St Anne's Community Services

Kings Mill Court

Inspection report

1-12, 14 Kings Mill Court
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Huddersfield.
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Website:

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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?	Inadequate

Overall summary

The inspection of Kings Mill Court took place on 23 April 2015 and was unannounced.

Kings Mill Court is a complex of 12 self contained flats in the Newsome area of Huddersfield. The service provides personal care and support for up to 12 people with complex physical needs, behaviours that can challenge and/or learning disabilities. People live in tenancies agreed with a landlord. The flats have a communal lounge and kitchen on the ground floor and secure gardens which provide a private leisure area. On the day of our inspection 11 flats were occupied.

There was a registered manager who had been registered since 3 June 2014 but at the time of our inspection they were being removed from the CQC register as they were no longer in post. There was an application in place for a different registered manager which was being processed. This person had been managing the home since the end of last year but had not been registered with CQC for this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 was not in work on the day of our inspection so we were unable to talk to them. However, there were two senior support workers who were providing management support.

People told us they felt safe living in Kings Mill Court as there were various means of getting help if needed such as through pendants and alarms. They also felt staff would support them. It was evident through information we looked at that staff knew how to respond when people raised concerns and reported any safeguarding concerns appropriately.

We observed a small staff team, some of whom seemed very busy. We were told that there was a shortage of regular staff and each day staff teams comprised bank and agency staff. This meant that people had little continuity of support. Staff were frequently asked to cover shifts and this led to them working long hours. We also found an inexperienced member of staff was covering the night time.

This is a breach of Regulation 18(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found staff working shifts who were not appropriately experienced and that the service was not able to provide adequate staffing levels on a daily basis, relying on people doing extra shifts or using agency staff.

We also had concerns with medicine administration. While it was clear that people were receiving their medicine correctly the systems of recording information about this were not robust, and had the potential for errors to occur.

This is a breach of Regulation 12(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we could not be certain that there was proper and safe management of medicines as when we checked the systems in place they did not correspond.

We found people were supported by properly inducted staff who received ongoing supervision and training. Staff had a good understanding of capacity issues and were supportive with people in relation to arranging healthcare appointments.

During the course of the inspection it became increasingly apparent that staff were under constant demand and this led to strain showing in interactions with people. It was not clear at times whether the service was being run as supported living, or a care home due to the lack of clarity around what tasks were needed and when. This lack of clarity was emphasised in people's own view as to whether they were receiving the correct support as expectations were high but this was not reflected in staffing levels, or indeed staff responses at times.

This is a breach of Regulation 17(2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not able to relay what support someone was receiving and how decisions had been taken.

The service felt chaotic at times and the provision haphazard. It was often difficult to determine if people's needs were being met as they should have been as staff were busy and very reactive, and records did not always detail what support someone should receive.

This is a breach of Regulation 9 Health And Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always receiving support in a person-centred way, often finding their staff member being called away to support someone else and they were not consistently involved in discussions around their support needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

We found that most people felt safe when in their flats and that appropriate checks were made when recruiting staff.

There was a shortage of regular staff and an over-reliance on staff goodwill to cover shifts.

Medicines were appropriately prescribed but there was a risk of errors as records were not consistent.

Requires Improvement

Is the service effective?
The service was not always effective.

Some staff had received an induction, supervision and ongoing training but this was not consistent.

Staff sought people's consent and supported people with arranging healthcare appointments as necessary.

Requires Improvement

Is the service caring?
The service was not always caring.

We observed individual members of staff having positive interactions with people but this became strained as the day wore on due to the volume of demands on staff time.

We did not see people always being treated respectfully and listened to.

Staff were aware of professional boundaries and did promote people's dignity.

Requires Improvement

Is the service responsive?
The service was not always responsive.

It was difficult to determine if the service was meeting people's needs as records were unclear as were staff as to what aspects of care they were supposed to be supporting with.

There was evidence that complaints had been dealt with appropriately up to September 2014 but we could find no subsequent records. The registered manager was unavailable to ask on the day of inspection and the provider was unable to clarify after our visit as the registered manager remained absent from work.

Requires Improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

On the day of our inspection staff spent most of their time reacting to requests rather than responding in a planned manner. Staff were very busy and in constant demand which reflected that the service was chaotic and no clear boundaries had been set to establish the nature of support people should be receiving.

The manager was not registered at the time of inspection but had made an application to do so. Although we saw clarity of leadership in staff meeting minutes this was not reflected in what we observed on the day. The service was disorganised and erratic.

Kings Mill Court

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.

The inspection took place on 23 April 2015 and was unannounced.

The inspection team comprised of two adult social care inspectors.

Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. Concerns had been raised about the lack of a permanent manager and a series of incidents where police had been called. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with six service users and interviewed four members of staff including two senior support workers and two support workers.

We looked at three care records and three personnel files. We also reviewed accident and incident reports, communication logs, medication records, staffing rotas, staff meeting minutes and resident meeting records.

Requires Improvement

Is the service safe?

Our findings

One person told us "I like living here and I feel safe". Another said they also felt safe and liked the fact that "I can come and go as I want as long as staff know when to expect me back". A further person said they liked living at the service but that they also "felt bullied" sometimes by another person living there. When asked if these concerns had been mentioned to anyone, we were told "I have told staff but they don't do anything". We did speak with staff after this issue was raised and found evidence that bullying behaviour had been challenged on previous occasions.

One person told us that "someone kept coming into my flat" and the member of staff said this was reported as safeguarding at the time. They also told us the person had initially been invited in but then the person had become uncomfortable with them visiting so often and so reported their concerns. This issue had now been resolved as the person had since left the service.

The same person also showed us a pendant they could wear on their wrist. This enabled them to summon help and we were told "the buzzer makes me feel safe". We asked them why and they said "staff will come if I press the alarm". A member of staff advised us that there were two pagers in the office and if the buzzer was pressed it would identify where the person was. We were also advised that if a flat door was left open, an alert would be raised.

We asked the senior care staff about the staffing ratios and shift patterns. We were told these varied according to the needs of the people each day. Starting times would adjust according to what support was needed. Rotas were planned a week in advance and there was use of agency staff. We were told that bank and agency staff were used every day as there were not enough permanent staff. A recruitment drive had just been completed and the service was in the process of ensuring all the necessary checks were undertaken.

On the day of the inspection there were two senior staff members working the day shift. Of the five other support workers on duty, one person had been bank staff but had just been recruited as permanent, two were permanent and two were agency. We asked about the agency staff and were told that they had both been a few times before. We were advised there were 15 permanent staff excluding the manager, three of whom were seniors. A further two were also joining. The senior staff said they were keen to ensure that regular staff were on every day to promote stability for people using the service.

Senior staff said they currently had to work one weekend in three and support staff also needed to work over weekends as well. We were told that there was an out of hours advice line for any staff working. This was supported by an area manager.

We asked staff their views on staffing levels and were told "there are usually enough but the problem is with agency staff they do not understand people's individual needs the same as staff who know people well and this can time consuming". One staff member told us there were fewer regular and full time staff than previously as staff have left. They also told us that they can be asked to cover staff absence. This was confirmed by the senior staff who said if a staff member rang in sick 'a senior may cover or we could ask other staff if they wanted to do an extra shift. If not, we would need to use bank or agency (the latter needed approval from the area manager)'.

This was the case on the day of inspection as one staff member had been asked to cover the sleepover on their arrival at work the previous day which they had agreed to, and then had carried on working while we were there despite that being their day off. The same member of staff finished this shift over one hour late due to lack of available staff to hand over to. This person had been working for the planned shift of six hours followed by a sleepover of eight hours and then a further nine hours during the following day. When we questioned the wisdom of this, we were told the person had agreed and 'it was unusual'. We looked at the staffing rotas and found these did not reflect what we had observed for that day. Staff were working for longer hours than recorded on the records.

In one of the staff files we looked at it mentioned that a keyworker for a particular individual had not been able to spend much time with them 'due to pressures from other clients requiring support'. This reinforced our view that there were not enough staff on duty at times and those that were, may not have been deployed in the most effective manner. We could find no mechanism by which the service determined the dependency needs of people using the service apart from their initial admission paperwork therefore this had the potential to create pressure points at certain times of day.

Requires Improvement

Is the service safe?

We were also concerned that no senior member of staff had been put on the rota to work the evening of the day of our inspection. The senior staff told us it would be a specific person as they were the longest serving member of staff. We later found out they were still in their probation period. When we asked what support was available for them we were advised that there was management support accessible via the telephone. We were concerned due to the fact that agency staff were working who they did not know, and who did not know the people in the service. The member of staff was aware that it was their role to ensure everyone knew what they were doing.

This is a breach of Regulation 18(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found staff working shifts who were not appropriately experienced and that the service was not able to provide adequate staffing levels on a daily basis, relying on people doing extra shifts or using agency staff.

We asked staff how many people were able to take their own medicine. We were told that one person was able to self-administer, another two took their own medicines while being observed and the remaining people all received assistance with taking their medicines. It was documented in the staff meeting minutes about how to support someone who was reluctant to take their medication. This was to ensure as many opportunities as possible were tried to encourage someone to take their medicines. However, if they refused this was to be recorded. It was also noted that if a person later wished to take their medicines they were to be informed that the medicine round had been completed. We asked staff how they would deal with this situation if refusing to take their medicine left the person at risk of harm. They told us they would liaise with the GP.

We saw printed medicine administration record (MAR) sheets from the chemist which were completed appropriately. Staff told us about the ordering system and the number of checks which occurred before requesting the prescriptions and after receipt of the medication from the chemist. Each person's medication was checked against what was ordered and signed and dated on the MAR sheet. If a person was on temporary medication for an infection then a new MAR sheet would be sent from the chemist.

We were told by senior staff that any changes to a person's medicines were written in the daily notes and the yellow medication file. They were also recorded in the black medication communication book. When we looked at the handover sheet for a specific day there were changes to medicines for two people recorded on this day but nothing had been entered in the medication communication book. This was the same for a specific day from the previous week. It was evident that the systems for recording were too complex and not being adhered to, leading to the likelihood of mistakes occurring as things were missed.

This is a breach of Regulation 12(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we could not be certain that there was proper and safe management of medicines as when we checked the systems in place they did not correspond.

On our arrival we were greeted by a support worker who checked our identification on entering the building but who did not inform us that we needed to sign in. Neither did they introduce themselves. This could have led to a problem in relation to fire safety.

We were given a tour of the premises at the outset of our visit. We were shown that people had their own post box with a key. Each of the floors was activated by a security fob, issued only to people living in the complex. While on the tour of the building the smoke alarm went off as someone had burnt some toast. Appropriate checks were made at the time. There were staircases at each end of the corridors, one of which was accessible through the fire door at the end. The building was on three floors and there was a lift.

Staff told us they knew what the safeguarding procedures were and they would not hesitate to report any concerns to the necessary agencies. This was evidenced by appropriate notifications to the Care Quality Commission. There was also evidence of in-depth discussions at staff team meetings concerning these issues.

We saw that accidents and incidents were logged appropriately, and action taken as necessary. These included records of unacceptable behaviour such as people mimicking others and there was evidence to show that staff had challenged this.

Staff files showed that necessary checks had been made on staff as there were dated and signed by the head office. It was also clear that staff were not employed until these had been checked.

Requires Improvement

Is the service effective?

Our findings

One person said they think staff try and control some people such as "telling them what they can and can't buy". We looked into this issue and found it related to some health concerns, and was on the recommendation of a nurse. It was unclear from the file whether a best interests meeting had been held. Most people in the service had capacity to make their own decisions, and where there were issues capacity assessments had been undertaken by the local authority.

There was evidence in the staff meeting minutes that the service encouraged people to be as independent as possible. It referred to one person who preferred to take their own medicine. Staff enabled the person to take their own medication by helping to open the medicine cupboard and observe the person taking out their own medicines. The person was then able to take their own medicine.

We asked staff about their induction. One staff member said they had 'done all the usual courses – medication, fire, reading support plans and information about the service users'. They had also completed safeguarding training within the past year. In staff files we saw evidence that appropriate induction training had been completed.

The staff files contained an induction checklist but this had not always been completed. However, there was evidence in the recordings on supervision notes that training had been competed in areas such as moving and handling and the care and safe handling of medication. There was also evidence of staff having been observed while working with people in the service and working towards the Skills for Care induction. We saw evidence of monthly supervision up until January 2015 in one file and a more in-depth appraisal following completion of the person's probationary period.

We asked staff about whether they had received any supervision. Two staff members said they had, both within the last two months. One told us about having to deal with issues of poor performance from a member of staff and how they had been supported through this process.

One of the senior staff advised us that staff are currently receiving training on the new care certificate, and that a new induction programme has also been developed. Senior staff told us that they had received Positive Behaviour Support training which was accredited by the British Institute for Learning Disabilities. However, this had not been extended to all staff yet. This training assists staff to promote positive behaviour in the people they cared for eradicating the need for use of restraint.

Another staff member said they 'thought there were training and development opportunities' but due to their own interest had taken to self study to learn about medication and its side effects. It was not clear whether they had been offered any formal training outside of their induction. In one staff file we saw it had been identified where training had expired and the person needed to attend a refresher. This had been actioned in both cases.

The ground floor flats were specially adapted for wheelchair users with lower worktop heights to facilitate independence in daily living activities. They also had ceiling hoists fitted. All flats had walk-in showers which enabled access for everyone . Each flat was personalised. We saw one person had red kitchen units as this helped with their visual cognition.

We overheard one support staff member booking an optician's appointment and liaising with medical professionals. There were good records in the health action files for people as these contained all recent input from health professionals including speech and language therapy and the GP.

Requires Improvement

Is the service caring?

Our findings

One person told us "it's not as good as I thought it would be. It's not bad, there's good stuff and bad stuff here". They said that staff "are always too busy, they say go away". People told us "some staff care, and some do not. Some staff have told me they are too busy to help and that staff are grumpy if woken while on the night shift". This had allegedly happened the previous week as someone had been ill - the person said "they were … grumpy. [They] were tired and complained about having to get out of bed". This was echoed by another person who said "when I ask for help, they ignore me". They went on to say "They might as well show a piece of paper that says (swear words), that's how it feels, they don't care".

Another person said "staff only intervene if people get aggressive with each other". They said "staff are more likely to turn away". The same person said they felt that "staff don't listen and do not take concerns seriously".

We observed one person knocking on the glass partition which divided the reception area from the office and trying to make eye contact with staff. However, staff ignored this on several occasions. Eventually the person asked the member of staff for a word in private. The staff member ignored this request initially saying they were making a drink and the tone of their voice showed a level of irritation.

Earlier in the day someone approached the glass door and banged loudly as they were concerned they had 'lost their fob'. He was told by a member of staff to stop shouting and advised that 'if staff lost theirs, they would have to pay'. It transpired on further investigation that the fob was in their pocket. However, we felt that this incident had not been handled in the most sensitive manner as the staff member's frustrations were shared with the person.

Another person asked for attention from a different member of staff later in the day but again was repeatedly brushed off telling the person they were 'too busy' and 'I've loads to do'. This staff member was rushing around but had worked past the end of their shift by some time so it was understandable they wanted to leave. However, there was no support from other staff in the office to allow this staff member to go.

Through our observations during the day it was clear that the regular staff had a good understanding of people's needs, likes and preferences. They also understood the different personalities of people living in Kings Mill Court. One staff member told us they 'were aware some people clash but were not aware of any bullying'. They told us they would challenge this if they witnessed it. They indicated that someone had recently left who had been disruptive and things had settled down considerably.

We overheard a phone conversation by a support worker talking with a GP about one of the people's recent appointments. It was evident they knew the individual well and was aware of their support needs. After the call they spoke with the person and reassured them of what had been arranged. Their tone was very reassuring and supportive.

Some of the regular staff had a very positive rapport with people but we felt this was stretched to the limit at times due to the number of requests for support from people during the day. We found it difficult to distinguish where the distinction between support for individuals, as required in supported living environments, and more general service support began and ended. At times it felt like the service was running a 24 hour residential home due to the amount of calls on staff time. This was indicative of poorly managed boundaries for the support of individuals within the service and a lack of consistent staff team who knew people well.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff help with chores such as cleaning their room and putting washing on the line. We observed this. However, they went on to say that "I feel my time is often interrupted because staff get called to help others and don't come back to help me". They mentioned they would like more staff time as they felt staff "spent more time with those who were more physically dependent". A different person told us they were happy when staff went to the shop with them and another was also keen to tell they enjoyed going shopping. However, they did say they also would like to know in advance who's going with them because they weren't always told and then often had to wait for them.

Another person said "I am not happy with the level of support. I do not feel that staff do the full length of time they should. I should have 45 minutes a day to help with personal care, conversation and shopping but it usually less than 15 minutes. I have help with my medicines but nothing else". We later observed the same person receiving help from a support worker in relation to arranging medical appointments. A further person who was also expecting more help said that the only thing they were certain of was help with their medication.

One person spoke with us about how they were given a tour of the providers' other locations recently and how much they had enjoyed this. Another person said they enjoyed going to the 629 club as they met up with friends there. Staff told us that tea times were arranged for 2.30pm and again later in the evening. They said people had to contribute a nominal amount towards the cost but this was sometimes hard to collect. The service saw tea time as a social time to encourage people to interact with each other. However, people could also make drinks in their own flats if so desired.

We spoke with staff who told us that "people were supported to make their own decisions". This could mean receiving assistance in a number of areas such as attending the 629 club, trips to town, to the shops, help with cooking and self care. One member of staff saw their role as "promoting independence in daily living and trying to encourage people to be more self-reliant". The same person was clear of their own professional boundaries as "their role was to support people in the hours they need it". Another was also aware of the importance of boundaries as some of the younger people "wanted to be mates".

We questioned how this support was determined and it became evident that there was little information around how this was delivered. Staff were person-focused as they allowed people to make decisions but it appeared very haphazard in how this support was apportioned to people. Witnessing interaction from the office, it was evident that certain people were more vocal than others and could seek more support. Without an adequate structure in place as to when and why support was being offered, it meant the service was more accessible for those who requested it, potentially leaving others without the help they required.

We were unable to determine easily if people were receiving the correct levels of support as there were no records of how much time has been spent on a particular activity. Staff told us that some people perceived they did not have enough support but they were not always able to factor in how much time was spent going on appointments or other trips out. Staff also said they were aware some people may not get their full support but "as it's not recorded anywhere, it's hard to know". One staff member said the only thing they knew about times of care and support was in relation to medication as the other task time allocations were not defined.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always receiving support as required by their specific needs, nor were they always included in discussions as to how this care was being provided.

We looked at the daily communication book. Each person using the service had one of these. One contained specific requests form the person to see if they could receive more help with external activities. They had requested a keyworker meeting. It wasn't clear what action had been taken since this request to discuss it further. The records were person-centred in that staff had responded to what the individual had asked for help with. In one instance rather than helping with tea preparation as had been specified, they had assisted with cleaning and changing bedding. The person had been encouraged to do what they could for themselves.

Requires Improvement

Is the service responsive?

We found the shift handover to be ad hoc; staff were disturbed while trying to pass on messages and were unclear in some cases what information they had to pass on. Not all information shared was recorded. At one point a member of staff left to find out who was supporting a particular person. In the staff team meeting minutes there was evidence of a discussion around handovers. It was suggested that any issues were written down and then handed over to only one person at night. We did not observe this practice happening.

We looked at care records and found them to lacking in detail and in need of reviewing. There was evidence that one person needed a significant amount of support as detailed by the social worker but that the support hours timetable was blank. In addition, the risk assessment said that one-to-one support was required for meal preparation but there was no record that this was happening. There was also contradictory information regarding medication. One support plan stated the person self medicated but an older one said they needed support. There was no evidence in the record as to how this change of need had been decided.

In one support plan it mentioned that staff were to assist someone in preparing food but we observed them doing it for them despite the person sitting next to them and having appropriate equipment to do it. The same plan was very specific in terms of how the hours were broken down but not written in an accessible format for the person with the use of pictures to aid understanding. However, it had been reviewed last in December 2014 and new goals set. These goals had been set by a community nurse. The risk assessments in this file had been reviewed in March 2015.

In another care record there were risk assessments in place for support with daily living and these had been signed by staff confirming they had read them. However, the review dates on these records had not been adhered to as there was no evidence of the review having occurred. Some of these had been due in June 2014. For one person there had been no updates to how a person liked to be supported on a daily basis since April 2014. This shows that people were not receiving regular reviews where their opinions were being sought about how they liked to receive support, and whether it was still meeting their needs.

We saw a daily log sheet for the service. This had each flat's timetable shown in hourly blocks and the various tasks that needed undertaking such as medicines, coffee and meal preparation. It was not evident how much support each person was supposed to receive or by whom as not all 'tasks' had names attached. Likewise, the handover sheet was sparsely filled in. The only completed sections were medicines and money. Again, there was not much detail within this. On one day we saw an entry had been made, but it wasn't signed and had some words crossed out.

This is a breach of Regulation 17(2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not able to relay what support someone was receiving and how decisions had been taken.

We observed in the communal lounge a dining table which had a semi-completed jigsaw on it. We asked one of the people living at Kings Mill Court whose it was and they said "anyone has a go". The same person told us that the lounge was used for self advocacy meetings. We were told the DVD player had recently been broken.

One person spoke with us and told us they were very unhappy as 'I do not get the support I need'. We asked them if they had complained and we were told they had asked staff on several occasions how to complain and been promised a form but this has never been forthcoming. The same person was aware of what support they were supposed to be receiving but said this didn't often happen as their keyworker 'does not turn up and no one else does either'. We asked how they were managing and they told us 'I just have to'.

We found in the accident and incident log details of another occasion where one person had said they had not been assisted with showering. Although this was recorded as an incident it was clear from the record the person wanted to complain. However, we could find no evidence this had been dealt with as a complaint.

Staff told us 'they would support people to make a complaint if they wanted to', though would try and sort it out first if it was a minor issue. They would also ensure that people felt supported to raise any concerns.

However, we looked at the complaints file and found these were recorded in detail but there had been no entries since 18 September 2014. In discussion with the staff present who, in the absence of the manager, we found no record of any further complaints. We later spoke with the area manager for the service who was also unaware and the registered manager remained absent from work at this time so could not be approached.

Inadequate

Is the service well-led?

Our findings

We asked people how they felt the service was run. Two people told us that "staff spent a lot of time talking in the office". We also observed that staff were in the office and were disturbed at regular intervals by people knocking on the glass partition.

One person told us about the residents' meetings that were arranged so 'people could have their say about things'. However, during the group discussion it became clear that some people did not feel these made any difference "as staff did not take our views seriously and the meetings did not achieve anything". We did see minutes of these meetings which reflected people's views and requests. However, it wasn't clear how many of these had been responded to or later actioned.

There were also records of tenant meetings where people had been reminded to check people's identification badges and not to smoke in the grounds. However, we noticed throughout the day that people were sitting on the wall towards the edge of car park smoking.

People told us about the changes to managers and that there were also lots of agency staff. The manager was not present on the day of the inspection due to personal circumstances. We were told that they would also be soon leaving and a new manager had been appointed, with a planned handover at the end of May.

Staff told us the service had been subject to a change of managers over the past year. This had not helped promote stability for the service. The previous manager had left and was in the process of de-registration with the Care Quality Commission. Their replacement was also leaving so the service had been subject to a period of instability. One member of staff said they had found the situation very stressful towards the end of last year but had received a lot of support from the area manager and staff team. Staff told us they felt supported and the current manager was approachable.

We saw records of staff meeting minutes which had been held monthly since September 2014. They covered a range of issues including specific service user issues, staffing, safeguarding, health and safety and staff policy. In the minutes of the January meeting it was identified that not all people "had an active key worker owing to absence or staff leaving". This was put as an action point for the next meeting. We later saw in the tenant meeting minutes from April 2015 that each person had a keyworker, and in some cases two workers. Minutes were shared with all staff and everyone was required to sign they had seen them whether in attendance at the meeting or not.

As the registered manager was unavailable on the day of inspection we had limited access to records and staff on duty also had limited awareness of any audits being undertaken. The service was not well led on the day of our inspection as staff spent most of their time reacting to requests rather than responding in a planned manner. Staff were very busy and in constant demand which reflected that the service was chaotic and no clear boundaries had been set to establish the nature of support people should be receiving.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We could not be certain that there was proper and safe management of medicines as when we checked the systems in place they did not correspond.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We found staff working shifts who were not appropriately experienced and that the service was not able to provide adequate staffing levels on a daily basis, relying on people doing extra shifts or using agency staff.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Records were not able to relay what support someone was receiving and how decisions had been taken.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not always receiving support in a person-centred way, often finding their staff member being called away to support someone else and they were not consistently involved in discussions around their support needs.

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.