Strada Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Care Unlimited Domcare Ltd provides care and support to people living in four '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 21 people were living at the four locations.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 13 and 15 November 2017 and was unannounced. We carried out this inspection in response to concerns raised about the standard of care being given to people at one of the locations. At the time of the inspection a police investigation was ongoing with regards to how people's monies were managed, and a local authority safeguarding process about allegations around staff conduct was also underway.

The lack of good leadership had an impact across all of the five key areas we looked at. It led to people experiencing inconsistent care and support, dependent on where they lived, and staff morale. It affected the safety of the service as medicines and risks where not always managed safely; it affected how effective the service was at meeting people's needs; it affected how caring and responsive staff were; and how well the service was led. Three of the locations gave a better level of care and support, with the majority of our concerns being with the fourth location.

People were not always kept safe. Lack of safe management of people's monies had put people at risk of financial abuse. Risks to people's health and safety had been carried out, but the least restrictive option to keep people safe had not always been explored. Accidents and incidents had not been consistently reviewed to ensure the risk of them happening again was minimised. There were areas for improvement in how people's medicines were managed.

The provider did not have effective systems in place to monitor the quality of care and support that people received. Quality assurance checks were completed on important aspects of the management of the home; however these had not been used to make improvements to the service that people received. Many of the issues identified by the provider's consultant in April 2017 were still happening at the time of our inspection, seven months later. The provider had not ensured that notifications where sent to the CQC as required by their registration under the Health and Social Care Act. This meant we had not been told of some accidents and incidents, so could not assure ourselves that the provider had taken appropriate action.

People received the care and support they needed, however the care plans did not always reflect peoples

current needs. Care plans were based around peoples support and medical needs and as such did not focus on people's goals and aspirations, and how staff could support them to achieve them. People's access to activities was inconsistent, with some receiving good support, and others not receiving activities that were scheduled.

Whilst staff were kind and caring and treated people with dignity and respect we heard one member of staff refer to people in a disrespectful manner. However the failures across the home demonstrated there was a lack of care and attention to following safe systems of work, and to meet the requirements of the Health and Social Care Act. There was positive feedback about the service and caring nature of staff from people who live here, and their relatives.

There were sufficient numbers of staff to meet the needs of the people. The manager regularly reviewed staffing levels to ensure they met the needs of people. The provider had carried out appropriate recruitment checks before staff commenced employment, to ensure they were safe to work with people who may be at risk. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

In the event of an emergency people were protected because there were clear procedures in place to evacuate the houses they lived in. Each person had a plan which detailed the support they needed to get safely out of the house in an emergency.

Staff received an induction and ongoing training, to help them meet and understand the care needs of the people they supported. However training around one person's specific medicines had either not been given or was out of date. Some staff supported people with specific conditions, without completing training to be able to meet those needs. This put them at risk, as staff may not be able to provide effective support if required. Not all staff received regular support in the form of annual appraisals and formal supervision to ensure they gave a good standard of safe care and support.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. People's individual dietary requirements where met. People were supported to have access to healthcare professionals to maintain good health.

We have identified six breaches in the regulations. You can see what action we have asked the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

- Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People's medicines were not managed in a safe way, and they did not always have their medicines when they needed them.

The provider had identified risks to people's health and safety but the least restrictive option was not always chosen.

Accidents and incidents were not consistently reviewed to minimise the risk of them happening again. Opportunities to learn lessons from incidents were missed.

Appropriate checks were completed to ensure staff were suitable to work at the home. There were enough staff to meet the needs of the people.

Is the service effective?

Requires Improvement

The service was not always effective

Staff said they felt supported by the manager, but gaps in training meant they may not be able to provide effective support to people in response to specific medical needs.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

People had access to health care professionals for routine check-ups, or if they felt unwell.

Is the service caring?

Requires Improvement

The service was not always caring.

Failures across the home demonstrated that the service could

not ensure they provided a caring service to people.

Staff were caring and friendly. We did see some good interactions by staff that showed respect and care; however this was inconsistent across the service.

Staff knew the people they cared for as individuals.

People could have visits from friends and family whenever they wanted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred and did not always give detail about the current support needs of people. People were involved in their care plans, and their reviews.

Some people had access to a range of activities that matched their interests; others did not receive activities that had been scheduled.

There was a clear complaints procedure in place. Complaints were responded to in accordance with the provider's policy.

Is the service well-led?

Inadequate

The service was not well- led.

Quality assurance checks had identified where the service was failing to meet the requirements of the Health and Social Care Act. The provider had not taken effective action in response to drive improvement throughout the service.

Records management was inconsistent, resulting in a risk that people would not receive the care and support they needed.

The registered manager understood their responsibilities with regards to the regulations, however the lack of knowledge of what was happening in the home meant that notifications were not always sent to us when they should be.

People and staff were involved in improving the service. Staff felt supported and able to discuss any issues with the manager, but their morale at one location was low, due to the lack of effective leadership. Feedback was sought from people via surveys and regular meetings.

Strada Care Ltd

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 service provides care and support to people living in a number of 'supported living' settings, so 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.

This inspection took place on 13 and 15 November 2017 and was unannounced. The inspection was carried out by two inspectors on the first day, and one inspector on the second day.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider was not asked to complete a Provider Information Return (PIR) as this inspection had been brought forward due to concerns raised. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

To find out about people's experience of using the service we visited all four supported living locations. We spoke with four people, two relatives and an advocate (who supported three people). We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how staff cared for people, and worked together as a team. We spoke with 10 staff which included the registered manager and a representative from the provider. We reviewed care and other records within the home. These included eight care plans and associated records, six medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted commissioners of the service to see if they had any information to share about the home. After the inspection we received feedback from the local authority safeguarding team when we attended a safeguarding meeting where the provider was present.

Our last inspection was in December 2016 when the service was rated 'Good.'

Inadequate

Is the service safe?

Our findings

People told us they felt safe however we identified concerns which had put people at risk of unsafe care and support.

People were not always protected from the risk of abuse. Concerns had been raised over people's finances being allegedly abused by some staff at one location. A concern with how staff at one location managed people's monies had already been identified by the provider's external consultant in April 2017. An action plan had been generated by the consultant; however the provider had taken no effective or documented action to address the issues identified. The response from the provider had not been suitable or sufficient to protect people and prevent further incidents being alleged seven months later. At the time of our inspection the police were carrying out an investigation into the allegations. The provider had since taken action to minimise the risk of further financial abuse while the investigation was ongoing. The provider had also been made aware of allegations against staff, which they had not immediately notified to the local authority safeguarding team. Instead they attempted to carry out an internal investigation, which did not follow the safeguarding protocols laid out by the local authority.

Failure to effectively operate processes upon becoming aware of any allegation of abuse meant there was a breach in Regulation 13 of the Health and Social Care Act 2008.

One person said, "I feel very safe." Staff had received safeguarding training and could tell us about the various forms of abuse and what they would do if they suspected or saw that it was taking place. This included taking action and making a referral to a relevant agency, such as the local Adult Services Safeguarding Team or police. Staff had followed these guidelines and reported directly to the appropriate authorities when the provider had failed to take action to address their concerns.

Accidents and incidents were not consistently reviewed to look for patterns or to check that effective measures had been put into place to reduce the chance of them happening again. Investigations into incidents were not carried out which meant that opportunities to learn from them were missed. During the inspection the registered manager discovered at least four accident reports in people's care plans that he had not been made aware of. In addition, for the reports that he was aware of, no analysis of the information had been completed to see if they indicated that a person's care and support needs had changed. We also found that the first aid box in one house contained out of date items, so first aid given as a result of an accident may not be done in a safe way.

People were not always kept safe because the risk of harm from their health and support needs had not been consistently assessed. In addition when managing risks the least restrictive option had not always been considered. Where bedrails had been used the provider had not considered other options, such as lowering the bed, and use of crash mats to reduce the risk of injury from a fall from bed. The bed rail risk assessment had also not taken into account the gaps between the rails, and the risk of entrapment, especially if someone had a seizure. At the time of the inspection no seizure had taken place. The person was receiving medicine for their seizures, so there was a risk this could happen. Results of accidents, such as

a person putting their hand through a pane of glass when they had become agitated, had not prompted any review of the risk of this being repeated by the person. Neither had it prompted a review of the environment to see if there were other areas where this could happen, or changes made to minimise the risk of injury.

Failure to adequately assess and manage risks to people was a breach in Regulation 12 of the Health and Social Care Act 2008.

Other risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs. Assessments had been carried out in areas such as nutrition and hydration, mobility, and behaviour management. Measures such as specialist equipment to help people mobilise around the home had been put in place to reduce these risks. People were assisted by staff in a safe way that matched the guidance in risk assessments.

The management of people's medicines had areas for improvement. There was an inconsistent approach by staff when they managed people's medicines. Staff at three of the supported living homes followed the providers' procedures when giving medicines. Two staff signed the medicine administration records (MAR) when medicines had been given to ensure it was correct before it was given to the person. The fourth supported living service had not consistently followed this process. In addition when we observed medicines being given at the fourth location these did not follow best practice protocols. The staff member was seen to remove the medicine from the container that identified it, and then they signed the MAR before the medicine had been taken by the person. They then took the medicine in their hand around the house, looking for the person to give it to. This introduced a number of risks, for example the medicine could be dropped, or the staff member distracted and the medicine forgotten resulting in the person not receiving it. This would then be compounded by the fact that the staff member had already signed the medicine as being given. When asked, the staff member confirmed that this was the way medicine was normally given.

Reviews of people's medicines had not consistently checked that the medicines were still appropriate, or needed. Medicine was prescribed by a GP to manage people's epilepsy; however staff had not discussed whether this was still needed at the dosage given. A number of people had not had a seizure for over a year, and no investigation had been carried out in conjunction with the GP to see if this could be reduced. In addition, one person was prescribed a medicine to manage their seizures in a format that did not promote dignity in care. Staff had not contacted the GP to see if more modern delivery methods would be suitable for the person.

The storage of people's medicines was not always safe. Medicines were stored in locked cabinets to keep them safe when not in use. However the medicines stored in people's rooms did not always have the temperature checked. There was a risk that staff would not then know that medicines were stored at safe temperatures as specified on the prescription label. Additionally some medicine that required refrigeration had been stored in a locked box within a food storage refrigerator in the kitchen. This posed a risk of the box going missing, or cross contamination with the outside of the box with food items in the refrigerator.

The number of issues identified with medicines management meant there was a breach in Regulation 12 of the Health and Social Care Act 2008.

People received the medicines they required. Each person had a Medicine's Administration Record (MAR). This had an up to date photograph of the person for identification purposes, any allergies they were subject to and any other relevant information in relation to their medicines. We did not identify any gaps or mistakes in the MAR records. For people who took medicines for diabetes their blood glucose was monitored regularly at the frequency specified in their care plans. There was guidance for staff about the action to take

in case of high blood sugar and low blood sugar. Peoples medicines were ordered as required and disposed of in a safe way. Medicines were arranged neatly so they could be accessed quickly.

People with limited mobility, were not prevented from moving around and were actively supported by carers who ensured their safety by following guidance in risk assessments such as safe moving and handling practices. Throughout the day people were able to move freely around the supported living houses. Staff encouraged people to maintain their mobility by only offering support if the person required this or was at risk from falling.

People lived in an environment that was not consistently clean and hygienic. We saw people and staff cleaning and tidying the houses throughout the days of our inspection. However, furniture in one of the locations was worn and stained. The provider said they were in the process of redecorating and renovating the house (which we did see during our inspection) and that furniture would be included in that process.

There were sufficient staff deployed to keep people safe and support their health and welfare needs. Staffing levels were based on the needs of the people at each location. Staffing rotas showed the amount of staff on shift over the past eight weeks matched with the calculated support needs of the people that lived there. We noted that the staff rotas did not identify which staff were supporting which people with which tasks, as would be expected in a supported living environment. They were instead based on numbers of staff in the house, which was a care home model. This would make it difficult for the provider to confirm to the commissioners of the service that they had provided the agreed support hours to individuals.

Staff were recruited safely. Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the supported living houses. People's individual support needs in the event of an emergency had been identified and recorded by staff in personalised fire evacuation plans. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely.

Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire, however the records of these checks had not always been easy to find during the inspection.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had received training to be able to meet their needs; however areas for improvement were identified. A number of people were being supported with their epilepsy; however three staff we spoke with said they had not received training in this condition. They were not clear on what action to take in the event of person having a seizure and said they would call the emergency service for any seizure. Additionally one person was prescribed a medicine in a delivery format that some staff had received no training in. Staff that had completed the training had done so in 2012, and had received no refresher training to ensure their knowledge was kept up to date. There had been no record of recent seizures by this person; however should this happen staff said they would not know how to effectively administer the medicine.

Staff were not consistently supported in an effective way by the management. Although staff told us that they felt supported in their work by the manager; many of them had not had the opportunity to have formal one to one meetings with their line manager. This included the registered manager not having a formal supervision with the provider for the eight months prior to this inspection. These meetings are important as they enable staff and managers to discuss any training needs and get feedback about how well they were doing their job and supporting people. Lack of effective supervision of staff at all levels can be seen as a contributing factor to the concerns raised prior to this inspection, and the issues we found on the day of our inspection.

Failure to ensure staff had the support, qualifications, competence and skills to provide care and support safely was a breach in Regulation 18 of the Health and Social Care Act 2008.

When staff commenced work at the service they underwent an induction. This included practical assessments of competency, for example for staff that gave medicines to people. Staff said they had an induction which included being told about the individuals who lived at the houses they would work in, as well as shadowing experienced staff. It also included mandatory training such as health and safety so they would know how to support people in an emergency.

Staff received some ongoing training to ensure they were kept up to date with current best practice. Staff training included safeguarding adults, first aid, health and safety, food hygiene, infection control, and behaviour management. The effectiveness of the training was displayed during the inspection where staff demonstrated the correct use of equipment such as walking aids when supporting people.

The supported living houses were not always well maintained or adapted to meet the needs of the people that lived there. One person had recently lost their sight and work to make the house more accessible for them had only been partially completed. The registered manager thought the work had been completed, so no one had followed this up with the responsible person to complete the job. This left the person vulnerable and in need of staff support to move around the house.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had complied with the requirements of the Mental Capacity Act 2005 (MCA). Some people were unable to understand why they had to stay at the houses they lived in. Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were effectively followed. Care staff had a basic understanding of the Mental Capacity Act (2005) and were seen to work within the legal framework of the act when supporting people, such as seeking and gaining consent before giving care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in supported living homes are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

People had enough to eat and drink to keep them healthy and had good quality, quantity and choice of food and drinks available to them. One person said, "The food is very good. They give you a choice." Tea and coffee was offered throughout the day and staff were seen to offer encouragement to people to remind them to drink plenty of fluids.

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating enough to stay healthy. A calculation was completed to assess each person's risk of malnutrition (this is called a MUST assessment). Nutritional care plans were developed from this. People's weight was monitored and recorded to identify any changes that might indicate a need for additional support. People at risk of malnutrition had food supplements, for example high protein drinks to help maintain their weight. If people had any dietary issues they were referred to the dietician or Speech and Language Therapy (SaLT) team. There was a choking policy in place and staff had undertaken first aid training to include choking.

People's special dietary needs and choices were met. Care plans documented peoples preferences, and how food may need to be presented to aid swallowing. Staff were able to describe these requirements to us without having to reference the care plans. On the day of our inspection people were supported to have food in the format they preferred. People were given choices about meals and choice of drinks.

People received support to keep them healthy. People had access to a range of medical professionals including, doctors, dentists, a chiropodist, and an optician. One relative said, "If he is unwell they are good are telling me." They added the staff were very good at getting health care professionals involved when needed. Where people's health needs had changed some appropriate referrals had been made to specialists to help them get better, for example speech and language therapists if people's eating habits changed.

Staff were aware of respecting people's diversity and human rights. People had access to local faith groups and were supported to attend meetings to practice their faith. Staff understood that their own personal beliefs must not stop people they supported from being able to follow different faiths or making lifestyle choices they [staff] may not agree with.

Requires Improvement

Is the service caring?

Our findings

We had positive feedback about the caring nature of staff from people and their relatives. We also saw many positive interactions during the inspection. However the issues we had identified across the home demonstrated a lack of care and attention by staff and management. Specific examples included the lack of effective management, the failure to manage medicines safely, and failure to complete daily records and care records not identifying people's current needs. We also heard one staff at one location referring to people as "mental" which was disrespectful. The service as a whole needed to improve to demonstrate that it provided a caring service to people.

Staff supported people's privacy and lifestyle choices. The atmosphere in the houses varied, depending on the people who lived in them. Some locations were quiet and calm, while others were more lively and noisy. Decoration of the houses was done in a way to reflect the people that lived there. One house that three ladies lived in had pictures and ornaments on display they had chosen. Another house where people with higher support needs lived, had less 'clutter' to enable them to move around more freely. People's bedrooms were personalised with furniture from home, ornaments and personal photographs. This made each house individual to the people that lived there.

People told us that the staff were kind and caring. One person said, "I like the staff they are kind to me." A relative said, "He is well cared for, he has a nice room, he is always clean. He has a good relationship with staff." She added, "It's a good family atmosphere." Staff had a positive and caring attitude to the work they did. They explained that caring for "the clients" was what gave them the most job satisfaction. One staff member said, "I love doing what I do and look forward to coming to work."

People were supported by staff that knew them as individuals. An advocate said, "It's a strong team with continuity. They are caring and respectful." Staff's knowledge of people's communication methods was good. They were able to advise on how best to talk with people, so we could get their feedback about the home. Throughout our inspection staff had positive, warm and professional interactions with people. Staff's communication skills meant people's choices and preferences could be understood. Many people had limited verbal communication and staff demonstrated to us they understood their sounds, words and gestures. We heard staff conversing with people in an appropriate manner, such as taking time to explain things to people before they gave care or support. During conversations staff spoke calmly and maintained eye contact with people to show they were listening and understanding what had been said.

Staff were caring with people. A relative said, "All staff seem to be caring." A staff member took the time to 'sing' goodbye to one person before they went off duty. Staff treated people with dignity and respect. Staff were caring and attentive throughout the inspection, and involved people in their support. Many respectful actions towards people by staff were observed during the inspection. Examples included paying attention to what people wanted when staff were talking to inspectors. Staff were seen to either invite people into the conversation, or they got up and went to see what the person wanted. Another sign that staff respected people was in the way they talked about people, and their behavioural support needs. When describing behaviour that may challenge staff understood that the person's behaviour was a result of an external

stimulus, so not caused by the person 'acting-up'. This placed the focus on what had triggered the behaviour as being the problem, not the person.

People's individuality and what was important to them was recognised by staff. One person liked to get up late after everyone else had gone out for day activities. This gave them the opportunity to carry out their morning routine when the house was quiet. Staff knew this mattered to them. Other people were supported to wear favourite items of jewellery, or clothing.

People were involved in their care and could make their own decisions. We saw evidence throughout people's care plans that they, or appropriate advocates, had been involved in decisions and the recording of their care. People were given information about their care and support in a manner they could understand. Information was available to people around each house. It covered areas such as local events and in house activities. Items such as clocks and calendars where correct, so people had a clear view of the time and date to help orientate themselves. Information such as emergency procedures and complaints policies were also in easy to read formats to help people understand them.

People were encouraged and supported to maintain relationships that meant something to them. Family members were able to keep in regular contact and visit whenever they liked. People were also supported to go home to visit relatives whenever possible. Support to local community events also enabled people to interact with friends and acquaintances.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to ensure that their needs could be met. Assessments contained information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility.

People received care and support that matched with their preferences or need; however records of care for staff to follow were inconsistent across the locations. Some were not always fully completed or reviewed to ensure they reflected people's current needs. One person had an injury of a broken bone and there was little information in their care plan about how to support them with this. A number of people were being supported with epilepsy, and although there was a risk assessment in place, the care plan did not give specific details of how to support them with this. Staff relied on memory as to the care people needed. There was a risk that people would not get responsive care when their needs had changed. Care plans were very task focussed and not centred on the person as an individual with objectives and goals they would like to achieve. Reviews were then focussed on whether the care given was as documented, rather than recording achievements people had made towards their life choices and aspirations.

People's choices and preferences were documented, but not always followed. One person had it clearly recorded in their care plan that they disliked soup, but were given soup for lunch. We also overheard a relative comment to a staff member that they had asked staff to ensure their family member had their lunch early because they were taking them out. This had not happened, so the person had to rush their lunch.

People and relatives were involved in their care and support planning if they wished. One person said, "I have a care plan, it's in my room." People who were able said staff always asked if they were happy with their care and said that when they made a suggestion the staff responded to their ideas. Some files gave a clear overview of the person, their life, preferences and support needs, but as with other records the completion of these was inconsistent. It was clear staff had read and understood the information where it was present. They were able to tell us about the people they cared for, and the information they gave matched with that recorded in the care records, to with what people had told us.

People had inconsistent access to activities some of which focussed and promoted their well-being, physical and mental health. These activities helped prevent them feeling isolated and gave the opportunity to follow their social interests. People at three of the houses had many opportunities to take part in activities in the local community, such as attending day clubs, going for meals, and walks. However activities provision was inconsistent across the service. One relative said, "My family member needs more stimulation and to be going out more." Care documents that recorded people's activities were incomplete at one of the houses, and activities did not always take place as scheduled. One person's care records stated that he should have an aromatherapy session on a Monday. This did not happen, and the registered manager was unable to explain why. As records were incomplete at this house, it was difficult for staff to demonstrate that people took part in the activities they enjoyed. One staff member said, "People don't go out as long as they could. They may go out for ¾ hour, but I would like to take them for a couple of hours or longer." They explained this was due to a lack of transport, although it had improved since the registered manager had

organised a second car. During the inspection we did see staff involve people in a number of activities, some of which was one to one, and some group work. During the inspection there was a constant choice of activities for people to take part in.

Failure to provide care to achieve peoples preferences and ensuring their needs were met was a breach in Regulation 9 of the Health and Social Care Act 2008.

People were supported by staff that listened to and responded to complaints or comments. People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. Relatives also said they would feel comfortable making a complaint. They had been given a copy of the service's complaints policy (which was also clearly displayed in the houses people lived in). They understood how to complain if they felt the needed to. The policy included clear guidelines on how the registered manager should respond and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

There had been one complaint received at the service in the last 12 months. This had been around a missing item. This had been clearly recorded and responded to in accordance with the provider's complaints policy. Staff discussed any comments or complaints received at team meetings so they could learn from any mistakes that had been made. Compliments had also been received about the dedication of staff, and their caring nature.

Inadequate

Is the service well-led?

Our findings

The service was not currently well managed to ensure people received a good quality of care and support. Although the provider was now taking action to address concerns raised, there had been earlier opportunities to address concerns which may have prevented them escalating. This lack of strong leadership has resulted in an ongoing police investigation of how people's monies were managed, and a safeguarding investigation around the care and support received by people at one of the providers locations. The provider acknowledged that improvements were needed when they said, "We should have acted faster. It's been a wake-up call for us." A new registered manager was being recruited by the provider as a result of the concerns that had been raised at the service.

Quality assurance processes had identified issues with the service but these had not been adequately addressed by the provider's management team. An external consultant had completed an assessment of one of the locations in April 2017. This highlighted a number of failings at the service which included concerns around the use of people's monies, poor staff performance (which had been identified prior to this assessment), and records not being completed and limited activities for people. All of the issues raised in April 2017 were evident seven months later during our inspection. The issue with people's monies had got worse, and was under police investigation at the time of our inspection. Staff performance was also still an issue, with concerns raised to the CQC.

The provider was unable to demonstrate that the service people received was adequately reviewed by them, nor that it had continuously improved. The consultant had generated a recovery plan to address the issues raised in April 2017; however this had not been effectively followed or implemented by the provider. We asked the provider about their responsibility to know if their service was giving a good standard of care to people. A director explained that they had been dealing with a number of issues at a high level within the organisation. However we noted that no ownership of the improvement process had been taken by any of the directors. All had been focussed on other areas of the business. As a result the provider had not reviewed progress with the registered manager to ensure the defined actions had been completed, or were progressing.

No reviews of service performance had been completed since the April 2017 external consultant report. For example the provider had not requested monthly review reports from the registered manager or team leaders to check the level of care had met the people's requirements. Reviews of accident and incidents, and that they had been addressed had not been completed, nor whether these had been notified to the relevant authorities. At a time where there were clear issues with the service, the provider had not given strong leadership to ensure these issues were addressed.

Regular monthly and weekly checks on the quality of service were not consistently effective at identifying areas for improvement around the service. Improvements in medicine management had not been identified or managed to reduce the risk of them happening again. The internal checks had also failed to identify gaps in care records, gaps in daily care notes or that reviews of care had not been effective at recording changes in people's needs.

Necessary repairs and maintenance were not well managed. One house had a large unsightly burn in the lounge carpet. The provider said they were in negotiations with the housing trust that owned the property to replace the carpet. However at the time of the inspection it was nearly three years since the carpet was burnt. This is not a reasonable time for people to have to wait to have essential repairs completed.

Records management was not good; resulting in lack of information about the care and support people had received, or if changes were needed. Accidents and incidents were not consistently reported to the registered manager. This meant they had not been reviewed to see if people's support needs should be increased. This could lead to ineffective care and support being given to people. Records of safety tests or equipment, such as fire alarms, were not easily available, so the registered manager was not able to demonstrate on the day of the inspection that these had been serviced.

Failure to operate effective systems and processes to assess and monitor the quality and safety of the service and failure to keep accurate, complete and contemporaneous records was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not reported accident and incidents reportable to the CQC under the Health and Social Care Act. The home manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies; however this had not always been done. This meant we could not check that appropriate action had been taken. Incidents included a person injuring themselves when they punched a pane of glass, failure of equipment resulting in a near miss and allegations of improper conduct by staff which could have resulted in people receiving unsafe care.

Failure to notify CQC of notifiable incidents was a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was an inconsistent culture within the service, with three of the locations having staff teams that felt supported and working together as a team. One of the locations had an issue with staff morale, with one staff member saying, "If staff were appreciated, they would step up." They said the culture within the staff team was not good and that, "Some staff worked and others didn't." This then gave an inconsistent level of care to people depending on which staff were on shift. People, relatives and staff described the registered manager as always being available, and somebody who would help if necessary.

Staff felt able to raise any concerns with the manager, or senior management within the provider, however they felt these had not been actioned fully, or as quickly as they could have been. Staff understood what whistle-blowing was but did not have confidence in the provider to take the necessary action to address their concerns.

People and relatives were included in how the service was managed. An advocate said, "I can attend keyworker meetings and if I raise thing they are addressed." People had access to regular house meetings where they could discuss items such as the food, activities and any issues they wanted to raise, and what activities they would like to take part in. Minutes of the meetings showed that people had the opportunity to raise any concerns, and were encouraged to tell the staff what needed to be done around the house, or in relation to their care and support needs.

The manager also ensured that various groups of people were consulted for feedback to see if the service had met people's needs. This was by the use of a questionnaire. People who lived here and their families were involved in these questionnaires, which covered all aspects of care and support provided at the home. The questionnaires for this year's survey were being prepared to be sent out at the time of our inspection.

After the inspection the provider supplied us with information to show that they were dealing with the issues raised. This included emails to arrange meetings to formalise responsibilities and how they would respond to the multiple corrective actions required by the local authority and our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008. Failure to provide care to achieve peoples preferences and ensuring their needs were met.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008. Failure to ensure staff had the support, qualifications, competence and skills to provide care and support safely.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009. Failure of the provider to notify CQC of other incidents.

The enforcement action we took:

A fixed penalty notice was issued.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not adequately assessed the risks to the health and safety of service users. Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have proper and Safe Management of medicines.

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 of the Health and Social Care Act 2008. The provider had not Safeguarded service users from abuse and improper treatment.

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The provider had not assessed, monitored and improved the quality and safety of services provided. Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The provider had failed to maintain an accurate record of in respect of each service user.

The enforcement action we took:

A warning notice was issued.