Craegmoor Homes Limited

Craegmoor Supporting You in the South East

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 28, 29, 30 June and 3 July 2017, and was announced. We gave '48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies.

Craegmoor Supporting You in The South East provides personal care and support to adults in their own homes. It provides care in five separate locations where people share a home together; and an outreach services to people that live alone. The service provides care and support for people living with a learning disability; it is registered to provide personal care. At the time of this inspection 23 people were receiving the regulated activity of personal care from the service.

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. There had been several changes of management over the past year, a new manager had been appointed in May 2017 and was present throughout the inspection, they were in the process of applying for their registration with The Commission. They were being supported by a senior manager who had provided support to the service since May 2017.

The service was last inspected in November 2016 where five breaches of our regulations were identified. The safe and well led domains were rated as inadequate and an overall rating of inadequate was given at that inspection. The breaches of regulation related to person centred care, risk assessments, reporting of accidents and incidents, safeguarding, staffing and training. We took enforcement action and required the provider to make improvements. This service was placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us regular information and records about actions taken to make improvements following our inspection. At this inspection we found that although improvements had been made in some areas, other significant problems had emerged and some new breaches were identified.

People had not been protected from harm, concerns about their safety had not always been listened to and incidents had gone unreported. One person told us they were frequently bullied by another person. The provider's processes for recording and responding to safeguarding incidents were not robust. Some incidents had not been reported to the correct professional bodies for further investigation and the provider had been unaware about some of the incidents we found during our visit.

There were not enough staff to protect people from harm or support them in a way which met their needs. During the inspection a person was asked to keep an eye on another person who was distressed so the staff member could seek guidance from another member of staff. People did not always receive all of their one to one hours of support; this meant they had been restricted in going out to pursue their outside interests.

People's health had been placed at risk. Staff did not have a good understanding of how risk should be minimised and the provider had been unaware about the assistive technology a person should use to monitor their seizures. Peoples health needs had not always been well monitored of responded to.

Concerns and complaints had not always been responded to or recorded well. A relative said they had raised concerns but had not received a response from the provider.

Staff had not received all of the necessary training to support people with their individual needs. Since the new manager had been appointed staff fedback supervisions and the support they received had improved.

People had choice around their meals. Staff demonstrated they respected people's individual likes and preferences, they understood people's preferences well. Staff engaged with people in a caring manner. People's privacy was respected; staff knocked on doors before entering people's homes and asked people if it was okay if we looked in their bedrooms.

Care plan documentation had been updated and improved to provide staff with more person centred informative which reflected people's individual needs.

Since the new manager had taken up post feedback from staff had been more positive. Prior to their appointment in May 2017 the provider had taken little action to improve the service and respond to the concerns we had raised during the previous inspection. People had continued to receive poor care and had been exposed to harm. People's individual needs had not been met.

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.

People had not been safeguarded from harm. Incidents had not always been reported.

Risk assessment was not adequate in reducing risks to people when potential harm was identified.

There were not always enough staff to support people with their outside interests or individual needs.

Medicines were not always safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's health needs had not always been responded to well.

People's rights had not consistently been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff had not received the specific training they required to support people with particular needs such as epilepsy or diabetes.

Staff had received some formal supervision.

People had choice around their meals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had been bullied by other people and little action had been taken to minimise this.

Staff engaged with people in a caring manner, people's privacy was respected.

Staff took an interest in what people said and communicated

with good humour and rapport.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints were not documented and responded to effectively.

People did not always have enough support to be able to do the activities they chose.

Care plans had been updated to be more person centred and offer staff guidance in how people should receive their support.

Is the service well-led?

Inadequate

The service was not well-led.

There was a new manager in post since the last inspection, but improvements they had implemented had not had time to take effect.

Not all concerns raised during the last inspection had been addressed and other significant issues had emerged.

The service lacked oversight; staff did not feel well consulted by the provider and had not been provided with effective support or leadership.

Craegmoor Supporting You in the South East

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 the 28, 29, 30 June and 3 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. The inspection was conducted by one inspector who spent time in the providers registered office as well as visiting people in their own homes. A second inspector visited one person in their home on the 3 July 2017.

Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. The provider had completed a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We visited 17 people who used the service in five of the shared locations. We spoke to 11 staff, one visitor, the manager and the senior manager. Before the inspection we received feedback from one healthcare professional, after the inspection we received feedback from three relatives. Not all people were able to express their views due to communication difficulties; others could, so during the inspection we observed interactions between staff and people.

We looked at a variety of documents including nine peoples support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, accident and incident records and quality assurance information.

Inadequate

Is the service safe?

Our findings

One person said, "I'm getting bullied by (other person). I'm fed up; they shout and swear at me. I want to get out of here, I tell staff I don't like (person) to upset me, it's not right. I'm not scared of them but they need to pack their case and go. It's been going on quite a long while now. When I'm left alone if staff not here, they start on me". A healthcare professional said, "Until the most recent change in management I did not feel that the care provided was safe or effective. I had concerns over the support that people were getting with their health needs as well as their support needs".

At our last inspection in November 2016 we found that safeguarding incidents had not been reported appropriately which was a breach of Regulation 13 of the Health and Social Care Act 2008. This continued to be an area of concern.

At this inspection we found people had not been protected from other people's behaviour. Although the current manager had taken steps to improve the situation for people, little action had been taken previously and incidents had been a regular occurrence since February 2017. Safeguarding incidents were still not being reported to the local authority or The Commission and the manager and senior manager had to report earlier incidents in retrospect when they took up their posts. Incidents where people had suffered alleged harm were being investigated by the local authority. The new manager had reported incidents appropriately since taking up their post.

Although staff understood the process of reporting incidents of abuse, incidents had not always been recorded or reported following the agreed procedure and the provider had not audited information to identify this. A relative said, "You are aware by now I'm sure of a lot of the incidents that have occurred, but I'm also aware that many were not recorded. I asked why at a meeting with (previous management) and was told incidents must be witnessed as with learning disability people they are not always reliable. Nothing has been reported in a timely manner. No one informed us of an incident, we will never know how many times this happened".

A recording in a staff communication book in February 2017 stated, "(Person) has made a verbal complaint to me that on Wednesday night (other person) came into their room twice and tried to kiss them. This is very confidential, sensitive and probably impossible to substantiate but I will inform the team leader and take advice". We asked the senior manager if this incident had been reported to the local authority, police or The Commission and if a complaint had been formally recorded. The incident had not been recorded or reported although other incidents of this nature had occurred. The alleged perpetrator had since moved from the service however, the provider could not be certain that the victim of this incident had not been subject to more which had been ignored or left unreported. Their complaint had not been formally recorded or investigated.

The provider did not have an effective system in place to ensure incidents of abuse were reported and investigated. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider was not properly assessing or mitigating risks to people's health and safety. There were ineffective reporting and recording of accidents and incidents which was a breach of Regulation 12 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

Although the provider had a system in place to record, report and analyse accidents and incidents, processes had not been followed consistently and several events had gone unreported meaning people had been left at risk of repeat incidents and further harm.

People's health had been placed at risk. One person who had epilepsy had an alarmed sensor mat on their bed which was activated if they suffered a seizure. The person had moved from a shared flat to their own individual flat in October 2016. When the person moved their sensor mat had been left in their old place of residence. The manager was not aware that the person should have this equipment and the persons care plan made no reference to this. The persons care plan stated, 'On average one seizure every 12-18 months'. There was no description of what seizures may present themselves as or how staff would recognise the person was having a seizure. One staff member had been regularly lone working with this person had not completed their epilepsy training. A staff member said, "It worries me about seizures, If (person) had a seizure (during the night) I wouldn't know unless I stayed awake".

We found documentation which identified the person had at least four seizures so far this year, one of which resulted in them being admitted into hospital. The provider could not be assured they understood the frequency or location of seizures as monitoring, recording and reporting was inconsistent and poor. During the inspection the persons monitoring equipment was repositioned on their bed, the care plan updated and a safeguarding raised with the local authority. The manager told us the person did not have capacity to agree to the monitor being used and there was no information to show how the person's capacity had been assessed and a best interest decision reached around this restriction. We have commented further on capacity and consent later in the report.

The provider had not assessed or mitigated risks to people's health and safety. There were ineffective reporting and recording of incidents. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some good work completed when people chose to take risks and people were given information to make their own informed choice. For example, one person had chosen not to keep their bedroom door locked although other people sometimes went into their room. Staff had explained the risk to the person and made an agreement with them to keep only a small amount of money in their purse. Another person enjoyed standing outside for prolonged periods of time, staff encouraged and reminded the person to wear their hat and apply sun cream. The person now understood this was a risk and told us they must remember to put their cream on so they did not burn.

There were inconsistencies across the service relating to people receiving their medicines safely. The new manager had implemented auditing systems across each location to improve the monitoring of medicines. At one location we found several concerns with how medicine was managed. A persons medicines had been stored in a filing cabinet in the staff room but temperatures of storage were not monitored which meant medicine may not be safe to use. The person had in the past been prescribed occasional use medicine (PRN) for pain relief. Staff said the PRN went out of date and was returned to the pharmacy, a new supply had not been obtained other than the person buying their own although during our visit no PRN was available. Medicine administration records (MAR) had been signed in advance of medicines being given which was poor practice. The provider had not completed regular audits to identify this.

The provider had failed to have robust management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not ensured that staff were deployed effectively which had impacted on people's ability to leave their home when they wanted to. This was a breach of Regulation 18 of the Health and Social Care Act 2008. Staffing continued to be an area of concern.

A relative said, "Again the staff have changed so much that there is no continuity. There is not enough staff on duty all the time". At this inspection we found people did not always have enough staff to support their needs. At two shared locations there was often times when only one staff member was available. This meant people did not have the freedom to leave their home. There were several entries in the staff communication book which showed the impact staffing had on people. For example, in February 2017 an entry stated, '(Person) was told by team leader they can't go to church this week as short staffed'. Another entry in February 2017 said, 'Would someone be able to get out and buy something for Sunday lunch for the tenants please? I have been on my own with a busy day and it was therefore impossible to leave'. Another entry in May 2017 stated, '(Person) remains in their room, undressed and refusing to dress or come out. As a male staff member working alone I can do nothing, I refuse to go in, it would not be appropriate'.

A staff member said, "It concerns me, what's happening here, in terms of protecting (person) it's really concerning. When you're working alone you haven't got eyes in the back of your head (Person) is really suffering because of this". Another staff member said, "Today staff called in sick so I'm working alone, this happens a lot".

During the inspection one person became distressed and upset; the staff member had to leave the person while they sought help from another staff member who was working in one of the neighbouring shared homes. Another person was asked to keep an eye on the distressed person and call the staff member if there were any problems. Staff told us two staff had called in sick that day so staffing was particularly thin on the ground but no arrangements of cover had been made.

The senior manager said staffing numbers were allocated by counting the one to one hours and shared hours people were commissioned for. It was not possible to see how people received their own specific one to one hours as recordings were inconsistent and in one location not recorded at all. If people did not receive all of their allotted one to one hours during a week these hours were lost. Staff did not understand what one to one or shared hours were specifically for. It was difficult to understand how people's one to one hours were allocated at three of the shared houses because only one rota was used to deploy staff. The rotas did not specify when staff were providing people with their own specific hours of support.

The provider had not ensured that there were sufficient numbers of suitably qualified, skilled and experienced staff deployed to fully meet people's needs. This is a continued breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although recruitment processes were in place to ensure only suitable individuals were employed, of the three staff files we reviewed, three staff employment histories had not been fully explored. Other checks had been made including reference checks, photographic identification obtained and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with adults. Other checks made prior to new staff beginning work included health and appropriate identification checks to ensure staff were suitable and of good character. This is an area that requires improvement.

Peoples personal emergency evacuation plans (PEEPS) had been updated since the last inspection. PEEPs described the support staff could offer people to support them to leave their home in the most appropriate way in the event of a fire or emergency situation.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that the provider had not ensured that staff were suitably qualified, skilled and experienced to fully meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008. Staff training continued to be a concern at this inspection.

Not all staff had received the required essential training in specialised areas to support people. This meant people were not supported by staff who had the most up to date knowledge and skills to meet their needs. A staff member told us a person could display particular behaviours which they did not understand due to their mental health and felt more robust training in this area was required so that they could support them more effectively. Several staff supported people with mental health issues including depression and bipolar but had not received any specific training to understand or recognise the changes in people's behaviour due to their mental health.

Some people had specific conditions such as epilepsy, diabetes, mental health issues and Prader-Willi syndrome (PWS). PWS is a rare genetic condition causing a wide range of symptoms including a constant desire to eat, and behavioural problems. Not all staff had received training that was relevant to the people they were supporting. For example, one staff member had not received epilepsy training and often lone worked. Three staff who lone worked supported people with diabetes but had not received any formal training.

Staff gave mixed responses about the induction they had received. New staff were expected to complete a period of induction during their probation. If new staff did not have a background in care they were expected to complete The Care Certificate to supplement the providers own induction. The Care Certificate is an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. New staff spent time shadowing other experienced staff until they felt confident to support people with their needs. One staff member told us they had been given a Care Certificate work book to complete in January 2017 but they had not started it because they had asked for instruction and guidance but none was provided.

The provider had not ensured that staff were suitably qualified and skilled to fully meet people's needs. The lack of adequately trained staff is a continued breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior manager had started to make improvements to training. They had implemented a training matrix to identify the areas of training staff required to complete and had booked training courses for staff to attend. During the inspection some staff received epilepsy training.

Most staff fed back positively about the new manager and said they had started to receive supervisions. One staff member said, "I was on the brink of leaving, I couldn't ask anyone for help, the management wasn't helping us but now the new manager is here I feel much better. Now I feel more in the loop. Supervisions actually happen now". Most staff had received a supervision in May 2017 and the manager had implemented

a supervision matrix to keep track of the supervisions staff had received.

A healthcare professional told us people's health care was a concern but felt it was better managed now as care plans now contained more detail. People's health had not always been monitored or responded to well. One person's care plan stated they had seizures only once or twice a year. A member of staff told us this had dramatically increased and seizures regularly occurred. Although the person had visited a neurologist there were no records of this appointment or any follow up that may be necessary. Staff did not have a good understanding of the reason why the persons seizures had increased or how they should be effectively monitoring them.

Another person had been assessed by the occupational therapist (OT) in June 2017. An entry in the communication book read, '(The OT) said due to risk to (person) not to use shower but to have 'strip wash' instead due to risk of falling'. The person still used the shower and a risk assessment had not been implemented around this. The provider contacted us after the inspection and said there had been confusion with the information recorded by staff and the OT had confirmed this should only apply when the person was feeling tired. Recordings of this assessment had not been made on the persons care file and the manager had been unaware the person had been assessed by the OT until we brought it to their attention. One person had consistently lost weight each month since December 2016. Until recently little action had been taken to investigate the reason for their weight loss. This demonstrated poor communication and monitoring of people's health needs.

A new care plan had been written for one person around the management of their diabetes. The care plan contained two contradictory risk assessments. One stated the person was type 1 diabetic and to be administered insulin, the other stated they were type 2 tablet controlled diabetic. A staff member confirmed the person was type 2 tablet controlled diabetic and that no insulin was administered. The staff commented, "It's as if the person writing the care plan doesn't know (person) and they've done one for each type of diabetes". The risk to the person was reduced as the staff that supported them knew them well, although occasionally the person was supported by agency staff if their usual staff were unavailable.

People had not been well supported to manage their health needs; this is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA.

At our last inspection we found that capacity assessments had not always been made when restrictions were placed on people. Assessment of capacity and best interest decisions continued to be a concern at this inspection. The senior manager told us they could not find recorded documentation around the decision to change people's homes from a residential setting to supported living. A person who had moved into their own flat from shared accommodation did not have capacity, and a best interest process had not been followed regarding their move or around the implementation of restrictive equipment to monitor their safety. The manager had started to take steps to comply with the Act. This is an area that needs to improve.

People who shared their home with other people had their own lockable storage for their food and snacks. Some people chose to take their meals together and decided each day what they wanted for their meals. A staff member said, "One person asked to have their main meal at lunch time as they liked to go to bed early

and some of the others asked to change to this also. I tend to ask people each day, everyone can choose on the day, there are no set menus". One person told us they were looking forward to ordering a take away with a staff member the following day.

Requires Improvement

Is the service caring?

Our findings

A person said, "Staff have been really nice and kind, I have been happy living in my house". A staff member said, "We always make sure shifts are covered, (person) is never left on their own, professionally we love (person)"

People had not been supported well by the provider and some people had been bullied by other people using the service. The new manager had taken steps to provide people with support but prior to this people had not been protected. People's concerns had been ignored or disregarded when they had reported concerns regarding their safety.

Staff had not always been proactive to support people with their needs and had up until recently received little guidance or supervision from management. A healthcare professional said, "I would come and (person) would be howling (sobbing and very distressed) and staff would say they didn't know why. I suggested maybe (person) needed to go to the GP something may be wrong".

During the inspection one person became very anxious and upset. Although a staff member responded positively to them they had to leave the person so they could seek further guidance from another staff member working in a separate location. Another person was left to watch the distressed person which did not provide the person with adequate reassurance or support. The person left to support the other person should not have been left in this situation as this could have been distressing to them. When the staff member returned they said, "Its daft, we have to rely on (person) to help, like a member of staff". The person who had been asked to watch the other person often referred to themselves as a staff member, which indicated they were often called upon to support other people.

We observed staff treat people with dignity, kindness and care. When people became anxious or distressed staff spoke calmly and patiently to reduce their anxieties. People were able to freely come to the office to talk to the manager when they wished. Two people came to the office to say hello to the manager, one showed them their new book they had purchased and told them they had been out for a drive in the car. People were supported to obtain advocates when they needed help with specific or complex decisions. (An advocate is a person who helps other people make their needs and wishes known).

People were supported to make their own choices and decisions, for example one person was not feeling well and told staff they did not want to attend their day centre. Staff reassured the person this was fine and asked them if they wanted to see their doctor. Another person liked to watch particular films and listen to certain music. A staff member showed them the various options and encouraged them to choose. The person handed the staff member their chosen DVD but the staff member gave it back to them and encouraged them to put the DVD on themselves to support their independence. The staff member said, "No you can do it, that's it well done".

People's privacy was respected; staff knocked on doors before entering people's homes and asked people if it was okay if we looked in their bedrooms. Staff waited for consent before entering people's personal space.

A staff member told us a person had gone back to bed, their choice was respected and the staff member did not disturb them but was available should they want any support. One person showed us around their home, they pointed out all of their personal objects in their room which they said they liked. One person did not like to open their bedroom windows so had been given two large fans to keep them cool as it had been very warm. A staff member told us they had been helping a person redecorate their bedroom, they spoke to the person's relative on the phone to update them of their progress during our visit.

There was good humour and rapport between people and staff. One person liked to make up nicknames for the staff but was reminded about the appropriateness of some of the names they called others. Staff took an interest in what people told them and spent time talking to people about their day and what they planned to do. Some people had objects which were very important to them, staff understood this well. One person carried a toy with them at all times another person showed us all of their DVDs, books and the pictures they had been drawing for their relative.

The manager came to one of the locations during our visit to conduct a staff meeting, people were free to join in parts of the meeting which were not confidential and the manager spent time talking to people and taking an interest in what they had been doing.

Requires Improvement

Is the service responsive?

Our findings

A staff member said, "It can be difficult sometimes to take people out due to the contracted hours. We try to do the best we can". A person said, "I know about my care plan, I am happy with the support I get, I don't want to make any changes to my support".

A staff member said, "The pressure of trying to cover the shifts between two staff is almost overwhelming. I complained about it, but never received a reply". The provider had a system for managing complaints. A complaints policy was available for people to use if they were unhappy with any aspect of the service; an easy read format was available for people who may need it. When concerns or complaints were made these were not always recorded or investigated. One complaint had been recorded on the 22 February 2017 which had been marked as 'not resolved', no outcome or conclusion had been noted. The senior manager said the complaint had been resolved with the complainant but the information had not been updated and closed which they would act on. One person had complained to a staff member about an incident which had compromised their safety which had not been recorded or investigated. We brought this to the manager and senior manager's attention who had not been aware. They said they would investigate the incident immediately. After the inspection we received notifications from the senior manager regarding the action they had taken to deal with the issues raised.

A person said, "I haven't had any problems, I haven't needed to complain. If I did need to complain, I would ask staff to help me". A relative said, "Last year I did write letters to the company requesting a reply within the statutory 28 days with our concerns but received no reply".

The provider had not responded or acted appropriately when dealing with complaints. This is a breach of Regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the provider had been in breach of Regulation 9 of the Health and Social Care Act 2008. Some Care plans and guidance documentation lacked sufficient detail to inform staff of how people required support to meet their needs and reflect their personal preferences. People could not always pursue their outside interest because there were not enough staff available. Although work had been completed to improve care plans and documentation the provider was still in breach of this regulation.

A staff member said, "Due to staffing levels activities need to be planned. We have one vehicle between three houses and there's a lot of medical appointments people need to get to". Not all people were able to independently leave their home to pursue their interests, and needed staff to support them to do this. Opportunities for people to attend outside activities were restricted at some of the shared locations because there were not enough staff available. A healthcare professional said, "A lot of the service users being supported used to attend the Craegmoor day service up to four days a week. This closed in July last year but some people are still waiting to start new activities. There has been a long gap, during which some people have not had any structured activities in the community".

People had 'My voice' meetings with their key workers to identify what was going well and what goals they

wished to achieve. One person's feedback in their meeting in May 2017 said, 'Go out more often if I have a chance'. Another person's feedback stated they were happy with staff but thought more were needed. A staff member and visitor commented that the lack of activities impacted on people's behaviour. One person looked forward to attending their day club and repeatedly sought reassurance from staff asking when they were going. A staff member said, "I have to remind person not to make their packed lunch too early for day centre. They would be much happier if they went every day, I think it's a contributing factor (to behaviour) because they are bored".

People did not always receive personalised care which was responsive to their needs. This is a continued breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection some people went out to do various activities such as attending their day centre or going shopping. Not all people wanted to leave their home and preferred to do activities in doors such as arts and crafts, writing and colouring.

The manager and senior manager had spent time updating people's care plans to be more detailed and reflective of the care and support required. People had been encouraged to help write their plans. For example, one person had been asked to describe how they felt when their diabetes became an issue, the information they had shared had been included in their care plan which made it more meaningful and person centred. Some documentation gave good detail about how staff could help support people with their basic needs and situations, such as personal care, social interactions, hobbies, key skills and personal preferences. People had reviews about the care and support they received and other individuals appropriate to the person were invited to discuss any issues.

We noticed at some of the shared locations how the updated care plans had impacted positively on the care and support people received. Previously staff had not understood how to support people well or how to minimise risk to their health and safety. Staff were now more confident and knowledgeable when describing how they supported people with their specific needs. A staff member said, "The care plans are much better and I use them, before they were a bundle of words. There was no content but now we have this its less time consuming finding things, they are more in depth".

Inadequate

Is the service well-led?

Our findings

We asked a relative if the management communicated effectively with them they responded, 'No, management never have. They were months without a manager, those that tried left. We have never ever been informed regarding change of manager. Is the service well led? Not for the last three years. It has been chaotic without any direction". Another relative said, "The manager phoned a week ago but before this no contact was made. I was the one who kept phoning". A staff member said, "Communication is bad, I don't know what's happening with (person) about their move, it makes it difficult to reassure (person)".

At the previous inspection the provider had been in breach of Regulation 17 of the Health and Social Care Act 2008. The provider lacked oversight of the service; The systems for assessing and monitoring the quality and safety of the service provided were not always effective. Many of the concerns found at the previous inspection continued to be areas of concern at this visit.

Since the provider had been placed into special measures in December 2016 they had failed to take enough action to improve the service people received. A relative said, "The company has never, in my opinion, acted on the CQC's reports over the last two years. I have read them. How long can 'Inadequate', 'Requires Improvement' be ignored. There has been little improvement and certainly no continuity, staffing is to the minimum". Many of the same concerns found at the previous inspection remained. The provider had not responded appropriately to safeguard people and provide them with the care and support they deserved. Staff morale up until recently was low.

There had been several changes to the management of the service over the last year. The service did not have a well embedded positive culture and people had received poor outcomes in regards of their care and support. Staff fedback positively about the new manager although felt prior to their arrival there had been little support or leadership in the service. An entry in a communication book dated February 2017 stated, 'I could not summon help or advice from a team leader. I am working alone and cannot dessert my post and buy supplies. Tried to contact (senior) at main office but no reply'. One staff member told us the concerns they had raised about people being bullied had not been responded to quickly. "Over the last six months it's been a lot worse. The powers that be look at me like I'm making a mountain out of a mole hill but the new manager does take it seriously". Staff that lone worked had not been provided with any means to communicate with the head office and relied on their own personal mobile phones. The senior manager said they had put an order in for mobile phones which staff would receive shortly.

The support staff received varied across the locations. One staff member commented the location they worked at, "Feels like a forgotten home. We don't get the support we need and that worries me". Another staff member said, "I have an on call procedure now and I can call someone at the weekend and they answer. The job has got harder but it's because we are doing what we should". Another staff member said, "We didn't have support, people were not getting what they needed and when we asked for advice they didn't get back to us. But the new manager is better as on site as much as possible".

The providers system for auditing and checking the quality of the service was not well embedded or robust.

Although the provider had sent The Commission regular updates of action following the previous inspection this did not accurately reflect the findings of this inspection. Additional audits of the service had not been conducted up until recently. The senior manager said when they had taken up post they reviewed the action plan. Although many areas had been signed off as completed this was not the case and further work was needed. They said they would use this inspection as a basis to identify the areas they needed to focus on to improve.

The systems for assessing and monitoring the quality and safety of the service provided was not always effective. This is a continued breach of regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had internal processes for recording and reporting incidents this had not always been followed and incidents had not been reported to the appropriate professional bodies. Internal systems had failed to identify the unreported incidents, which had been uncovered at this inspection. The provider had failed to inform CQC of notifiable incidents involving people who used the service. In March 2017 the police had attended one of the shared houses because of concerns raised by a person about their safety but this had not been reported to the appropriate bodies and the provider had been unaware about this incident. An incident that had not been reported to The Commission in May 2017 stated 'Incident report filled for the second day in a row. Concerns with (person and person). Even (other person) tried to intervene to stop the bullying'.

The provider had failed to notify the Commission of safeguarding and other incidents. This is a breach of regulation 18 of the Health & Social Care Act 2008 (Registration) Regulations 2009.

Since the new manager had started in May 2017 they had begun to make improvements in the service such as updating care plans, staff supervisions, planning appraisal's and beginning a weekly audit at each shared location which monitored incidents, medicines, rotas, staffing levels, and documentation. They had also implemented an essential information folder into each location which gave staff important information. Included was information about safeguarding, lone working, on call procedures, fire action, and general information such as upcoming staff meetings and general policies. The manager said, "I'm trying to meet service users and get to know them. The senior manager has been very supportive, I've got a lot to do and a lot to learn its playing catch up there's more training to be done for staff, I want to do a recruitment drive. The staff need a lot of reassuring, they've put a wager on me, how long I will stay". A healthcare professional said, "(Manager) is new in post but appears to be leading the staff well".

The senior manager had sent quality assurance questionnaires to people, relatives and other professionals and had received some responses. They said once they had obtained a sufficient amount of responses they planned to analyse the results and implement an action plan to respond to the feedback received so the service could be improved.