Lifeways Community Care Limited

Lifeways Community Care (Gloucestershire)

Inspection report

Suite 3
Bath Road Trading Estate
Stroud
Gloucestershire
GL5 3QF

Tel: 01453766441

Date of inspection visit:
31 May 2018
01 June 2018
05 June 2018

Date of publication:
27 July 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 May and 1 and 5 June 2018. We previously inspected the service on March 2016 and it was rated 'Good' overall. At this inspection the service was rated 'Requires Improvement' overall.

Lifeways Community Care (Gloucestershire) provides care and support to people living in 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating.

People using the service lived in four different supported living households across Gloucestershire. At the time of our inspection there were eight people receiving personal care in four different households. These were Davelia, Mildenhall, Woodend and Rowantree. As part of our inspection we visited Davelia, Mildenhall and Rowantree.

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

The inspection was also prompted in part by concerning information about the management of risk at Rowantree; including notification of an incident suggesting potential concerns relating to the management of medicines. This inspection examined those risks.

People using the service and their relatives provided some good feedback about the service. However, this was not consistent across the various schemes.

We found that the standard of services people received was inconsistent across the households. Risks to people at Davelia and Mildenhall were managed effectively. However, we found that people at Rowantree did not always have enough staff that knew them, which may have impacted on their safety and how well their needs were met. We made the local authority aware of our concerns.

The provider was aware of the risks in the service and had put plans in place to mitigate the impact on people whilst they recruited a full staff team. However, at the time of our inspection the Rowantree service manager and team leader were on annual leave. We found some of these actions for example, in relation to agency staff induction had not taken place to ensure staff understood how they needed to provide people's support. During our inspection people had moved from Rowantree whilst their care arrangements were

being reviewed.

The provider had been working with the local authority to address shortfalls in the service prior to our inspection. The provider used a number of in-depth quality-auditing systems. However, we found that these were not consistently effective at identifying and addressing risks to the health, safety and welfare of people. For example, Rowantree had been lacking sufficient management action when concerns were reported by staff.

The provider had completed an internal quality audit two days before our inspection and had identified the shortfalls we found. Time was needed for these plans to be completed and evaluated before we could judge them to have been effective in supporting the registered manager to make the required improvements

Whilst the quality of staff training was positive, staff did not always receive training relevant to their care roles. There was also varied support and supervision of staff across the households that sometimes undermined effective service delivery. Systems to identify when staff required training and supervision were not always effective.

Improvements were being made in how people's medicines were managed however people's records did not always support the safe administration of medicines at Rowantree. At Davelia and Mildenhall medicines were properly managed so that people were supported to take them safely.

People experienced good services in some respects. People were supported to maintain good health and eat healthily. The advice of community healthcare professionals was appropriately sought and acted on.

The service ensured that people were ordinarily supported by the same small team of staff. This helped to develop positive, caring relationships.

We found that most people and their relatives were involved in making decisions about care and support. The ethos of a person-centred, user-led approach by which to lead meaningful and fulfilling lives was being encouraged. Most people received personalised care that was responsive to their needs. For example, staff supported people to undertake planned activities at Davelia and Mildenhall and in the community. Improvements were needed at Rowantree to ensure staff support people appropriately in accordance with their wishes and preferences.

The service worked in line with the principles of the Mental Capacity Act 2005 in terms of people's consent to care and acting in their best interests where appropriate.

The service had suitable systems for identifying and responding to allegations of abuse. Recruitment processes ensured that new staff were of good character and suitable to work with people.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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

Some areas of the service were not always safe.

Recruitment procedures were safe. A number of staff were being employed at Rowantree who did not know people well and people therefore did not always receive care that met their individual needs.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse.

Improvements were needed to ensure information that could indicate safety concerns would always be acted on promptly.

People's medicine records did not always support the safe administration of medicines as staff did not always have all the information they needed to know how people required their medicines.

Is the service effective?

Requires Improvement

Some areas of the service was not always effective.

The service was not consistently effective. Whilst the quality of staff training was positive, staff did not always receive training relevant to their care roles. There was also varied support and supervision of staff across the service that sometimes undermined effective service delivery.

People were supported to maintain good health and eat healthily. The advice of community healthcare professionals was appropriately sought and acted on.

The service worked in line with the principles of the Mental Act 2005 in terms of people's consent to care and acting in their best interests where appropriate.

Is the service caring?

Good

The service was caring.

Throughout our inspection at all three households we found staff

to have a caring attitude and person centred approach.

We found new staff at Rowantree were working hard to build relationships with people. People were treated with dignity and respect and supported to develop their independence.

The service ensured that people were ordinarily supported by the same small team of staff. This helped to develop positive, caring relationships.

We also found that most people and their relatives were involved in making decisions about care and support.

Is the service responsive?

Requires Improvement

Some areas of the service was not responsive.

Improvements were needed to ensure people's records were up to date and reflected the care they received and required to develop their independence.

People at Rowantree were not always supported to engage in meaningful activities. At the other households people received personalised care that was responsive to their needs. For example, staff supported people to undertake planned activities in the community.

The service managers spoke openly about complaints received, and recognised that relatives wanted the best for their family members. We saw evidence of action in response to complaints.

Is the service well-led?

Inadequate

Some areas of the service were not always well-led across all the households.

The provider used a number of in-depth quality-auditing systems. However, we found that these were not consistently effective at identifying and addressing risks to the health, safety and welfare of people.

The ethos of a person-centred, user-led approach by which to lead meaningful and fulfilling lives was being encouraged. However due to management and staff changes people did not always experience personalised care at Rowantree.

Lifeways Community Care (Gloucestershire)

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.

Prior to the inspection, we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

The inspection took place on 30 and 31 May and 5 June 2018. This was an unannounced inspection, and was carried out by two adult social care inspectors.

This inspection was partly prompted by concerning information we received about the management of risk in the service following an incident which had a serious impact on a person using the service. While we did not look at the circumstances of the specific incident we did look at associated risks.

As part of our inspection we spoke with nine members of staff including the registered manager. We also spoke to two relatives and four health and social care professionals. This included the Local Authority who had carried out a quality review before our inspection.

During our visit, we briefly spoke to five people using the service. Because we were unable to speak to everyone because of their communication or learning disabilities we spent time observing what was happening within the service.

We looked at the care records for seven people being supported at the service, six staff files, organisational records, staff rotas and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We received positive feedback from people living at Davelia about their safety. One person living at Davelia told us "I feel like this is a safe place, never had concerns. I would know". However, some staff had concerns about how the on-going staff changes might be impacting on people receiving safe care at Rowantree. For example, one staff member working at Rowantree said, "There have been lots of changes, but we had a meeting. I worry about the safety of people living here".

At Davelia and Mildenhall medicines were managed safely and people received their medicines as prescribed. Following a medicine administration error in April 2018 at Rowantree the provider had completed a medicine audit of three people's prescribed medicines. This action had improved the storage and stock management of three people's medicines at Rowantree. For the fourth person these actions were still to be completed.

At Rowantree further improvement was needed to ensure staff would always support people to manage their medicines in accordance with current best practice. Guidance was not always available to inform staff how people were to be supported to take their medicines, including people's preferences on how they would like to take them. For example, there were no 'as required' protocols in place for one person who occasionally required medicines for pain relief. Staff therefore did not have the information they required to know for example, whether the person was able to ask for the medicine or if they needed prompting or observing for signs to know that they were in pain. Three people had been prescribed a cream to aid their skin care needs. There was no information for staff on the areas of the relevant person's body this should be applied to, the thickness of application or how often it was needed.

On two occasions in the week before our inspection staff had administered medicines without a medicine administration record (MAR). This was because these records were not available to staff. The daily handover form stated on 26 May 2018 that one person's medication would not be available until 29 May 2018. We could not determine from their records whether this medicine had been obtained and they had received their medicines as prescribed. Incomplete information increased the risk of medicine errors occurring and placed people at risk of not receiving their medicines as prescribed.

People's medicine records did not always support the safe administration of medicines. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The number of staff needed for each shift was calculated using the hours contracted by the local authority. People living at Davelia and Mildenhall were supported by the required number of staff. We found they understood people's risks and how to support people to remain safe.

The provider was experiencing difficulties recruiting staff at Rowantree and were reliant on agency staff whilst recruitment was on-going. There were only three permanent members of staff employed at Rowantree. We found this had reduced the continuity of care people experienced and had impacted on their wellbeing. Some people explained how the changing staff team affected their lives. One person told us, "The

person who is on shift all weekend is someone I do not like. They change all of the time". Another person said, "Some staff are ok but there are lots of agency workers. I don't like all of them". A handover form completed on 21 May 2018 stated '[The person] crying uncontrollably about new staff'. Staff told us staffing was a concern and it was affecting the service and people who were living there. One staff member said, "I stayed on shift for four extra hours last night as I just didn't feel comfortable that medicines would be administered properly in the evening''.

To ensure new agency staff understood people's risks the provider had introduced a new Workplace Induction Checklist that needed to be completed with agency staff to provide them with information about people's needs. Pen pictures summarising people's care had also developed for quick reference. However, at the time of our inspection the service manager and team leader were both on annual leave and we found not all agency staff had received the required induction. For example; one agency staff member we spoke with told us they had received no induction or been given the opportunity to read the relevant documentation. They said "I started this morning but I've not read anything". They had been at the service for six hours and delivered personal care to people but were unable to tell us the names of the people they were supporting.

People did at times not receive appropriate care that met their needs at Rowantree. Records showed staff had to wake someone throughout a night shift to change their clothes and bedding due to the previous shift not knowing how to do this appropriately. There had also been occasions when people had worn the wrong clothes. Records showed that one person had not been supported to sleep in the correct position which resulted in them having a sore chest and bruising. People had not always been given the opportunity to undertake their planned activities. We could not be assured that staff at Rowantree always knew people's preferred routines and their care needs sufficiently to meet the needs of people and enable their independence and wellbeing.

The above demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take risks to retain their independence; these protected people and enabled people to maintain their freedom. We saw individual risk screen assessments in people's care and support plans with information in areas such as; choice and control, health and wellbeing, living safely and taking risks, community access and using household appliances.

Some improvement was needed to ensure risks relating to eating and sleeping would always be mitigated for people living at Rowantree. For example, one person's support plan and risk assessment contained conflicting guidance in what action staff were to take to ensure people did not choke when eating. One document stated they required thickened fluids and in the other it stated they did not. Staff might therefore not know what action they needed to take to support people to drink safely. The provider was taking action to ensure people at risk of choking were reviewed by the Speech and Language Therapist and additional training was being provided to staff. However, it was unclear what safeguards were in place to ensure people were safe when supported to eat by new or agency staff that still needed to complete the service induction, training and practice observations.

When safety incidents or injury had occurred prompt robust action had not always been taken to ensure concerns were investigated, lessons were learned and safeguards put in place to prevent recurrence. We looked at some accident and incident records at Rowantree. For example, there was a completed body map in one person's daily notes showing bruises and marks for May 2018 but these were unexplained. The record did not show what action had been taken to investigate the cause and to prevent future bruising. Staff had

also raised concerns on 26 May 2018 that one person's medicines were not available however action had not been taken to investigate this concern and we could not determine whether this person had received their medicine as prescribed. Improvements were needed to ensure information that could indicate safety concerns would always be acted on promptly.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. The registered manager and staff recognised their responsibilities and, duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, CQC and the police. One staff member at location four said, "I nearly whistle blew as I was concerned. I spoke with my manager who organised a big meeting for us all to discuss concerns. Things got better but they are still not right". We found staff had felt confident to raise concerns regarding medicine management and staffing prior to our inspection.

New employees were appropriately checked through robust recruitment processes to ensure their suitability for the role. Records showed us staff had a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people. We looked at records for six staff which evidenced staff had been recruited safely.

Health and safety checks were mostly carried out to ensure the environment remained safe. The provider's internal audit completed on 29 May 2018 had identified that bedrail safety checks needed to improve and staff needed to complete the required bedrail e-learning to ensure they knew how to support people to use their bedrails safely. Fire checks and fire evacuation drills had taken place. There were policies and procedures in the event of a fire and each person had a personal emergency evacuation plan (PEEP) to ensure their support needs were identified in an emergency situation. From our observations, it was evident there were sufficient food safety practices in place. There were different coloured chopping boards used for different foods to minimise the risk of cross contamination. The register manager was awaiting an internal health and safety audit of Rowantree to ensure all environmental risks were sufficiently mitigated.

Requires Improvement

Is the service effective?

Our findings

Some people spoke positively about staff and told us they were skilled to meet their needs. One person at Davelia said "The staff look after me well". One relative said, "There were issues last year, they have now been resolved ". One person at Rowantree said, "It depends who's on shift really".

Training records confirmed that not all staff had received the provider's required training to support people effectively. Not all staff members had training in adult safeguarding, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), Health and Safety, Managing Diabetes, Bedrails and First Aid. One member of staff who had been employed since February 2018 had not received training in several of these subjects. When asked what their understanding of safeguarding and MCA they were unable to tell us. Their training needs had not been addressed promptly. This shortfall had been identified by the provider and Moving and Handling training had been completed on 14 May 2018, glucose monitoring training was booked for July 2018, epilepsy training was being sourced and in the interim an e-Learning course were being completed.

The registered manager had not always identified when staff training was due or had expired. This had been identified in provider's 29 May 2018 audit and the provider was putting plans in place to improve in this area. Staff had therefore not always received refresher training promptly to ensure they would remain up to date with current care practices. Health and Safety, MCA/DOL's, Safeguarding, Basic Life Support Refresher Training were being completed in June 2018.

The Care Certificate had been introduced and newer members of staff were completing this as part of their induction. The Care Certificate is a set of nationally recognised standards to ensure staff new to care develop the skills, knowledge and behaviours to provide compassionate, safe and high quality care. Staff completed an induction when they first started working with the provider. This was a mixture of face to face training, online training and shadowing more experienced staff. The provider had identified that this was an area that required improvement and in their May 2018 action plan had put plans in place to ensure induction books would always be completed to evidence staff had completed the provider's required induction.

At Rowantree, staff had not consistently received regular one to one supervisions or an appraisal with a line manager. Individual supervision and appraisals are an opportunity for the line manager and staff to evaluate performance and plan to improve their effectiveness in providing care and support to people. This meant the registered manager had not systematically monitored staff performance and identify their support and development needs. One staff member said, "I don't feel supported at all. There are lots of changes right now". The provider had identified this as a shortfall in the service and was taking action to ensure staff would receive the support they needed. At the time of our inspection this action was still to be completed before we could judge whether it would be effective in ensuring all staff were sufficiently trained and supervised.

People were able chose the food they wanted and were supported by staff to assist with food preparation.

People were supported to eat a healthy diet and to manage their dietary needs. People had been referred to the dietician or speech and language therapist when needed for advice around their diet and safe eating and drinking. People were supported to plan in advance what they would like to eat and were able to change their mind if they didn't feel like what was on the menu.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 and legally authorised under the MCA. The provider had policies and procedures in place regarding the MCA and DoLS. Everyone's mental capacity had been assessed if required and records confirmed this. One person had MCA's for areas such as; where they live, mobility, personal care and finances. The provider had identified during their audit of 29 May 2018 that some improvement was needed and was taking action to ensure for example; further discussion with the placing authorities to determine whether a DoLS application would be required for people. For people living in their own home or in shared domestic settings, this would be authorised via an application to the Court of Protection (COP).

People received support to keep them healthy. People had access to a range of medical professionals including, doctors, dentists, a chiropodist, and an optician. Where people's health needs had changed some appropriate referrals had been made to specialists to help them get better, for example one person had visited the local doctors for support with their diabetes management.

Good

Is the service caring?

Our findings

Throughout our inspection at all three households we found staff to have a caring attitude and person centred approach. At Davelia and Mildenhall found many examples of how this had resulted in people experiencing their staff as caring, compassionate and kind. One person told us, "I am happy."

We found new staff at Rowantree were working hard to build relationships with people. One staff member working at Rowantree told us, "We really do care and we are really trying to help the people here. But it's just so difficult right now. Morale is so low". We observed staff from another of the provider's services provide positive support in a kind caring manner to people at Rowantree. They told us that they had spent time trying, and would continue to sort out things for people but there was 'a lot to do'.

At Davelia and Mildenhall we discussed with people and staff how they are promoted to be independent. One person said, "I am able to use the microwave and I help staff with cooking. I cut the veg and stuff. I am hoping to move on soon so I can live more independently without so many staff". Another person's support plan showed the support they required to prepare their own meals and where they needed help with using the microwave as they struggled to operate it. Support workers were looking at ways to support the person to use the microwave independently using different communication methods.

People were supported to follow their interests and display the things they liked. One person had created a picture board of their favourite movie superheroes. The person had been supported to get pictures by support staff, with the aim of putting the picture board in their room for the person to enjoy. The person was also wearing a t-shirt with a superhero logo which they were happy about.

Support workers employed to work at Davelia and Mildenhall knew the people they supported well including their care and wellbeing needs. For example, one support worker discussed the preferences people such as how they liked to run their home and spend their days. They explained how one person liked to "keep a tidy home." They told us how they supported this person to achieve this. We found the person's home was clean and tidy, which made the person happy.

Support workers at Mildenhall supported one person with making choices which promoted their dignity and wellbeing. For example, support workers told us they often struggled with feeling warm. On the day of our inspection support workers were supporting the person to make a choice which promoted their wellbeing. They discussed if the person would like to wear shorts and prompted this change, knowing this would make the person feel comfortable. The person told us, "I'm wearing shorts, its hot outside."

People were supported to make decisions and choices regarding their personal relationships. These choices were recorded and respected. For example, one person no longer wished to maintain contact with some of their relatives. Support workers had recorded this and the person's support plan detailed that support workers should only discuss this with the person if the person initiates the conversation. Support workers understood this need

People we were able to speak with told us about their family and friends and how they maintained contact with them. Staff told us supporting people to maintain contact with their family and friends was an important part of providing good care and support. A relative of one person who lived at location one told us, "They are doing really well. We visit often and take them out. It's a great place".

Requires Improvement

Is the service responsive?

Our findings

Each person had a care and support plan to record and review information. The one page profile gave an overview of what was important to people, what people liked and what others admire about them and also how to support them. One person's one page profile said, 'I am funny and friendly. I can be very strong willed and people find me stubborn if I am asked to do something I do not want to. I know what I like and don't like. I like football and computer games, but I do not like going to bed'.

The support plans detailed individual needs and covered areas such as; communication, support needs, keeping healthy, leisure/hobby interests, cultural aspects, decision making and goals and outcomes. At location one and two all recorded information had bene reviewed and updated. At location four we were unable to ascertain whether regular reviews had taken place. The registered manager told us, "People's needs have changed here over time and we have not always responded as responsively to this".

People's daily notes had a section for targets and goals to promote independence and improve the quality of their lives. At Davelia and Mildenhall people were encouraged to increase their independence and achieve their personalised goals on a daily basis. At Rowantree, these notes were not routinely completed to indicate what progress people had made to achieve their desired goals. Without detailed and regularly review people might not achieve the quality of life they wished or be supported to be as independent as possible. This was identified as an area that required improvement during the provider's audit of 29 May 2018.

The section in the daily notes about what people did each day were thorough in Davelia and Mildenhall and contained a good level of detail of how people had spent their day. The daily notes contained information around what support had been provided to people, what they had to eat and drink and any activities they had taken part in. This gave staff a good overview of how people were feeling and if any emotional support was needed. If people were feeling anxious or upset this was clearly documented. At Rowantree people's daily notes were brief and did not contain the same level of information about people's day to inform staff of any additional support people might need.

Staff confirmed any changes to people's care was discussed regularly through the shift handover process to ensure they were responding to people's current care and support needs. Staff at Davelia and Mildenhall said these always took place and communication was good. At Rowantree staff told us they were trying to ensure important things were communicated and they had a book to write in and new handover sheets had been introduced.

Not all people had regular access to meaningful activities. We found that some people led busy and active lives whilst others had fewer opportunities to participate in activities that met their needs People explained that they were able to choose what activities they liked to do. At Davelia and Mildenhall people had activity planners and were able to access activities and spend time doing what they enjoyed. One relative from a person supported at Davelia told us that there were a good range of activities on offer. They said, "There is a lot to do. They are always out on visits or going places. It's really lovely". At Rowantree, all four people who

lived there had activity planners; however due to staffing pressures people had not accessed the community or all their planned activities for the previous seven days of our inspection. People did not always receive the support they needed to pursue their interests and social needs outside of their home.

People living at Mildenhall enjoyed a full and busy life. Support workers told us that the three people enjoyed spending time together, including going to the local shops and going to the cinema. On the second day of our inspection, people were planning to go to the cinema and were being supported to choose which film they liked to see. One support worker told us, "Majority rules and they're into superhero films." They also explained that one person liked to go to the cinema as a chosen activity and they would be supported to go with a member of staff to watch a film that they enjoyed.

People were involved in discussions and decisions around their home. For example, one person was supported to make changes to their home and was supported to make decisions about their daily routine. For example, one support worker told us, "(Person) is involved in everything. She is involved in cooking. We are supporting her to develop her skills and support her with moving on" and "They wanted a new sofa. We said if you want to then discuss it with "mum". They talked about the sofa and decided not to. We always talk and help her with choice. She's quite sensible."

People living at Mildenhall were supported to make changes to their home. They had decided that they wanted to change the garage into a gym as people liked to keep fit. This change was happening to provide a different space for people to enjoy. People and support workers showed us this space and the plans they had to personalise and utilise the gym. One person was really looking forward to this change.

The service managers spoke openly about complaints received, and recognised that relatives wanted the best for their family members. We saw evidence of action in response to complaints. One relative told us, "I have a great relationship with the service manager and things get sorted quickly".

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post for the service. They were also employed as an area manager and individual service managers and team leaders were responsible for the day to day running of each household. At our previous inspection in March 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 manager for Rowantree had left in January 2018 and quality concerns had arisen; including recruitment challenges. The provider had pulled together a team of staff from their other services to support the staff team at Rowantree since February 2018 but further improvement was needed to ensure a stable staff team were in place to support people at Rowantree.

The ethos of a person-centred, user-led approach by which to lead meaningful and fulfilling lives was being encouraged. However due to management and staff changes people did not always experience personalised care at Rowantree.

Since January 2018, internal auditing and quality assurance systems were not planned for or carried out regularly at Rowantree. The provider had therefore not promptly identified all the shortfalls in the service. An internal quality audit had been completed at Rowantree on 29 May 2018 which identified most of the concerns we found. We found the provider had been working on an improvement plan since May 2018. This was put in place to address the shortfalls in relation to staff training and supervision, to ensure people at risk of choking received safe care and to address the staffing and governance concerns they found at Rowantree. Time was needed for these plans to be completed and evaluated before we could judge them to have been effective in supporting the registered manager to make the required improvements.

The provider had also put immediate safeguards in place to mitigate the risk of people receiving unsafe and inappropriate care whilst their action plan was being completed. This included for example; undertaking increased spot checks, including detailed handover information was provided to staff at the end of each shift, ensuring concerns were escalated promptly as well as ensuring new staff and agency staff unfamiliar with people's needs receive a comprehensive induction.

We saw these actions were beginning to be implemented at Rowntree. However, at the time of our inspection with both the service manager and team leader on annual leave these systems that had been put in place to keep people safe had not been implemented effectively. For example, agency staff had not been inducted, concerns noted in the handover sheet in relation to a person's medicine not being available had not been addressed and an incident of a person not being supported appropriately in bed had not been promptly investigated to manage this risk. Systems that had put in place to capture and reduce the impact of the service shortfalls on people had not been implemented effectively and people were placed at risk of receiving unsafe care.

Systems in place to support staff through training, supervision and team meetings had not been operated effectively at Rowantree. The registered manager therefore did not have all the information they needed to identify any risks relating to staff performance and practice in the service. Team meetings were not being

held regularly and we found only one set of team meeting notes for the previous 12 months. This was completed in May 2018. One staff member said, "There are no keyworkers, no meetings and morale is low". One staff member said, "I had concerns but they took a long time to get sorted". There were no records of meetings with people using the service to have a voice or discuss issues arising within the home.

The provider's medicine audit had made some improvements to people's medicine management. However, if had not been effective in ensuring people's medicines would be received on time and completed records would be available to evidence people had received their medicines as prescribed. People's records in Rowantree were not always accurate and therefore people were at risk of not receiving the care they required. Up to date and comprehensive records were needed to supported staff, who did not know people well, to know how to provide safe care to people.

We found that the quality monitoring systems implemented to managed risks in the service were not always effective and record keeping was not sufficiently maintained. This was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At Davelia and Mildenhall there were effective service managers employed who were consistent, caring and knew people well. We had positive feedback from relatives and health professionals about the quality of care people received.

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 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate, complete and contemporaneous record in respect of each service user; • maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity. Regulation 17(1)(2)(a)(b)(c)(d)(ii)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to ensure people would always receive personalised care. Regulation 18(1)(2)(a)