FitzRoy Support

FitzRoy Support at Home - Hampshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection took place on 19, 21 December 2017 and 5 January 2018 and was announced.

Fitzroy Support at Home provides care and support to people living in five 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults with learning disabilities, sensory impairment and physical disabilities and/or autistic spectrum disorder in and around Basingstoke.

Not everyone using Fitzroy Support at Home received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.
At the time of our inspection there were 24 people using the service who received personal care.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager managed the supported living services; the provider had appointed another manager to manage the community services. This person was in the process of applying to CQC to become registered.

Medicines were not always managed safely. People did not always receive their medicines as prescribed. Staff were administering prescribed medicines to people that were not recorded on their Medicines Administration Records (MAR). There were gaps in the recording on MAR with no explanation of why the dose had been missed.

Risks were not always identified so that safety measures could be put in place. Whilst some risk assessments were in place and were comprehensive this was not found to be the case across the service.

Staff we spoke to demonstrated some knowledge of the Mental Capacity Act (MCA) 2005 however; records did not always contain the documents needed to demonstrate that the service was working within the principles of the MCA.

The systems in place for assessing the quality and safety of the service were not always effective. The service had not identified the shortfalls we found during the inspection. This placed people at risk and compromised the quality and safety of the service.

Complaints had not been managed effectively. Relatives told us they had tried to complain but felt due to

the changes in management their voices were not always heard. The provider had not routinely sought feedback from people or relatives so opportunity to raise concerns had not been formally provided.

Out of hours arrangements were not always effective. Relatives and staff told us they had no confidence in the out of hour's arrangements; they were not always able to get in touch with the provider. When they left messages on an answerphone these were not always responded to.

We had mixed comments from relatives about staffing. Relatives told us that workers did not always arrive for planned visits or changes were made at short notice, which was not always satisfactory. The service had relied on the use of agency staff so people had not received a consistent worker. This had caused anxiety and disappointment for people and their relatives.

Staff understood how to keep people safe and knew what actions to take if they had any concerns.

The service had robust recruitment procedures to make sure that staff were recruited safely.

People were supported by staff who had the knowledge and skills necessary to carry out their roles. Staff received a variety of training on a range of topics. However we found that staff did not always receive regular supervision in line with the provider's policy.

People were supported to access health and social care professionals to help maintain their health and well-being.

People had person-centred care and support plans, which contained good information on how best to support the person.

During this inspection, we found four breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Management did not have an oversight of medicines management and were not monitoring to ensure safe practice.

Risks to people's safety were not always identified so that a suitable risk assessment could be put in place.

Staff were often late to their calls, or changes were made to staff at short notice which relatives found unsatisfactory.

There were safe recruitment procedures in place to make sure suitable staff were recruited.

Staff were knowledgeable about the different types of abuse and how to report any concerns. Staff were confident that their concerns would be dealt with by management.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make some decisions mental capacity assessments had not been completed. There was not always evidence that best interest meetings had taken place.

Staff did not always receive supervision in line with the provider's policy. Staff were suitably trained.

People were encouraged and supported to eat regular and balanced meals where appropriate, however improvements were needed to the presentation of some meals.

Is the service caring?

Requires Improvement

The service was not always caring.

The service used agency staff to compliment permanent staff, which resulted in people not always having the same worker. This contributed to increased anxiety for some people.

Staff knew what it meant to treat people with dignity and respect. We observed that people had their privacy and dignity respected by staff throughout the inspection.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints and compliments policy and procedure; however, it had not been effective in capturing complaints and their investigation and outcome.

The rotas and schedules were not always produced in good time so that people and/or their relatives knew who was visiting ahead of their visit.

People's care records were well written in part but not always kept up to date to reflect people's current needs.

People had access to a range of activity and were supported to access their local community.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager and community services manager were not fully aware of their legal responsibilities with regard to being registered.

The provider had a system for monitoring the quality of the service but this was not consistent across the location. Where quality monitoring had taken place action plans were slow in being closed to evidence the necessary improvement had taken place.

People's feedback had not been regularly sought.

FitzRoy Support at Home - Hampshire

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 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. This was the first inspection for this service.

The inspection took place on 19, 21 December 2017 and 5 January 2018 and was announced. We gave the provider 24 hours' notice because we wanted to make sure there was someone available to assist us with the inspection. The inspection was carried out by one inspector.

Before the inspection, we reviewed the Provider Information Return (PIR). 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 reviewed records held by CQC, which included notifications, complaints and any safeguarding concerns. A notification is information about important events, which the service is required to send us by law. We used this information to help us decide what areas to focus on during our inspection.

We spoke with the registered manager, the community services manager, two deputy managers, the organisation's development manager and six members of staff. We spoke with six relatives and observed care and support in three supported living homes. We looked at records relating to the service including six care and support records, six personnel files, medicines records, risk assessments, a variety of policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. Staff were administering people's prescribed medicines without these being documented on the persons individual Medicines Administration Record (MAR). This meant there was no record of all medicines that had been administered. We could not be confident that people were receiving their medicines as prescribed. For example, in one person's support plan a GP had written to the service asking for a change in dose to a person's medicine, this had not been changed on the persons MAR record in line with the provider's medicines policy and procedures. Whilst staff on duty told us, they were aware of the new instructions this service uses agency staff who are not always familiar with people's needs. Agency staff did administer medicines after completion of the provider medicines training and competence check. Prescribing instructions need to be recorded on people's MAR so all staff are clear about what medicines are to be given and when. We saw three people had run out of their medicines on a number of occasions. Staff had recorded on the MAR 'no medicines to give'. People are prescribed medicines for a variety of health reasons and should be supported to take them as prescribed by their GP.

Staff were using topical creams that had been prescribed. These were not documented on the person's MAR and there was no guidance written in the person's support plan to inform them what cream should be applied or where on the person's body. There was no date of opening on any topical creams to indicate when they had been opened. The provider's medicines policy stated that dates should be recorded on the tub or tube when opened so that expiry dates could be monitored. Creams may become less effective if open and in use for long periods. The service had no risk assessment for paraffin-based emollients being used. Paraffin-based emollients whilst safe to use can become flammable when exposed to an ignition source so a risk assessment is required.

Staff had not administered one person's night medicines on four separate occasions. We saw that the administering guidance for this medicines stated that it should be taken with food. Staff had not considered seeking medical advice as to whether the time of administration of the medicine could be moved from the night time to a meal time. This action may have supported the person to have their medicines regularly. There were a number of unexplained gaps on people's MAR. Staff were not recording in the MAR when people were on social leave as per the provider's policy. This meant there was no safe system to prevent staff from re-administering medicines, as they did not know when relatives had administered medicines. Some relatives told us that their family members had not always received their medicines as prescribed as their support visits had been changed or cancelled.

Where staff had hand written details of medicines onto people's MAR we saw that entries had not been signed by the member of staff as per the provider's policy. In addition hand written entries had not been signed by an additional member of staff to witness the instruction. The provider's policy states that hand written entries must 'always' be signed by two members of staff. This is to make sure that the details recorded on the MAR match the details recorded on the prescription.

Incidents and accidents were recorded on forms which the provider called occurrence forms. These forms did not routinely have follow up information recorded. There was not an audit trail of what actions the

provider had taken in response to each incident. There was no monitoring of these forms to identify patterns or trends. This meant that lessons were not always being learned from incidents.

Risk assessments had not always been put in place for identified risks. We found one person used bed rails to make sure they did not fall out of bed. This had not been risk assessed to make sure safety measures were in place to prevent entrapment. We asked the provider to address this at the time of our inspection. Staff had not received training in the safe use of bed rails, we found the bed rails were not placed in a safe position and staff were not aware of what a safe position was. We found two members of staff had health conditions that could pose a risk to service delivery. These had not been identified so that safety arrangements could be put in place. We asked the manager to address this at the time of our inspection.

We looked at one person's support plan and saw their key safe code was recorded next to their address. Whilst the record was electronic and required, a password to gain access this practice is not safe. We raised this with the manager of the community services at the time of our inspection; they told us they would store key safe codes on a separate document.

There had been a fire safety visit at one of the supported living properties in March 2017. The fire officer had raised a number of issues, which the service needed to address. We were not able to establish with the service whether the actions raised had been addressed. We have asked the service to provide us with evidence of this as a matter of urgency.

The above areas are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment.

People's relatives consistently raised concerns regarding calls. Some relatives told us they frequently had agency workers turn up without being told about it or frequently nobody turned up at all. One relative told us, "No-one turned up for the visit on the first day with Fitzroy and it has been like that since, there is no continuity." Another relative told us, "There has been little continuity in staff, there are too many changes, and this has been upsetting." Another relative told us, "They missed one day last week, nobody has phoned, I did it myself." "It is very haphazard, lots of changes, we don't get told." The community services manager told us, "There has been issues with staffing and the organisation of rotas has been poor." The provider had identified that rotas had not been organised effectively and were looking to improve this area as soon as possible. People who had time specific calls were less affected by the lack of organisation, we found these calls were met but not always by a regular worker. Some people who are supported by Fitzroy support at home get anxious about changes, having a regular visit at identified times is important to prevent episodes of distress.

Policies and procedures for the safe recruitment and selection of staff were robust. We looked at six staff personnel files and saw appropriate recruitment checks were undertaken before staff commenced employment. We saw checks in each file included two references, a full employment history including a full explanation of gaps where found, identification checks and a Disclosure and Barring (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with adults at risk. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with people. Where agency staff were used, there was a staff profile in place which showed their qualifications, a current photograph and checks that had been made by the agency.

Staff were aware of the types of abuse, the signs and indications of abuse and how to report any concerns. They were confident that any concerns would be handled effectively by the registered manager or a senior staff member. Staff were aware of support available to them outside of the organisation where they could

raise safeguarding concerns. All staff received safeguarding training, which was refreshed annually.

People had behaviour support plans, which guided staff on how to support people should they become distressed or require specific support to de-escalate anxieties. These were well written with clear strategies for staff to follow to ensure people's safety.

There were comprehensive risk assessments for environments that covered areas of concern such as legionella, fire, first aid and infection prevention and control. People had comprehensive personal emergency evacuation plans, which guided staff on how to support people to evacuate their homes in an emergency.

Staff were clear about their responsibilities in relation to infection prevention and control; they had access to personal protective equipment.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the service was not working within the principles of the MCA. Mental capacity assessments had not always been completed for people when they were needed. There was not always evidence of a best interest meeting for people when decisions that are more complex had been made.

We reviewed care and support records for one person who used bed rails and a lap belt on their wheelchair, this person had complex needs and we were told could not consent to these restrictions. We reviewed this person's support plan and found there was no capacity assessment and no best interests meeting so that the service could record who was involved in supporting the person to make these decisions. There was no evidence to record that these were the least restrictive options.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. For some people the care being provided was depriving them of their liberty and they were unable to consent to this. Staff had written to the local authority asking for an application to the Court of Protection be made to authorise the restrictions. The date on the letter was April 2016; we found no evidence of any other action taken by the service. There were no mental capacity assessments or best interest meetings to support the applications for those people.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent.

Not all staff told us they felt supported. Staff had supervision but this was not being completed in line with the provider's policy. The provider would like all staff to have at least six supervisions per year. We found four members of staff who had one supervision during 2017. One member of staff told us they would welcome more opportunity to discuss concerns with a manager.

Staff were suitably trained to make sure they had the skills needed for their role Training records were comprehensive and shared with senior management teams to make sure training was completed and updated when needed. We spoke to the organisational development manager who monitored training for the service, they talked us through the process and showed us some content for one of the courses provided. They explained the provider used a blend of online learning and face-to-face courses, which they found beneficial for all staff. Where assessments of practice to check for competence was needed this was completed in the workplace, for example medicines competencies were checked by the deputy or registered manager during three observations of practice. If the worker was deemed competent they would be signed off, if further training was needed this was provided.

People's needs were assessed by management prior to any service being offered. We found that there was

no evidence of discrimination with regards to care packages being put in place. Where the service was not able to offer a service this was due to staff availability alone.

People were encouraged to eat and drink sufficient amounts to meet their needs, where the service was responsible for this. People were supported to plan their own menus and do their own shopping. They had opportunity to access shops in their local community. For one person their food was being pureed to a soft texture. We found all of their meal was pureed together. The deputy manager told us they had changed this practice by our last day of inspection. People's support needs around eating and drinking were detailed in their support plans.

People were supported to maintain their health. On the day of inspection, we saw a member of staff come in to escort a person to the dentist. People were supported to visit their GP surgery and have access to a range of other healthcare professionals. We saw in people's records they had health passports, which documented information that would be useful if the person was admitted to hospital.

Where people needed additional support from other agencies, this had been sought. For example, one person had specific needs in relation to their meal times. The local psychology services had been to visit and identified specific meal time strategies for staff to use with this person to reduce their anxieties. Another person had been referred to the Speech and Language Team to review their swallowing abilities and reduce their risks of choking.

Requires Improvement

Is the service caring?

Our findings

There was some evidence that the service tried to meet people's individual preferences regarding choice of care worker, however, this was not each person's experience. One relative told us, "I have mixed feelings, they are trying to get it right but when you use agency staff a lot some are not so good." Another relative said, "The older workers are very good but I have not found all the workers to be good." "I find there is no communication with them [staff]." One relative told us, "Some staff don't want to communicate with you, I don't find them satisfactory at all." Relatives consistently told us their family member did not experience good continuity of care. One relative told us, "The changes in the staff upset him [their relative]; he can't understand some of the agency workers." Another relative told us, "My [relative] likes to know what is happening, I asked for a team of four or five workers to establish continuity; I get different people every day."

Relatives and staff expressed concerns about a recent decrease in support hours. The provider told us this was a commissioning decision and had affected the service provision. One relative told us, "The biggest disappointment is the hours being cut, there is no longer any time to go shopping." Another relative told us, "Hours have been cut, I have written to Fitzroy, I have had no reply." One support worker told us, "The reduction in hours has affected people, they can't always go out now as we are lone working, people are fed up and bored at times."

The manager told us they planned the rotas so that staff had time to travel between visits. They felt there was enough time allocated so that staff did not need to rush through visits. Records demonstrated two people had experienced staff leaving early or not staying for their allocated time. Some staff told us the service struggled when people phoned in sick and there had been a lot of sickness.

We observed people being supported by staff who treated them with kindness. We observed people being included in conversations, being addressed by their preferred name and supported to access their local community. Staff told us they tried to maintain people's independence as much as possible and support people to do as much as they could for themselves. People were encouraged to do light domestic duties where appropriate.

The service supported some people with complex need, some of whom were visually or hearing impaired or had a range of other health needs such as epilepsy. To support effective communication, for one person who used British sign language (BSL) to communicate, the service had employed a staff member who also used this method of communication. Other staff at that specific service told us they did not know BSL fully but knew some key signs so they could communicate with the person. They felt they knew enough about the person to communicate effectively.

Staff spoke about people in a respectful manner and without exception wanted to make a difference to people's lives. Care plans were also written in a manner that was mindful of people's privacy and dignity. Information was person-centred and respectful of people's needs and circumstances. A member of staff told us they always worked to Fitzroy values, 'see the person'. They told us, "We care for the person as they want, we respect them and make sure their dignity is always maintained." One relative told us, "There is one

worker who is marvellous, they are very, very good." Another relative told us, "The person in charge of the house is brilliant, she is so caring."

The service had a key worker system, this is a system where one worker is allocated to a person to be the main worker, overseeing the support plan, attending reviews and responsible for communication between the person, their relative and the office. Two relatives told us they found this system beneficial and were able to communicate effectively with their key workers.

People were involved in making decisions as much as possible about their day-to-day lives. The support at home service held house meetings so that people could voice their views and plan for events such as holidays. If needed the service used a local advocacy service to support people to make their views known.

Requires Improvement

Is the service responsive?

Our findings

The provider had a complaints policy in place. However, the service was not able to evidence that they had followed this policy consistently and their complaints records were incomplete. The provider could not be assured that all complaints had been investigated thoroughly and used as an opportunity to drive improvements within the service. For example, one complaint demonstrated that the manager had met with the complainant but no outcome had been recorded. The provider had not ensured that any required learning had been used to drive improvements in the quality of service provided.

Relatives were not confident about complaining as they felt they would not be listened to. One relative told us, "I phone the office to complain, nobody answered, I left a message, nobody phoned me back." Another one told us, "I try not to complain, I ring up, the phone is not answered." One relative told us, "I have written letters to them, they don't respond." "I complain but I feel like I am hitting a brick wall." Another relative told us, "I hate having to complain but they have to talk to us, it is very frustrating." One relative told us, "I don't want to complain as I don't want [my relative] moved." Another said, "I have complained, I feel I get somewhere with the manager, then they move and so it goes on, nothing gets resolved."

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

People did not always have continuity in their support worker. Due to issues with staffing, the service had used high numbers of agency staff. Relatives told us they worried about the impact of the continued use of agency staff. For example, people did not always experience care provided by regular staff of their preferred gender.

The service produced rotas on Friday so people knew who would be supporting them the following Monday. Relatives consistently told us they had not received schedules in time so they did not know who would be turning up. This had caused people and relatives to experience increased anxieties and a loss of confidence in the service.

Overall people had individual care and support plans that were person-centred and there was detailed information for staff on how to meet people's individual needs. For example, where people had epilepsy there were support plans to provide staff guidance about what to do, for example; if a person experienced a seizure. However, one person's skin care support plan did not provide staff with the required information to meet their needs, effectively. Another person's care plan had not been updated to demonstrate that a medicine to support a health condition was no longer prescribed. We asked the manager to address this at the time of our inspection.

Care and support plans were all written with the aim to support independence as much as possible. Information was also available about what was important to the person and how to support them well or what a good day might look like for the person. This supported staff to provide person-centred care.

The service was meeting the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw that people were given information in text or picture format, and language used was simple and clear.

People had access to activities that they had chosen. We observed one person engaged in sorting beads. This activity had been written in the person's support plan as a positive way for them to spend time. We observed another person engaged in massage therapy. An external therapist visited weekly to offer a range of therapies. It was clear this was a relaxing activity for this person, they looked content. Staff supported people to go on holiday if they wished, for example; one holiday that had been arranged was a tour of the Netherlands.

The service is not providing end of life care at this time, although some people had recorded their wishes in this regard in their support plans.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. Fitzroy Support at Home was made up of two separate services. The support at home service was overseen and managed by the registered manager, the community services was being managed by a manager in the process of becoming registered. Both services had a deputy manager. We found neither manager had a full understanding of their responsibilities. For example, we spoke with both managers who were not aware that being the registered manager of Fitzroy Support at Home meant they were legally responsible for both services.

Not all referrals made to the local authority safeguarding team had been shared with us. One person had alleged a member of staff had hurt their arm. The provider had taken the right course of action in response to this incident, but had failed to inform us. This meant that we had not been provided with the required information to assess, monitor and regulate the service effectively. Following our inspection the provider submitted the required notification.

The provider did not have effective systems in place to monitor the quality of the service being provided. The registered manager had not ensured that regular audits were being undertaken to assess the quality and safety of the care being provided to people. The last audit for the community services was completed in 2016. The manager told us an audit was planned for January 2018. There had been two quality audits for the supported living services during 2017. These were completed by the provider's quality manager who had produced comprehensive reports identifying various issues. The registered manager showed us the service improvement plan for 2017 produced following these audits. This plan did not clearly demonstrate what actions had been completed, by whom or when. The provider could not be assured that all identified actions had been completed.

In response to a medicines error, the registered manager had commenced a monthly medicines audit, but this had not been fully effective at identifying areas for improvement. The audit started in November 2017 but had not found the issues we found during our inspection in December 2017. The deputy manager was completing weekly medicines checks, again these had not picked up the issues we found. Used MAR charts were stored at the office, but these were not routinely checked or audited to make sure people received their medicines as prescribed. We checked a number of these MAR and found high levels of recording shortfalls. The provider had completed a serious case review following a major incident in October 2017. We saw three learning outcomes were related to medicines administration. These had not been shared with the team or implemented. A quality monitoring visit in August 2017 had raised issues with some medicines management; some of these issues had not been resolved. The issues we found had been identified in part by the provider but had not been resolved. The provider is not routinely evaluating and improving their practice with regard to medicines management.

Feedback about the service from people and relatives had not been sought by the provider. Relatives told us they had not had the opportunity to give feedback. One relative said, "They are not going to ask me what I think, they know they won't like it." Another said, "I feel like Fitzroy are not taking any notice of me or them [relative]." Another told us, "I have had no contact with them [Fitzroy], they don't listen." The registered

manager told us, "Due to changes in management and the need to stabilise the service the management focus has been on other issues." The community services manager told us, "Surveys have not been done for a while; we need to do this soon."

The above areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The registered manager and manager of the community services were both open and honest about the shortfalls that existed within the service. They recognised that since the provider had been awarded the contract to provide care and support services, there had been an unsettled period. During this time, people had not been provided with the quality of service they would have liked. On the last day of our inspection, we were told the rota co-ordinator was not available for the service. This meant this role was being completed by the deputy manager. This prevented them from doing their regular duties such as reviews, staff supervisions and quality monitoring. They told us that covering the additional role was acceptable for them in the short term but they were not confident they could sustain both roles for a longer period of time.

Some relatives and some staff told us they had no confidence in the out of hour's arrangements. When they had called to report that their support worker had not turned up they had either not had an answer, or left a message but not had a return call. Two relatives told us they had given up with the on call arrangements. Staff told us that they had not always been able to contact management via the on call system to get support. A member of staff told us, "Sometimes staff don't turn up, it is hard to cover shifts." Another told us, "Weekend cover can be difficult, people don't turn up, and nobody answers the on call phone." The service needs to provide effective out of hours on call arrangements whereby management advice and guidance can be sought.

Staff and relatives told us there had been many changes in the management of the service, which had been unsettling. One relative told us, "The service has improved a bit but it is not satisfactory, management has changed so many times." Another said, "I give up trying to talk to them, we are not told what is going on." One staff worker told us, "There has been a high turnover in managers over the past couple of years, it has caused issues but things are changing." There was a feeling amongst the staff we spoke to that the current management were stabilising the service. One member of staff told us, "I feel really supported now; my feelings are being listened to." Another told us they felt the registered manager supported them, "There have been a few problems, changes to the management has been difficult, but I feel supported now." Another told us, "I can chat with the manager all the time, they are trying their best."

The registered manager told us that the service had experienced a high turnover in staff. The provider inherited a staff team from a previous provider, which had caused some issues. The previous staff team had found it difficult at times to adapt to the provider's values, this had led to conflict and some staff leaving. The registered manager was positive that things were improving and that the recent recruitment would bring improvements to the continuity of care provided.

The registered manager and deputy visited the supported living homes each week. This enabled them to get to know people well. We saw the deputy manager interacting with people; they clearly knew people's needs and were able to communicate effectively.

Equality and inclusion was promoted within the workforce. There was a diverse workforce who all felt welcomed by the provider. Staff who had health conditions were supported to work at the service without discrimination. We saw staff working together to try to make sure people's needs were being met. This was done with a mutual respect for each other.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in accordance with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. Complaints received were not investigated so that the provider could take proportionate action to respond to any failures identified.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided. The provider had failed to seek and act on feedback from people and their relatives in order to evaluate and improve the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Risks had not always been identified so that safety measures could be put in place.

The enforcement action we took:

Warning notice