inspection, we received information of concern from whistle blowers who reported concerns about the management and reporting of safeguarding incidents. The Commission referred the information received to the local authority in accordance with local safeguarding procedures.

The registered provider had a 'safeguarding' and a 'whistleblowing' policy and procedure in place. We noted that copies of the adult protection procedures for the local authority areas where people lived were not available for reference at the time of our inspection. We received evidence from the management team that they had obtained copies of the adult protection procedures for each of the local authority areas the service covered following our inspection.

We asked the senior management team for information on any safeguarding incidents that had occurred in the service or that were known to the service for the last 12 months. We noted that tracking systems and records had not been developed to record any safeguarding incidents, action taken and outcomes. This meant that the provider had no oversight of safeguarding incidents which is necessary keep people safe from abuse.

The senior management team reported that there had been safeguarding incidents within the service and that these had been discussed during management meetings. However, the precise number, details of the incidents and action taken was unclear. The inspection team also noted potential difficulties in separating information between services as the minutes combined data for the supported living service and another regulated service. We asked for information on any safeguarding incidents to be forwarded to the commission following the completion of our site visit.

Whilst undertaking the site visit, the management team reported that there had been three incidents reported regarding a person using the service during July 2017. The information recorded in the minutes was not clear. We also identified one safeguarding incident within the minutes concerning a person using the service during November 2017. During our inspection, a member of the inspection team was also informed of an allegation of financial abuse.

We received assurance from the senior management team that the incidents had been referred to the local authority safeguarding teams. However, none of the incidents had been notified to the Commission. Training records indicated that 11 out of 20 staff had also not completed safeguarding training to help staff understand the different types of abuse and the action they should take in response to suspicion or evidence of abuse.

Three members of staff spoken with during our home visits also told us that they had not received any safeguarding training, were not fully aware of abuse issues and had no understanding or knowledge of what to do if they needed to raise a safeguarding alert. One employee had no idea of what was meant by safeguarding. Other staff spoken with during telephone calls also raised concerns regarding the standard and lack of training provided.

This is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to establish and operate effective systems and processes to protect people using the service from abuse and improper treatment.

The registered provider had a medication policy and procedure in place.

Medication administration charts were found to be available in people's homes where staff were required to assist in the administration of medication. At the time of our inspection six of the nine people using the service self-administered their own medication.

We found that medication was stored in metal storage boxes in people's homes. We noted that two medication administration records (MARs) viewed during the inspection were found not to be correctly dated although staff had signed to confirm the medication had been administered. Furthermore, systems to ensure the effective monitoring and auditing of medication administration records were not robust and training records indicated that 11 out of 20 staff had not completed medication training.

We looked at the files of eight people who received support from the service. We saw that each person had a range of risk assessments.

However, we noted gaps in the information available to staff as only three of the eight risk assessments viewed gave satisfactory information and guidance in how to manage potential risks. For example, we found that one person was at risk of choking. There was no risk assessment in place to address the risk, nor was there a risk assessment in place to explain that the person needed to be moved frequently because of the person's physical disability.

These issues are a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure the proper and safe management of medicines and had failed to ensure that risks to the health and safety of service users were appropriately assessed and mitigated..

The registered provider had an Accident and Incident Reporting Policy and Procedure in place. We asked the senior management team for information on any accidents and incidents that had occurred in the service in the last 12 months. We were informed that there were no central records maintained at the registered office to provide an audit trail and oversight of any incidents that had occurred within the service. Without appropriate analysis, the provider is unable to identify themes, action taken and any necessary learning to minimise the potential for reoccurrence.

The senior management team informed us that incidents and accidents were discussed during management meetings but again we noted that records were vague and potential difficulties in separating information between services - as the minutes combined data for the supported living service and another regulated service.

This is a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to assess, monitor and mitigate the risks relating 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 registered provider had an infection control policy and procedure in place.

The majority of staff spoken with reported that they had access to personal protective equipment for the provision of personal care and we noted that spare supplies were stored at the registered location.

Training records indicated that 13 out of 20 staff had not completed training in infection control.

A 'business continuity plan' had been produced for the service which outlined the action that would be

taken in the event of significant business disruption such as loss of workspace; loss of IT / data; managing loss of key staff and / or other key resources. The plan indicated that an out of hours was available for the service and a certificate of public liability insurance was in place.

One whistle blower spoken with reported concerns about the responsiveness of the on-call system which was shared with the senior management team.

Inadequate

Is the service effective?

Our findings

We asked people who used the service and their relatives if they felt the service was effective.

Comments received included: "No I don't always feel safe. They (staff) are not trained in hoisting me" and "I don't think the staff are trained, not even had first aid training. Doesn't help you feel safe."

One relative said, "We don't know who is coming. We don't know if they are trained. We don't have any confidence in the agency".

Additionally, staff feedback highlighted that: "Staff morale has been very low", "It's been awful. I hope it will get better" and "It's been really difficult with continuity with staff. It's been extremely difficult for staff to know what is going on."

Prior to our inspection, we received information of concern from whistle blowers who reported concerns about a lack of induction, training and supervision for staff employed within the service.

We spoke with the senior management team and requested information on the training provided to staff. We were informed that the provider commissioned an external training provider to deliver face-to-face training to operational staff.

We were provided with a training audit that had been completed by the former deputy manager. We were also provided with a 'training planner' that had been completed by a member of the senior management team which consisted of projected dates for staff training.

Examination of the training information showed that eight staff in post had completed training ranging from six to twelve training courses in one day. Likewise, the information showed that over 50% of the workforce had not completed any training. This raised concerns regarding the quality of the training programme available to staff.

We asked the senior management team to provide us with information on the range of training provided by the external training provider, a breakdown of the course content for each training course and the required timeframe to deliver each training course. Upon completion of our inspection the chief executive officer notified us that he was no longer going to use the external training provider. The training information requested was not forwarded to CQC.

We looked at a sample of staff personnel files and noted that training records were incomplete or not-up-to-date. Additional training records showed that five staff members had been assigned one day to complete training ranging from 18 to 31 subjects.

We enquired how the competency of staff was assessed or monitored. We were informed by the senior management team that competency should have been assessed by the deputy manager and the

governance director but no records of such assessments were available for reference.

The information available to the inspection team was flawed and did not provide assurance that staff had received appropriate induction, training or regular supervision prior to and following being deployed to work in the service.

A number of staff spoken with confirmed they were working in the service and had not received appropriate induction, training or supervision. We also found that staff had not received training to help them understand their roles and the support requirements of people living with complex and enduring mental health needs such as mental health awareness and specific risks to people's wellbeing such as how to support people living with suicidal tendencies. Staff told us that they felt at risk by this.

Furthermore, we saw no evidence of team meetings to enable staff to share and receive information.

This is a breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure that persons employed in the provision of the regulated activity had received appropriate training and supervision to enable them to carry out the duties they are employed to perform.

The registered provider had a 'Mental Capacity Act 2005' policy and procedure in place.

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 found no evidence during the inspection that people's liberty was being restricted however training records indicated that over 50% of staff had not completed training in the Mental Capacity Act to equip them with the necessary knowledge and understanding of how to work within the framework of the (MCA) and to have due regard for this this protective legislation.

This is a further breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure that persons employed in the provision of the regulated activity had the necessary knowledge of how to work within the framework of the MCA.

Prior to our inspection, we received information of concern from a whistle blower who reported concerns that the former registered manager had taken on packages of care that the provider did not know anything about. For example, one of the whistle blowers reported that the service had 14 people using the service and the registered manager claimed that there were only 12.

We referred this information to the chief executive officer who investigated the matter and advised that the information was correct and that there was in fact 14 people using the service at that time. The chief executive officer reported that they viewed this as a deliberate attempt by the registered manager to mislead and cover up certain agreements and actions with the intention of misinforming the senior management team.

The chief executive officer subsequently advised the CQC that this intelligence had led him to also undertake a review of all the care packages provided by the service during which it had been identified that four people using the service did not meet the provider's set admission and exclusion criteria. This led to the chief executive officer advising commissioners that the service could not continue to provide a service for four people.

This raised concerns regarding the assessment systems and processes within the service which has the potential to place the welfare of people using the service at risk.

This is a breach of Regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure that the care and treatment of service users was appropriate to meet their needs.

The senior management team told us that the service endeavoured to work in partnership with other teams and services to ensure the delivery of quality care and support for people using the service. For example, local clinical and commissioning teams and housing providers.

We spoke with staff regarding the promotion of healthcare, hydration and good nutritional intake within the context of person-centred care and respecting people's rights to choose what they eat and drink.

Staff we spoke with confirmed they promoted healthy eating and monitored any changes in the wellbeing and needs of people they cared for on an on-going basis. Systems were also in place to arrange GP call outs and initiate referrals to health and social care professionals when necessary.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service and their relatives if they felt the service was caring.

Comments received from people included: "They [the staff] treat me with dignity and respect", "I have some really good carers" and "Don't know what I would do without [name of staff member]."

We also spoke with a health care professional who was visiting a service user who provided complimentary feedback on the service provided to the person. The comments included: "The staff are really good"; "They have really brought (X – a service user) on" and "(X – a service user) has been motivated and encouraged to have a healthier lifestyle, particularly around diet."

We undertook home visits by invitation to six people receiving support from the service and contacted a further two people who used the service by telephone. One person was unavailable to speak to.

People spoken with were happy living independently in their own homes with varying levels of support.

We observed staff interacting in a positive and respectful way towards the people they supported. It was one person's birthday on the day we visited their home and we noted that two support workers had each given the person they supported a birthday card. The support workers had also purchased a present for the person between them. One person told us that their carer took them to the shops and to the market and supported them to visit their relative.

We found in some of the service provision that people did not always receive their support from whom they were expecting to get it from. People told us that this could cause them uncertainty and anxiety. Staff also told us that they had not received any training in the principles of good care practice such as promoting dignity, diversity and respect.

Information about people using the service and employees was stored securely in filing cabinets in the organisation's office. We were also assured that information held on computers was password protected.

During a home visit we observed staff members talking to service users about other members of staff and people using the service. This was immediately challenged by an inspector who expressed the on-going need for confidentiality, data protection and privacy. This information was shared with the management team and highlighted as a training need that required action.

The provider had produced information on the service in the form of a Statement of Purpose and a service user guide to provide people using the service and their representatives with key information on the service. This outlined the organisation's philosophy of care, principles and values underpinning the service; risk taking and risk management; how to access the service; information on the key worker system and other information relevant to the delivery of the service.

Inadequate

Is the service responsive?

Our findings

We asked people who used the service and their relatives if they felt the service was responsive to their needs.

People told us that staff did not always provide the care and support that they needed. This was mainly because of missed calls, inconsistency of staff and some carers were not appropriately trained for their roles.

Comments received from people included: "I get support every day, supposed to be for eight hours. Sometimes I get two hours. One day last month I only got five minutes. It is very inconsistent. They (the management) always give different excuses"; "I didn't know (X – a staff member) was coming today. Didn't know if anyone was coming to support me. Nobody came yesterday"; "I have complained every time. They (management) say they will do something, but they don't" and "I have two staff. One morning last week nobody turned up. I just had to wait until the afternoon".

Prior to our inspection, we received information of concern from whistle blowers who reported concerns that staff working within the service did not always have access to care plan and supporting documentation in people's homes and that this had left them with insufficient information to understand the needs of people using the service.

We referred this information to the chief executive officer who investigated the matter and advised us that this concern had been substantiated. The chief executive officer confirmed that this was poor practice and assured us that this matter had been rectified.

Furthermore, the CQC received assurance from the Chief Executive Officer that in the future no files, care plans or risk assessments would be removed from the homes of people using the service unless this was an agreed requirement. Additionally, the CQC was informed that a duplicate suite of documents would be developed and retained at the main office. This work had not been completed at the time of our inspection.

During our inspection, we requested to view the records relating to eight people using the service in order to review the quality and range of information that had been developed.

We found that three of the eight files contained up-to-date and relevant information including a service user profile page, pre-admission assessment, support plans and risk assessments which detailed control factors to manage the identified risks.

The other files viewed were lacking in sufficient or correct information regarding areas such as: next of kin; date of birth; GP contact details; professional visit records; background, social and medical history; weekly activities; present conditions; information around people's communication; medication and spiritual needs. Inconsistency with people's risk assessments also had the potential to place people at risk of harm.

This was a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014, in that, the

registered person had failed to maintain an accurate, complete and contemporaneous record, including a record of the care and treatment provided to each service user. Furthermore, the registered person had failed to assess, monitor and mitigate the risks relating 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 management team was informed of the ad hoc state of the care files and it was agreed that there would be a full review of all files, in order to ensure that the necessary information was available and up-to-date, including care plan and risk assessment reviews.

The registered provider had a 'Complaints, Suggestions and Compliments Policy and Procedure' together with a 'Complaint Procedure for Service Users'. The documentation had not been produced in an easy read format for service users.

We requested to view the complaint records for the service. We noted that a system had not been established to track or log the details of any complaints or to provide details of the action taken, findings or outcomes.

The senior management team reported that there had been no complaints regarding the service in the last 12 months however one person using the service reported a concern to a member of the inspection team during the inspection which was dealt with as a safeguarding matter. We also received information of concern from whistle blowers, people using the service and staff regarding the operation of the service. Some people told us that they had reported their concerns to the management team before approaching the CQC and were not satisfied with the response.

This was a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to establish and operate effectively an accessible system for identifying, receiving, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

The service did not provide end of life care but had a policy and procedure to follow in the event of the death of a person using the service.

Inadequate

Is the service well-led?

Our findings

We asked people who used the service and staff if they felt the service was well led.

No direct comments were received from people using the service. Staff we spoke with were generally not very positive about the organisation. For example, we received comments such as: "I don't have much contact with the office. Just get on with it"; "I don't know who the manager is now", "I know there were issues with the Registered Manager and the Deputy Manager. They kept things from each other" and "We don't get much information through. It's about communication, with the staff and especially with the service users".

The provider (Krinvest Limited) was owned by one individual who was listed at Companies House as the sole director of the company.

A senior executive management team had been established which had overall responsibility for the operation of the organisation. This consisted of an Executive Chairman; Chief Executive Officer / Nominated Individual; a Head of Development; Head of Business Administration; Head of Finance and a Business Development Director. A team of operations staff was also in place which included roles such as a Governance Director, Finance Manager and an Architectural Designer.

We noted that the provider had developed a strategic plan for the organisation and had published information on the organisation's vision, aims and objectives on its website. This stated that "KR Health and Social Care Group commit to providing a consistently high standard of individualised care and support across an integrated service network. Our vision is to help each person accessing our services to achieve their full potential and to keep on achieving it."

Prior to our inspection, the CQC received information of concern from whistle blowers regarding the operation of the supported living service. The concerns covered a range of areas such as: governance and poor records; inappropriate admissions to the service; fitness and conduct of the registered manager and deputy manager; poor recruitment practices; training, supervision and competency of staff; reliability of the service and deployment of inappropriate staffing levels and failure to safeguard people using the service from abuse and to notify CQC of reportable incidents.

The CQC referred the concerns to the chief executive officer / nominated individual in the first instance who arranged to suspend the registered manager whilst he undertook an investigation into a number of the concerns raised. We were later informed that the registered manager had been invited to attend a disciplinary hearing however she resigned from post before the hearing. Therefore, at the time of the inspection the service did not have a registered manager in post. Following our inspection, the chief executive officer informed CQC that he had met with the registered manager and concluded that her actions constituted gross misconduct.

The inspection team met with the chief executive officer / nominated individual and the business

development director during the inspection, who were overseeing the day-to-day management of the service. We were informed that a new manager had been appointed for the service who was due to commence employment with the provider during April 2018.

We asked the chief executive officer for information on the provider's governance systems and processes to assess, monitor and improve the quality of the service provided. We were informed that representatives from the executive management team had met every four to six weeks with representatives from the management of the supported living service and this was confirmed by looking at minutes of the meetings. We saw no evidence that operational staff working within the service had attended any team meetings to share and receive information.

We were also informed that governance meetings for the service should have been coordinated four times per year however these had not taken place for a considerable period of time due to the long-term absence of the governance director. The chief executive officer reported that the primary function of this role was to provide governance management within the group and to also oversee the human resource provision within the group. The chief executive officer reported that he was unable to locate the minutes of any governance meetings following our site visit.

The chief executive officer acknowledged that there was clearly a gap in the structure for oversight in the service and reported he had therefore appointed a head of clinical research who had been tasked to take on the governance brief since February 2018 until the return of the governance director. We met this employee during the inspection and noted that they were in the process of undertaking visits to people's homes to undertake service audits and to report on their findings.

We noted that the provider had purchased a range of policies and procedures for use within the service from an external supplier and that a 'quality assurance policy and procedure' was available for reference at the registered location. A 'supported living services audit checklist' had also been developed which outlined 15 audits that were to be undertaken at different timescales by the management team and staff working within the service.

When requested, the management team reported that they were unaware of the existence or whereabouts of a number of audits, despite them being listed on the provider's audit checklist. Consequently, we saw no evidence of audits for topics such as: service user files; monthly management; environmental; maintenance; fire alarm tests; support plans and risk assessments.

Furthermore, the management team were unable to locate a number of records either electronically or manually to verify that key aspects of the service had been subject to regular scrutiny and monitoring.

For example, the audit checklist indicated that 'service audits' should be completed on a monthly basis for each property. We asked to view all of the audits for each property over the last 12 months and were provided with a total of seven audits covering a combined total of only four properties.

Likewise, we asked to view the monthly medication audits for each property. The management team were unable to locate monthly medication audits and only incomplete medication stock checks were provided for two properties.

We asked the management team whether any surveys had been undertaken to obtain feedback from people using the service, their representatives or staff. We were informed that no surveys had been distributed, returned or analysed at the time of our site visit activity. We were assured by the business

development director that they would make arrangements to distribute surveys as a matter of priority.

We saw that the business development director had periodically monitored key performance indicators (KPI) that were based upon returns submitted by the registered manager and deputy manager. We noted that KPI records were not available from 31/08/2017 to 28/02/2018. When questioned where the missing records were, the business development director reported that he had not been provided with the monthly returns from the registered manager and deputy manager whilst they were in post. The information provided was based on quantitative data and it transpired that there had been no proper scrutiny of the information submitted or effective monitoring of the service by the provider. This meant that significant failings had taken place in the service.

This was a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to ensure that effective systems were in place to assess, monitor and improve the quality of the service.

The registered person is required to notify the CQC of certain significant events that may occur within the service. We noted that the registered person had not always notified the Commission of safeguarding concerns. This meant that the registered person had not complied with the legal obligations attached to their role.

This is an offence under Regulation 18 (1) (e) of the Care Quality Commission (Registration) Regulations 2009, in that, the registered person had failed to notify the Commission without delay of any incidents of abuse or allegations of abuse in relation to a service user. We will be writing to the registered provider separately about this matter.