Elite Care Homes Ltd

278 Moseley Road

Inspection report

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West Midlands
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06 February 2018

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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**

Summary of findings

Overall summary

This inspection took place on 01 and 06 February 2018. The first day was an unannounced visit, but we informed the provider we would return for a second day. We last inspected this service in November 2016. At this time, the service was providing support to three people. We rated the service as 'Good' overall and found that the provider was meeting the requirements of the Health and Social Care Act 2008 and associated regulations. However, we found that some improvements were required to the provider's systems and processes for monitoring the safety and quality of the service therefore, we rated them as 'requires improvement' in the key question of 'Well-led'. At this inspection, we found that the service had expanded and further improvements were required to the safety and governance of the service.

278 Moseley Road provides care and support to people living with learning disabilities and/or mental health conditions, in three separate 'supported living' settings so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of our inspection, the provider was supporting 16 people with their personal care needs.

The provider was required to deploy a registered manager to manage the service as part of the conditions of their registration. There had not been a registered manager in post since June 2017. This is an offence under section 33 of the Health and Social Care Act 2008 for failing to comply with the conditions of registration. The provider had appointed a manager who had been managing the day to day running of the service since the departure of the registered manager, information we hold showed they had submitted an application to register with us in January 2018. However, this manager left the service during the inspection process. We were told that a new manager had been appointed, but was yet to start their employment with the provider. 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.

It is a legal requirement for providers to display their rating, to show whether a service was rated as outstanding, good, requires improvement or inadequate following an inspection. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of the care provided. The provider has a regulatory duty to ensure that ratings are displayed legibly and conspicuously at both the office location and on their website within 21 calendar days of the date at which the inspection report was published. We found that the provider had not displayed their rating on their website or at their office location. This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A common theme throughout the inspection, which was found to have impacted upon the safety and the quality of the service provided to people was poor record keeping and ineffective quality monitoring systems and processes. Information we requested to support our inspection was not always provided and

information providers are required to send to us by law, by way of statutory notifications, had not always been sent. Inconsistencies within the provider's quality monitoring practices had failed to identify or remedy the shortfalls we found within the service, which collectively formulated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 concerning the governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

The service was not always safe because staff were not always aware of some of the risks associated with people's support needs and records concerning risks to people's safety and well-being were sometimes inconsistent and/or incomplete. The provider's quality monitoring systems and processes had failed to ensure that safety checks within the supported living properties, including fire safety, had been consistently carried out and appropriate records maintained. On the whole, people received support to take their medicines as prescribed but some improvements were required to the risk management and recording of medicine administration within the service. The provider's recruitment checks were not always robust and incidents were not always recognised as potential safeguarding concerns to ensure they were referred on to the appropriate agencies.

The service was not always effective because staff had not always received the training they required. Training records were not available for us to view at the time of our inspection. People were cared for in the least restrictive ways possible and staff understood their responsibilities associated with the Mental Capacity Act 2005. People were supported to choose foods and prepare meals that they enjoyed and were supported to access to health and social care professionals, as required. People were supported to maintain good health because the provider worked collaboratively with other agencies. People were encouraged to develop and maintain their independence as far as reasonably possible and were supported to sustain relationships with people that were important to them.

We received mixed reviews about the level of involvement people and those that were important to them, had had in the planning and review of their care. However, we found that care records contained information about people's needs, likes, dislikes and preferences, which reflected our observations and the feedback we had received from people, staff and relatives we spoke with.

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.

People were not always supported by staff that were aware of the risks associated with their care needs.

Care records did not always contain the relevant information required pertaining risks and associated management plans to promote people's health and safety.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow. Although, not all incidents were recognised as potential safeguarding concerns.

People received their prescribed medicines when they required them, but improvements were required to the management and recording of medicine administration processes.

The provider's recruitment process was not always robust to ensure the appropriate check had been carried out for new employees.

Is the service effective?

Requires Improvement

The service was not always effective

People received care from staff who had not always received the training they required.

People's rights were protected because staff understood and worked in accordance with the Mental Capacity Act 2005.

People were supported to choose, prepare and eat food that they enjoyed.

People were supported to maintain good health because they were supported to access health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had failed to ensure other aspects of the service were safe, effective, responsive and well-led which impacted upon the quality and safety of care people received. This meant the service was not always caring.

People were cared for by staff that were kind, caring and friendly.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little evidence to show that people and/or those that were important to them, were involved in the planning or review of their care.

There was little evidence to show that the provider proactively sought feedback on the service provided to people.

People, relatives and staff told us that the provider was not always responsive to information, suggestions or ideas they shared with them.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not meeting the conditions of their registration because they had not ensured that there was a registered manager in post.

The provider had failed to display their rating.

Notifiable incidents had not always been reported to CQC as required by law.

The systems and processes in place to assess and monitor the safety and quality of the service were ineffective.

278 Moseley Road

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 unannounced inspection took place on 01 and 06 February 2018. This inspection was conducted by three inspectors. We carried out this inspection because of concerns we found at the provider's other registered location.

Before the inspection, we looked at the information we held about the service. This included statutory notifications from the provider that they are required to send to us by law about events that occur within the service, such as deaths, accidents/incidents and safeguarding alerts. We contacted the local authority and commissioning services to request their views about the service provided to people, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection, we visited the provider's main office location and spoke with the manager (who has since left) and the provider. We also visited two out of the three supported living homes and spoke or spent time with three of the people who used the service. Some of the people who used the service had complex care needs and were unable to tell us about their experiences of using the service. Therefore, we also spoke with two people's relatives. We spoke with six members of staff including the provider, the manager, a senior support worker, and three support workers. We also made general observations around the properties and reviewed the care records of three people to see how their care was planned and reviewed. We looked at the medicine administration processes within the service and looked at records which supported the provider to monitor the quality and management of the service. These included health and safety audits and staff recruitment. Some of the information we requested was not made available to us such as records of staff training, staff rotas or evidence of quality assurance practices such as feedback surveys or meetings minutes.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection we found that people received care and support that promoted their safety. During this inspection, we found that some improvements were required in this area.

Some of the people and relatives we spoke with told us that there was not always enough staff available to keep people safe and to meet their needs. For example, one person we spoke with told us that sometimes they were left alone in the house and that this made them feel unsafe. A relative we spoke with told us that staffing levels at night caused them some concern. They said, "I worry at night because if anything was to happen, one member of staff would not be enough; some people have high needs and one staff member could be occupied supporting them; who's there to support the others [people] then? They [provider] need another member of staff as a 'back-up'". They also told us that they had raised this as a concern with the provider some months ago when a member of night staff walked out and left the service un-staffed. At this time, the relative said that they had stayed at the home until another member of staff was deployed. The provider had informed the relative some weeks ago that they were looking to deploy a second member of staff at one of the supported living settings at night time, but this had not yet happened. Staff we spoke with told us that staffing levels were generally 'okay' but it often depended upon what was happening within the service at any given time. One member of staff said, "I think staffing levels are okay, but there are times when we are really busy, if someone requires more support which doesn't leave staff to support other people, but that's difficult to predict and manage in advance as every day is different". We asked the manager how they calculated the number of staff they deployed within each of the three supported living homes. They told us that this was based upon people's varying levels of needs and how many paid support hours people required from the service. We asked to see the provider's staff dependency tool (a tool used to calculate the required number of staff based on people's level of dependency needs) and staffing rotas; but these were not made available to us at the time of our inspection. Information we hold about the service showed that there had been two safeguarding concerns raised regarding staff leaving people unsupported. The manager told us that not everyone required 24 hour care and support and that some people were safe to be left alone for a period of time. However, they acknowledged that this should not have happened and the staff concerned had been disciplined; and all staff members had also been re-trained in understanding their roles and responsibilities in promoting people's safety. We did not identify any further incidents which indicated that people had not received the support they required to maintain their safety in relation to staffing levels, but the manager advised that staffing levels would be reviewed. This showed that some lessons were learned when incidents occurred within the home. However, we found the provider to be reactive, rather than proactive in their approach to preventing incidents from arising in the first instance. This reflected the lack of quality monitoring and assurance practices within the service.

Records we looked at showed that the provider had assessed and identified risks associated with people's health and care needs. For example, we found that some people required support with managing the risks related to their epilepsy, diabetes and behavioural symptoms associated with their learning or mental health needs; such as self-harm and/or sexualised behaviour and vulnerability. However, some of the records we looked at lacked detail and/or were inconsistent with the information provided. We saw that one person had a diagnosis of epilepsy which was referred to in their care records. Their care plan stated that the

provider had little knowledge of their seizure history when they were initially assessed to receive support from the service and further information was required from the GP. However, the provider had failed to update this information following a review with the GP. This meant staff had very little information concerning this person's seizure history, the type of seizures this person experienced including the signs, symptoms and triggers that staff needed to be aware of. It also failed to detail what action staff needed to take should this person experience a seizure. We saw similar issues with a care plan for a person living with diabetes and also where people were identified to be at risk of either gaining or losing weight; there were no records of how staff were supporting people with this or monitoring their weights. Furthermore, some of the staff we spoke with were not always aware of the risks associated with people's care needs. One member of staff did not know that one person they supported regularly had a diagnosis of epilepsy whilst another member of staff was unaware of a person at risk of self-harm or vulnerability within the community. We fed these concerns back to the provider at the time of our inspection. They recognised that record keeping was an area in need of improvement and advised that staff will be reminded of their responsibility to ensure they were fully aware of the risks to people's health and well-being.

We looked at other records concerning the safety of the service. We found that staff were responsible for supporting people to ensure that the property was safe to live in, which included fire safety checks. We found that some fire safety checks had not been consistently maintained across all three of the supported living properties. The manager told us that these checks were typically the responsibility of senior staff. However, we found that at one of the homes, when the senior staff member was absent from work, there had been no-one else allocated to manage the safety checks within the home, including the fire systems. Records we looked at also showed that practice fire drills were not facilitated. We saw that some people had personal emergency evacuation plans [PEEPs] in place, whilst others did not. Nevertheless, despite the inconsistency and/or lack of fire safety checks, most of the staff we spoke with were aware of the fire evacuation policies and procedures within the home and were able to tell us how they would support people in the event of a fire.

Some of the people we spoke with told us and records we looked at showed that staff supported people to take their medicines. On the whole, we found that people were supported to take their medicines as prescribed. However, we found some inconsistencies to the way medicines were managed within the service. For example, we found that some people had been assessed as requiring medicines on an 'as required' basis (often termed 'PRN'). Whilst some people had protocols in place to inform staff on how to support a person with their medicines in this way, others did not. We also found that care records did not always reflect people's medicine administration records (MAR) with regards to PRN medicines. For example, one person's care records stated that when they became 'agitated' staff should offer PRN medicine. However, their MAR charts indicated that this medicine was prescribed and administered on a regular basis. We also found that some people managed their own medicines, but it was not always clear from the records that we looked at, how this had been assessed for safety or reviewed for efficacy. Furthermore, despite the service supporting people within their own homes, there appeared to be some restrictions around medicines, often called 'homely remedies', which are available to buy over the counter, such as paracetamol. We asked one person what they would do if they had a headache. They told us that they do not have any paracetamol in the house so they would not be able to take any if they needed it. They went on to tell us that they would like to have that option and that they would speak to staff about it. Staff we spoke with told us that if a person complained of pain, such as a headache, they would book a GP appointment. The provider acknowledged that they would look in to how they can safely support people with these types of medicines on an individual and risk assessed basis.

Staff we spoke with were familiar with the systems and processes in place to protect people from the risk of abuse and avoidable harm. All of the staff we spoke with were able to tell us the signs and symptoms they

would look out for to indicate that someone may be at risk of abuse or avoidable harm. Records we hold showed that the provider had made some safeguarding alerts. However, records we looked at referred to incidents that should have been raised as safeguarding alerts but instead the provider had reviewed peoples care plans and risk assessments as a management plan. We fed this back to the provider at the time of our inspection and they assured us that the new manager they had appointed was aware of their roles and responsibilities in this area and had a good understanding of safeguarding practices and what constituted a notifiable incident.

We looked at four staff files and found that the provider's recruitment practices were not always robust to ensure that only staff that were suitable to work with people were deployed to work within the service. Two out of the four files we looked had did not have sufficient reference checks. The provider acknowledged that improvements were required in this area and they had started to review all of the staffs' recruitment records to ensure the appropriate checks had been carried out and recorded. Staff we spoke with confirmed that recruitment checks were carried out before they started work, which included providing details for referees. Other checks also included verification of their identity, previous work practices and the disclosure and barring service. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

Collectively, the evidence presented above demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of the report.

People and relatives we spoke with told us that they felt confident that the service provided to people promoted their safety. One person said, "I feel safe, the staff are nice". Another person told us, "It's okay here, I am safe". A relative we spoke with said, "I have no concerns about safety; I just think there should be more staff at night". Another relative told us, "I never come away worrying about [person] so that's a good sign". Staff we spoke with were able to tell us how they would support someone in the event of a medical emergency such as a fall, head injury or choking.

Requires Improvement

Is the service effective?

Our findings

We found that whilst people and relatives were confident that staff had the relevant knowledge and skills they required to do their jobs safely and effectively, staff we spoke with told us that they felt the training offered to them by the provider required improvement. One member of staff said, "I have a lot of experience from my previous job, but I'm not sure about the other staff, as I think the training could be better". Another member of staff told us, "I haven't had all of the training I should have had yet and I feel like I've had to keep nagging for certain training like medication and updates; it could be better". We found that new staff completed an induction period whereby they would 'shadow' existing staff. However, it was unclear how effective this was, given the lack of training for existing staff and also whether staff undertaking their induction were not required to carry out caring roles and responsibilities. For example, we saw one member of staff working at one of the supported living homes alongside a more experienced member of staff. There were two members of staff in total as per the needs of the service (as determined by the provider). However, when we asked the provider about this member of staff later on, we were told they were a new member of staff on their induction. Therefore, it was not clear why there were not three members of staff available at that time. We requested a copy of the provider's record of staffing rotas and staff training to try to corroborate our concerns, but these were not made available to us during the inspection process. The provider told us they would look in to this to ensure that all new staff were 'supernumerary' (in addition to the required numbers of staff) whilst undertaking their induction.

We discussed staff training with the provider and they told us that staff had recently been signed up to an online training resource and they were required to work through this independently. Staff we spoke with confirmed this. The provider also told us that they had recently forged links with a number of local educational institutions to promote apprenticeship opportunities within the organisation, which in turn would also give them access to enhanced learning and development opportunities for staff. We did not find any evidence to suggest that the initial lack of training provision had had a negative impact on the safety of care provided to people. Staff we spoke with explained that they had experience of working within the social care industry and had received training from previous employers (within an appropriate time frame) which they transferred in to their work. However, the provider recognised the need to improve in this area and told us that moving forward they planned to enhance the governance of staff training by 'starting from scratch' to ensure that all staff are trained to the required standard, in accordance with the care certificate. This is a framework for good practice for the induction of staff and sets out what they should know. They said, "This will enable us to keep a better check on when updates are due and monitor staff development needs".

Staff we spoke with confirmed that they received 'regular' supervision and attended staff meetings, but the frequency of these could not be determined because no records were available for us to view. The provider recognised that they needed greater governance over these processes and planned to ensure this was embedded within the service moving forward.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this within the community, such as in people's own homes falls under the court of protection and is called Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA. The manager and the provider had a good understanding of the MCA and the process of DoLS within the community. They confirmed this by showing us communications they had held with the local authority to request an assessment of people they felt required this protection.

Staff we spoke with were also familiar with the MCA and were able to tell us how they applied these principles within their role. One member of staff said, "We have to remember this is their homes; we are here to support and enable them to do whatever it is they wish to do. We make sure people have choices and are given enough information to enable them to do this, safely". Another member of staff told us that some people lacked the capacity to keep themselves safe and therefore relied upon staff to support them with this. They explained that, "The manager is following the necessary procedures to ensure they [person] receive this care properly [lawfully]". They showed a basic awareness of the principles of DoLs and what this meant for people living in the community.

People we spoke with told us that staff supported them to make their meals. One person said, "They [staff] come with me shopping and I cook for myself". Another person said, "I choose what I want to eat and staff help me to cook it". Staff we spoke with confirmed this and told us that people required varying levels of support with shopping and meal preparation and that they promoted people's independence with these daily living skills as much as possible. Records we looked at showed that peoples nutritional needs had been assessed and referrals had been made to the relevant professionals where required. We found that some people were identified to be at risk of gaining or losing too much weight and required support to make healthy choices. However, it was not evident how people's weight was being monitored. We shared this with the provider at the time of our inspection.

We found that there was a diverse staffing team and staff we spoke with and records we looked at showed regard for the Equality Act and what this meant in practice. For example, we were told about peoples different cultural and religious backgrounds and how people were supported to maintain these. We found that the provider explored and supported people to express their sexuality and any associated needs by way of planning this as a part of their care and liaison with other agencies, where required. For example, staff we spoke with told us that they suspected that one person they cared for may be confused about their sexuality because they had noticed changes to the person's behaviour. Therefore they had referred them to a health care practitioner to explore this with them further and offer any associated support they required.

We found that people were supported to access doctors and other health and social care professionals, as required. People, relatives and staff we spoke with and records we looked at showed that people were supported to maintain contact with external agencies involved in monitoring and supporting their health and well-being. These included specialist learning disability and mental health services. We also found that staff were efficient in noticing any changes in people's physical and/or mental health and referrals were made to the necessary services without delay. Hospital passports had been prepared to ensure that if a person needed to stay in hospital information would be available to healthcare professionals about the person's individual care needs and how these should be met. People had Health Action Plans (HAP) in place. HAP tells you about what you can do to stay healthy and the help you can get, although some of these would have benefitted from being more tailored to people's individualised health needs and personal goals. One relative we spoke with said, "I've noticed [person] gets out of breath climbing the stairs, I think they [staff] could do more to support [person] with her physical activity; I have mentioned this to them

previously". Staff we spoke with told us and health action plans we looked at showed that people were encouraged to engage in activities that promoted their physical health and well-being, but it was evident that these needed to be more specific to people's individual needs, abilities and interests. This was shared with the provider during the inspection process.

Requires Improvement

Is the service caring?

Our findings

A service that is not consistently safe, effective, responsive or well-led is not considered to be caring. This is because whilst individual staff members were found to be caring, the provider's systems and processes did not always ensure that people's overall experience of receiving support was caring.

Everyone we spoke with was consistently positive about the caring and kind nature of staff. One person said, "They [staff] are nice". Another person told us, "The staff are kind and help me a lot; I should get a 'Thank You' card for them really". A relative we spoke with told us that they had no concerns with the way people were looked after by the support staff and always found them to be friendly and polite. One relative gave us an example of their experience of the kind and caring approach of staff, when they attended a family funeral to support the person they cared for.

Two people we spoke with told us that at times, they were unhappy living at one of the supported living houses because their peace and quiet was compromised due to the complex care needs of another person who shared their house. One person said, "[Person] keeps me awake through the night and the staff can't always stop it". Another person said, "[Person] bangs on my door really loudly and it can be scary at times; it's really noisy". We spoke with staff and the provider about this and asked how they emotionally supported people, during such times. One staff member told us, "It's difficult, we reassure them and try to distract [person] away as best we can". The provider told us and records we looked at showed that referrals had been made to the relevant services to consider ways forward in promoting a more peaceful living environment within the home. The provider explained, "We try to match people as best we can during assessments but sometimes, peoples health and behavioural needs fluctuate and we have to get the support we need to help us to manage this for everyone living in the shared houses". They gave us an example of how they had tried to manage conflict between people when one person had tried to dominate the use of the television. They told us that they had adapted the living environment to support the needs of all of the people living at the home by creating an alternative 'TV' space.

We found that people were supported in ways that promoted their independence and individuality. One person told us, "I often go out and about on my own and I have a key so I can lock my door if I want to". Another person said, "I do as much as I can for myself but I do need their [staffs] help". We found that people were encouraged to engage in activities of daily living with the support of staff to develop their life skills and promote their independence, such as shopping, cooking, and self-directed leisure/work activities like attending day centres and colleges. Care records we looked at included personalised information about people as individuals which included their life histories, likes, dislikes and preferences. They also detailed some people's hobbies, interests and recognised family and friends who were important to them. People we spoke with told us that they were looking forward to personalising their rooms more. One person said, "[Provider] has said we can paint our rooms whatever colour we want to; I've chosen sunshine yellow because it is nice and bright; I can't stand this bland beige colour". Another person said, "They [staff] have started to talk about painting our rooms but we can't hang pictures up because it will damage the walls and it says we can't in our tenancy contract". We explored this with the provider who explained that they would liaise with the landlords of the properties to clarify this clause in the tenancy agreements in order to

advocate for the people living at the homes.

People's privacy and dignity were respected within the service as far as reasonably possible. Records we looked at advocated for people's privacy and staff we spoke with confirmed that, where possible, people were encouraged to tend to their own personal care needs with prompting from staff in order to protect their privacy. We also found that most people were given the autonomy to choose where they spent their time, and some people enjoyed spending time on their own in their bedroom which enabled them to have their own personal space and privacy.

We found that information was presented in ways that people could understand. For example, care plans and other information such as tenancy agreements were provided to people in 'easy read' formats. However, we reminded the provider that not everyone who received support from the service required information to be presented in this way. We also saw that people had individualised home risk assessments which were designed to be specific to people's individual support needs. However, these were not always personalised or reflective of people's needs. For example, we saw that one persons' home risk assessment, who managed their own medicines, stated that they were at risk of having access to their prescribed medicines, which was not truly reflective of their support needs. We fed this back to the provider at the time of our inspection and advised that they needed to avoid a 'blanket approach' as this placed them at risk of compromising person-centred care.

Requires Improvement

Is the service responsive?

Our findings

We received variable feedback on the level of involvement people and relatives had in the planning and review of their care. One person told us, "We [person and staff] sit down and go through the paperwork". A relative we spoke with said, "There's a meeting soon with us [relatives], doctors, staff and others who are involved [in supporting the person who used the service]; but otherwise, not forthcoming; I make it my business to be involved". Another relative said, "I told them as much as I thought they needed to know when [person] first arrived but they haven't asked anything since or anything on a more personal level, like what she enjoys doing and that sort of thing; I haven't been involved really. The only time they [staff] really get in touch is to do with anything financially, which I haven't minded, but perhaps I should have more contact with them". One person we spoke with confirmed with us that they attended 'house' meetings where they discussed things with staff, like decorating their bedrooms. However, relatives we spoke with confirmed that better communication systems were required within the home and they would welcome a feedback forum to discuss ideas or issues as a group with the provider.

Everyone we spoke with knew how to complain and were aware of who the manager and provider were. However, we were consistently told that their responsiveness to feedback required improvement. One person we spoke with said, "They [management] don't always do anything; it's just talk and no action". A relative told us, "Generally, they [management] are ok and they listen but it seems to take a long time for things to get done". We heard an example of how one person had complained about their room being cold, but they had had to wait for a senior member of staff to return to work before a maintenance person came to investigate and found a gap in their window, which was then sealed. They said, "I had to wait for [senior staff member] to come back because they are the senior. They [staff] wait for [senior's name] for everything". Staff we spoke with confirmed that they too found the responsiveness of management to require improvement. One member of staff said, "I think they could do more for people and for us [staff]. Whenever we say anything, about 30% will be dealt with but no more". Another member of staff told us, "They [management] are very slow; I have had to nag them a lot about all sorts of things, I am hoping things will improve". We requested records of meetings or contact held with people, staff, relatives and/or visitors to the service as well as any complaints records. However, we were told that meeting minutes could not be found and they did not routinely source feedback by way of surveys or questions. Both the manager and the provider told us this was something they have been intending to do, but had not yet done. We were also told that no complaints had been received so there were no records available for us to review. The provider acknowledged that they needed to improve the way in which they collected, responded to and recorded feedback they received within the service.

We saw that some people were supported to engage in activities that were meaningful to them, such as going to college, attending day centres, going for walks or to the local shops. We also saw people engaged in self-directed activity such as gaming. One person told us, "I love my play station; the staff play 'doubles' with me, its great fun". Upon leaving the one home, we went to say goodbye to this person and saw them playing with staff on the computer; both of them were sharing in the excitement and enjoyment of the game; it was a pleasure to see. We also saw photographs of a holiday people went on together last year. One person told us how much they enjoyed the holiday which was evident from the pictures we saw. However, some

relatives and staff we spoke with felt more could be done to engage people in activities. One relative said, "I'm not sure what they [staff] do with her or how she spends her time. Perhaps I should spend time talking to the staff about things she enjoys, like colouring. She would spend hours at home colouring". A staff member we spoke with told us, "We go on day trips and do things, but I think more day to day stuff could be done with people". They went on to tell us that staff became frustrated because management were not always responsive to suggestions or ideas put forward by staff in relation to activities.

We found that on the whole people were supported to maintain relationships with people that were important to them. One person told us that they enjoyed having friends over to see them and would often go out with family and friends. This was echoed by another person we spoke with too. A relative told us that they visited their family member daily and spent time with them at the house or took them back to the family home. However, another relative explained that they felt too much reliance was left on the relatives with regards to contact with family members. They said, "I will often take [person] out and we will visit [family member]; [person] loves spending time with them as they do [person] but I think it would be nice if the staff supported [person] to call [family member] more often to maintain that relationship more regularly without relying on me doing it with [person]". The relative told us they planned to speak with staff about this the next time they visited.

Inadequate

Is the service well-led?

Our findings

The service was required to have a registered manager in post as part of the provider's conditions of registration. 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 not been a registered manager in post since June 2017. This is an offence under section 33 of the Health and Social Care Act 2008 for failing to comply with the conditions of registration. We found that a manager had been deployed to manage the day to day running of the service since the previous manager's departure and they had applied for their registration with us in January 2018. This manager was present on 01 February 2018 for our first day of inspection, during which they told us that they were due to leave the service the following day. This meant they were not available on the second day of our inspection. The provider, however, was available to support the inspection process and told us that a replacement manager had been appointed and was due to start the week commencing 12 February 2018. They assured us that they would apply for their registration without delay. Whilst communications about the manager's departure had been communicated with staff and some of the people who used the service, some of the relatives we spoke with were unaware of this change. We fed this back to the provider at the time of our inspection, although it was recognised to be a recent decision and change.

It is a legal requirement for providers to display their rating, to show whether a service was rated as outstanding, good, requires improvement or inadequate following an inspection. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of the care provided. The provider has a regulatory duty to ensure that ratings are displayed legibly and conspicuously at both the office location and on their website within 21 calendar days of the date at which the inspection report was published. We found that the provider had not displayed their rating on their website or at their office location. This is a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of this report.

At our previous inspection in November 2016 we found that the provider was delivering a 'good' service to people in all of the areas we looked at. However, since this time, the service had expanded and it was evident that standards had slipped and improvements were required. We found that the governance of the service had consistently failed to ensure that record keeping was sufficiently maintained and quality monitoring systems had been implemented to identify shortfalls and make the required improvements. We therefore found evidence, as detailed below to support a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end of this report.

We were told that regular staff meetings were held as well as meetings with people who used the service. However, records of these were not kept or used to inform any action plans arising from issues discussed. The provider's other quality monitoring processes were also inconsistent and ineffective. Feedback had not

been sourced to support the provider to drive improvements. Information that had been shared with the management team was not always acted upon in a timely or responsive way. There was also an inconsistent approach to the frequency of safety and quality monitoring tools used within the service and staff were not always aware of their roles and responsibilities within these areas. For example, each of the three supported living houses had auditing tools completed at varying levels and frequencies. One folder we looked at for one of the properties had nine auditing tools comprising of a health and safety risk management audit, monthly medicine audits, temperature checks and fire system monitoring records, which dated back to 2017. Whilst, one of the other properties' auditing file started at the end of January 2018 and had only four quality monitoring tools included. We also found that some of the records we looked at on our first day of inspection had gaps where checks had not been completed as per the providers protocols because a senior member of staff had been absent from work during that time frame and other staff were not skilled or instructed to take over this role on their behalf. However, when we returned for the second day of inspection, we found that these records had been completed retrospectively. This meant that the records had potentially been falsified. We fed this back to the provider regarding our concerns in relation to Duty of Candour and the reliability and validity of other records we were due to see. The provider acknowledged that this was unacceptable and was unaware that this had happened, but informed they would investigate it accordingly.

Communication systems within the service had not ensured that all staff were aware of risks associated with people's health and social care needs and staff we spoke with did not always feel listened to. Information shared with the management of the service was not always acted upon in a timely or responsive way which demonstrated that the leadership of the service was not inclusive or empowering.

From the quality monitoring that had been carried out, it was not clear what action, if any had been taken to remedy any of the issues identified or how this information had been used to drive improvements. However, discussions held with the provider showed that they had a good level of insight in to the areas that required improvement within the service. They told us that any plans to develop the service further had been put on hold, as they were committed to making the required improvements to get the service up to standard. They explained that difficult decisions had been made concerning the management of the service, but they were optimistic that changes within the leadership structure would have a positive impact on the service moving forward. The provider told us that a new manager with a good level of experience had been appointed and they were looking to recruit a deputy manager and a new nominated individual (a point of contact delegated to act on behalf of the provider) which they hoped would enhance the governance of the service.

Information we held about the service showed us that the provider had not always ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, was shared. For example, records we looked at showed that some incidents that had occurred within the home should have been notified to us, this included altercations between people living at the home, and incidents that had involved the police. Other notifications safeguarding reports had been sent.

The provider also told us that priorities moving forward were to invest in the recruitment and retention of staff, with improved governance around recruitment checks. They also told us that they planned to develop a pool of 'bank staff', which are staff that are employed by the provider on an ad-hoc basis to cover staffing shortfalls. They hoped that this would promote consistency and reliability within the service and mitigate the need to use agency staff. The provider also told us they had started to develop improved learning, development opportunities for staff, and again enhance the governance around this. In addition, they were working to undertake a complete overview of the record keeping practices and had deployed administration apprentices to support this work. The provider recognised the need to develop and sustain a more robust quality monitoring system and was confident that the new manager, together with the

additional resource of a deputy manager would support this development. We will monitor the implementation of these action plans and assess the effectiveness of these at our next inspection.

We found the provider to be open and co-operative during the inspection, although some of the information we requested was not provided. They were receptive to feedback throughout the process. It was evident that they recognised the failings that we had identified and offered assurances that they would make the required improvements.

At the time of our inspection, the provider was working collaboratively with other external agencies such as the local safeguarding authority, commissioners and community learning disability, physical and mental health teams to ensure people's needs were met. They had also forged links with a number of local educational institutions to offer apprenticeship opportunities to students but also to enhance learning and development opportunities internally for staff.

Staff we spoke with reported to be generally happy within their work and were hopeful that improvements would be made to benefit the people who used the service, first and foremost, but also them as employees. One member of staff we spoke with said, "I have no concerns really as a staff member. They [management and provider] are approachable and do listen, but it's frustrating when nothing comes of it; more so for the service users, but hopefully things will improve". Staff we spoke with were aware of the whistle-blowing policy should they need to use it. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved.

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 People were not always kept safe from risks associated with their care and support needs. Risks had not always been sufficiently assessed, effective risk management plans were not always in place and staff were not always aware of risks what action to take.

The enforcement action we took:

We imposed conditions on to the provider's registration for this location requiring them to take action to ensure the risks we identified as part of this inspection were addressed, management plans were put in place and that staff were informed of and trained on how to manage these risks. We asked the provider to tell us how and when this requirement had been met.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective monitoring systems and processes in order to identify the shortfalls and mitigate against the risks we found during this inspection. This meant they had failed to promote the safety and quality of the service being provided to people.

The enforcement action we took:

We imposed a condition on to the provider registration for this location which restricted them from expanding the service. The provider is not permitted to increase the care packages they provide to people already in their care, or provide care to any additional people by way of taking on new care packages, without the prior consent of the CQC.