Krinvest Limited

Krinvest Head Office

Inspection report

141 Marsh House Lane
Warrington
Cheshire
WA1 3QZ

Tel: 02086487269

Date of inspection visit:
13 September 2018
14 September 2018

Date of publication:
08 October 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 13 and 14 September 2018 and was announced.

Krinvest Head Office was previously inspected in March 2018. During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to: staffing; fit and proper persons employed; safeguarding service users from abuse and improper treatment; safe care and treatment; receiving and acting on complaints and governance arrangements. We also found that an offence had been committed under the Care Quality Commission (Registration) Regulations 2009 as the registered person had not notified the Commission of incidents or allegations of abuse.

Following the last inspection, the registered provider was placed into special measures by CQC. The registered provider was asked to complete an action plan to confirm what they would do and by when to improve the five key questions we ask. They are: is the service safe, effective, caring, responsive and well led.

At this inspection we found that the registered provider had taken action to address the breaches identified at the last inspection and made enough improvements to be taken out of special measures.

Krinvest Head Office provides care and support to people living in supported living settings, so that people can live in their own home and reach greater autonomy, social integration and independence.

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 the inspection, the service was providing the regulated activity of personal care to six people with complex mental health and social care needs who were living in their own homes in Warrington and Liverpool. The service is provided by Krinvest Limited and coordinated from an office in Warrington.

The service did not have 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 2008 and associated Regulations about how the service is run.

Since our last inspection, the registered provider had appointed a new manager for the service who had applied to register as the manager of Krinvest Head Office with the Care Quality Commission. During the second day of our inspection we noted that the manager attended a site visit from a registration inspector employed by CQC. We received confirmation on the same day that that the new manager's application had been approved and that they would be registered as the manager of the service in due course.

We found that people's needs had been assessed and planned for. Records contained information on the holistic needs of people using the service, their care and support plans, risk assessments and crisis

management plans.

Support plans and supporting documentation had been audited, updated and reviewed to ensure they contained personalised information about people's needs, their short and long-term goals and the required interventions by staff. This information helped staff to be aware of how to provide effective support and keep people safe.

People told us that they received care and support from staff and other health and social care professionals who treated them with dignity and respect and were responsive to their needs.

People were encouraged to maintain a healthy diet subject to people's individual choice and preferences. Likewise, people were supported to access routine health care appointments when required.

We found that staff responsible for administering medication had been provided with medication training so that they understood how to support people to manage their medication safely. We identified that further action was needed in regard to checking the information recorded on medicines administration charts (MAR) and the development of risk assessment processes for people who may chose to self-administer their medication.

Upon completion of our inspection, the manager provided us with evidence to confirm that a risk assessment had been completed for a person who managed their own medication. Furthermore, we received confirmation that a system had been introduced to check and counter check the information recorded on MAR was correct. This practice helps to safeguard the health and wellbeing of people using the service.

Staff recruitment records and systems had been reviewed to ensure staff were appropriately recruited and suitable to work with vulnerable people. A programme of staff training and development had also been established which was subject to ongoing review and development. Staff also benefitted from regular supervision and support from the manager.

The registered provider had developed a policy and obtained guidance for staff relating to the Mental Capacity Act 2005. Staff had completed training in this topic and understood the importance of this protective legislation.

An accessible complaints procedure had been developed and people had been provided with a copy of the complaints procedure for reference. People told us that they knew how to complain in the event they needed to raise a concern.

Safeguarding policies and procedures were in place and systems had been developed to ensure oversight of any safeguarding incidents, action taken, lessons learned and outcomes. Records confirmed that any safeguarding incidents were managed correctly and reported to the local authority's safeguarding team in accordance with local policies and procedures.

A comprehensive range of management information and quality assurance systems had been developed to enable improved oversight and scrutiny of the service. This involved seeking the views of people who use the service and staff.

Following completion of the service user survey, a summary report was produced which indicated that four people (65%) had completed a survey. All participants reported that they were happy with staff and that

staff arrived on time and stayed for as long as they should or were needed for. Areas for development included activities, involvement in writing care plan and risk assessments, contact with the office and engagement with management. An action plan was included within the summary report and this provided details of action the provider proposed to take to improve the experience of people supported by the supported living service.

The registered provider had notified the Care Quality Commission of reportable events and incidents in the service in accordance with statutory requirements.

This service has been in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Policies and procedures were in place to provide guidance to staff about safeguarding adults and staff understood how to recognise and respond to allegations or suspicion of abuse.

Recruitment records and processes had been reviewed and developed to minimise the risk of unsuitable people being employed to work with vulnerable people.

Systems had been established and further initiatives were being introduced to help protect people from the risks associated with unsafe medicines management.

Staff were aware of current risks to people using the service and the required actions to keep people safe.

Is the service effective?

Requires Improvement

The service was effective.

People's needs had been assessed to ensure they received care and support that was tailored toward their individual needs and within the eligibility criteria of the service.

Training and development systems had been improved to ensure staff had access to induction, mandatory and service specific training.

Policies, procedures and training relating to the Mental Capacity Act had been developed, to provide guidance and information for staff on this protective legislation.

Staff supported people to maintain a healthy lifestyle and worked in partnership with other health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was caring

People were able to express their views and were actively involved in decisions about their care.

People were treated with respect and their dignity and privacy was respected and promoted by the service.

Is the service responsive?

Requires Improvement

The service was responsive.

Care planning processes had been established to ensure the diverse needs and support requirements of people were identified and acted upon.

People received care that was personalised to their needs and focussed on promoting their independence and well-being.

Accessible systems had been developed for managing and responding to formal complaints.

Is the service well-led?

Requires Improvement

The service was well led.

A new manager had been appointed to provide leadership and direction for the service who was in the process of registering with the CQC.

Governance processes had been reviewed and quality assurance systems developed to improve oversight and scrutiny of the service. This included seeking the views of people using the service.

Krinvest Head Office

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.

Following our last inspection in March 2018, we rated Krinvest Head Office as inadequate and the service was placed in special measures. This inspection was therefore undertaken to assess and review what action had been taken since our last inspection and to report on our findings.

The registered provider was given 48 hours' notice because the location provides a supported living service and we needed to be sure that someone would be at the office to assist with the inspection.

Inspection site visit activity started on 13 September 2018 and ended on 14 September 2018. It included speaking with people who used the service and staff via the telephone. We also visited the office location on both dates to see the manager and office administrator and to review care records, staff recruitment files, staff training, complaint and safeguarding information, staffing rotas, policies and procedures and audit documentation.

The inspection was made up of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case of people receiving the regulated activity 'personal care' in a supported living service.

Prior to our inspection, we requested the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed all the information which the Care Quality Commission already held on Krinvest Head Office such as intelligence, statutory notifications and / or any information received from third parties. We also contacted the local authority to obtain their views of the quality of care delivered by the service. We took any

information provided to us into account.

During the inspection we spoke with the manager and office administrator who were based at the registered office. We also spoke with one social worker, seven staff and three people receiving support from the provider via the telephone as they did not wish to receive a home visit. A further three people receiving support from the service were unavailable at the time of our inspection. We were therefore unable to receive feedback from them due to their personal circumstances.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they felt the service was safe. People spoken with confirmed that they felt safe and we received comments such as: "Yes I am very safe. I know who to contact if I don't"; "Always enough staff on for me" and "I have my medication on time. The staff are very good now. It's great".

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'person centred care'. The was because the registered person had failed to ensure that the care and treatment provided to people was appropriate to meet their needs.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

At the time of our inspection the service was providing the regulated activity of personal care to six people. Fourteen staff were employed within the service who worked variable hours subject to the needs of the people using the service and their individually commissioned packages of care.

Examination of rotas and discussion with the manager confirmed that wherever possible the service endeavoured to deploy the same staff to support people using the service to ensure continuity of care. However, this could sometimes change due to annual leave, sickness, staff training or when staff had moved on to new jobs.

Since our last inspection, the provider had established a monthly log to record missed visits. The logs outlined the date, reason why a missed visit had occurred, action taken and outcome. Analysis of the records highlighted that the number of missed visits had significantly reduced in the last two months and that the manager or agency staff had always offered to provide care and support when necessary.

We noted that people using the service had often refused support from agency staff. The manager informed us that the provider was in the process of recruiting more staff to cover a vacant post and were developing a bank of regular staff to ensure continuity of care.

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 19 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'fit and proper persons employed'. The was because the registered person had not operated robust recruitment procedures or obtained the necessary information prior to staff commencing employment.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach.

The registered provider had a recruitment policy in place that provided guidance for management and staff responsible for recruiting new employees. We noted that since the last inspection, the provider had undertaken a full review of all staff personnel files to ensure missing information was obtained and placed in files. We looked at the staff file audit spread sheet which had been reviewed each month. This provided evidence that significant progress had been made in updating files with the required information.

We also sampled three personnel files for staff who had commenced employment since our last inspection. In each file we found that appropriate checks had been made to ensure prospective employees were suitable to work with vulnerable adults. Files viewed were well constructed and contained an index sheet, application forms, interview notes, terms and conditions of employment, health and fitness questionnaires, two references, proof of identity and a disclosure and barring service (DBS) check. A DBS check aims to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'safeguarding service users from abuse and improper treatment'. The was because the registered person had failed to establish and operate effective systems and processes to protect people using the service from abuse.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach.

The registered provider had a 'safeguarding' and a 'whistleblowing' policy and procedure in place. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. Copies of the adult protection procedures for the local authority areas where people lived had also been obtained for staff to refer to.

Discussion with the manager and staff together with a review of training records confirmed all staff working within the service had completed safeguarding training. Staff spoken with demonstrated a satisfactory awareness of the different types of abuse and the action they should take in response to suspicion or evidence of abuse. Staff also told us that they knew how to whistleblow should the need arise.

We asked the manager for information on any safeguarding incidents that had occurred in the service or that were known to the service since our last inspection. We noted that tracking systems had been developed by the registered provider to ensure oversight of safeguarding incidents, action taken, lessons learned and outcomes and that four safeguarding incidents had been recorded.

Records confirmed that where safeguarding incidents had been identified by the registered provider, the service had managed them correctly and reported them to the local authority's safeguarding team in accordance with local policies and procedures.

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'safe care and treatment'. The was because the registered person had failed to ensure the proper and safe management of medicines and had failed to ensure that risks to the health and safety of service users were appropriately assessed and mitigated.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach. For example, since our last inspection, the provider had undertaken a review of all risk

management assessments and crisis management plans to ensure the information recorded was up-to-date and accurate. Records viewed were found to be person centred and outlined key information for staff such as current and historical risks, potential triggers, possible interventions and actions to be taken if the identified risk was occurring.

Furthermore, since the last inspection, all staff except for one newly appointed employee had completed medication training. Systems were also in place to check the competency of staff via observation checks which included checks on the administration of medication.

At the time of our inspection only two people using the service required assistance with the administration of medication. One person retained responsibility for the administration of their own medication.

We looked at the arrangements in place for the management of people's medication within the service. The registered provider had a medication policy and procedure in place and medicine administration charts (MAR) were provided for staff to record the administration of medication when required.

We looked at a sample of MAR and found that they had been correctly completed. However, we noted that the prescribed instructions had been typed and the details of the person who had recorded the information had not been recorded. Likewise, there was no evidence that the prescribed instructions had been checked by another competent member of staff to verify that the details were correct. We also noted that in the case of a service user who self-administered their medication, there were no records to confirm that a risk assessment had been undertaken.

We received assurance from the manager during our inspection that arrangements would be made to ensure that all typed MAR were signed and countersigned to confirm the information recorded had been checked against the prescriptions. We also received assurance that a risk assessment would be undertaken for a person who self-administered medication to safeguard the health and wellbeing of people. Upon completion of our inspection the manager provided us with a copy of a risk assessment and confirmation that a system had been established to ensure the information recorded on MAR charts had been routinely checked and counter checked.

Systems were also in place to check medication stocks on a weekly basis and to audit medication systems and records monthly.

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'good governance. The was because the registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach.

The registered provider had an Accident and Incident Reporting Policy and Procedure in place. We asked the senior management team for information on any accidents and incidents that had occurred in the service since our last inspection.

We noted that tracking systems had been developed to record and analyse any accidents and incidents with the service. This enabled the provider to maintain an overview of the details of incidents, action taken,

lessons learned and outcomes. Additional information was also recorded on individual incident forms.

The registered provider had an infection control policy for staff to reference. Staff spoken with reported that they had completed training in infection control and that they had access to personal protective equipment for the provision of personal care. We noted that spare supplies were also stored at the registered office.

A 'business continuity plan' had been produced for the service which outlined the action that would be taken in the event of significant business disruption such as loss of workspace; loss of IT / data; managing loss of key staff and / or other key resources. The plan indicated that an out of hours service was available for the service and a certificate of public liability insurance was in place.

We noted that individual risk assessments had been completed and health and safety audits of each person's home environment were routinely undertaken to ensure the premises were safe. The manager told us that they were also in the process of developing environmental risk assessments to ensure actual and potential risks were identified and acted upon.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if they felt the service was effective. People spoken with confirmed the service was effective and their care needs were met by the provider. For example, we received comments such as: "I make my own decisions. Staff are very good at what they do. I feel involved with everything" and "I don't have to wait for anything. The service is okay."

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'staffing'. The was because the registered person had failed to ensure that persons employed in the provision of the regulated activity had received appropriate training and supervision to enable them to carry out the duties they are employed to perform.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

Since our last inspection, the registered provider had developed a programme of staff training and development which covered a range of areas such as induction, mandatory, service specific and national vocational level / diploma level qualifications. Staff were also provided with a handbook and other key information upon commencing employment with the registered provider.

The manager told us that a mixture of face-to-face and e-learning training was used to deliver training for staff which was sourced from two independent training providers. Senior staff from within the organisation also provided training in subjects such as mental health, positive behaviour support and suicide prevention.

We discussed the ongoing development of the training programme as we noted that a range of training topics had been compressed into a one-day statutory mandatary training course.
The manager informed us that the training programme had been established to ensure the basic training needs of staff were met in response to the last inspection and that moving forward the programme would evolve and be subject to further change.

Discussion with staff and examination of training records confirmed significant progress had been made in supporting staff to complete a range of training since we last inspected the service. Staff also told us that they had completed several training courses and confirmed that the training had helped to develop their knowledge, skills and understanding of the needs of people using the service.

Staff we spoke with told us that they felt supported in their roles by the manager, had received periodic supervision and the opportunity to attend team meetings. An on-call system was also in place to offer staff and people using the service additional help or assistance outside of office hours.

At our last inspection on the 12 and 13 March 2018, we found a breach of 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'safe care and treatment'. The was because the registered person had failed to ensure that the care and treatment of service users was appropriate to meet their needs.

At this inspection we found the provider had met their legal requirement and that action had been taken to address the breach. Since the last inspection, the provider commenced a voluntary embargo on all new placements whilst action was taken to improve assessment systems and processes within the service. Furthermore, all new referrals to the supported living service now require authorisation from a member of the executive team, to confirm the service was able to meet the needs of prospective service users.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We noted that the registered provider had a 'Mental Capacity Act 2005' policy and procedure in place and the provider information return for the service indicated that none of the people who used the service were the subject of an order by the Court of Protection that resulted in the care provided restricting a person's liberty, rights or choices. This information was also confirmed during the inspection.

The manager and staff spoken with demonstrated a satisfactory understanding of their roles and responsibilities regarding this protective legislation and confirmed they had received training in the MCA since our last inspection.

The manager demonstrated an awareness of the need to liaise closely with care management teams, formal appointees, advocates and relatives in the event a mental capacity assessment was required for a person using the service. We also heard examples of how the service had worked in partnership with other teams and services to ensure the delivery of quality care and support for people using the service such as local commissioning teams and health and social care professionals i.e. social workers, occupational therapists, hospital staff, community psychiatric nurses and dual diagnosis practitioners.

For example, during our inspection we observed the manager engage in several telephone calls with a social worker and hospital staff in order to arrange an occupational therapy assessment for a service user, prior to their discharge from hospital.

We spoke with staff regarding the promotion of healthcare, hydration and good nutritional intake within the context of person-centred care and respecting people's right to choose what they eat and drink. Staff we spoke with confirmed they promoted healthy eating and recorded dietary intake via food diary records. Likewise, staff monitored and recorded any changes in people's wellbeing and their needs via daily records and understood when to escalate or report concerns to the manager.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service if they felt the service was caring. People spoken with confirmed that they were well cared for and treated with dignity and respect by staff. For example, we received comments such as: "The staff are very kind and lovely to me. I like my staff. I ask them to help me"; I'm independent and get help from staff. Staff speak to me all the time. I'm not left out. I'm involved. I know what's going on. I like everything the way it is" and "Staff are nice. They treat me well. I've no complaints".

Due to Krinvest Head Office operating a supported living service, the inspector was unable to undertake observations of the standard of care provided to people. This was because people receiving support from the provider were living in the privacy of their own homes and were either away from their homes during our site visit or declined to receive a visit from the inspector.

However, three people receiving care and support from the supported living service agreed to talk to a member of the inspection team via telephone calls. People told us that the service had improved since our last inspection and that staff were attentive, caring and responsive to their needs.

We also spoke with a social worker who conveyed positive feedback about the standard of care and support provided to a person they were involved with. The social worker also told us that in their opinion the service was person centred, focussed on the needs of their client and effective at communicating key information.

Staff spoken with during the inspection demonstrated a good understanding of the needs of the people they supported. Staff told us that since our last inspection they had received induction and other training that had helped them to develop their understanding of the needs of people living with complex mental health needs and how to provide effective care and support. Staff also told us that they had been given opportunities to familiarise themselves with information on the needs of people using the service such as their updated support plans, crisis management plans and risk assessments.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

Through discussion with staff it was evident that they were committed to the wellbeing of the people they cared for and that they were mindful of the importance of nurturing good care practice such as promoting and supporting dignity; citizenship; independence and safety; respecting and acknowledging each person's personal belief and identity and the importance of protecting individuals from abuse and harm.

This outlined the organisation's philosophy of care; principles and values underpinning the service; confidentiality issues; risk taking and risk management; service users and equal opportunities; how to access the service; information on the key worker system and other information relevant to the delivery of the service.

The manager told us that the supported living service had links to advocacy services including 'Warrington

Speak Up'. This is an advocacy service that promotes social inclusion, equality and social justice for people who may face discrimination, disadvantage and social isolation. Information on the advocacy service and how to obtain help and support was displayed in the foyer of the office and was provided to people using the service subject to individual need.

The registered provider had developed a policy on the general data protection regulations. Information about people using the service and employees was stored securely in filing cabinets in the organisation's office and information held on computers was password protected. Systems were also in place to transfer records from people's home to the office on a monthly basis for safe storage.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

Requires Improvement

Is the service responsive?

Our findings

We asked people who used the service if they felt the service was responsive. People spoken with told us that they found the service was responsive to their individual needs and that they felt listened to. For example, we received comments such as; "Staff know me well. I go out with them. They look after me and make sure I'm okay. I've no complaints"; "I have one to one staff so I've plenty. They know what I like and what I don't" and "I choose what I want to do. I get up when I want and go to bed when I want. I go out whenever I want too. I like it [the service] and I have enough support".

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'good governance'. This was because the registered person had failed to maintain an accurate, complete and contemporaneous record, including a record of the care and treatment provided to each service user. Furthermore, the registered person had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

Since our last inspection, the former Chief Executive Officer had undertaken a comprehensive audit of each service user's file to ensure information stored in central files and people's home was up-to-date and accurate.

During our inspection we asked permission to view records relating to two people using the service in order to review the quality and range of information recorded. We found that files included index sheets, were well organised and contained information relevant to the care and support needs of people using the service.

Files viewed included information on the assessed needs of people using the service, their care and support plans, risk assessments and crisis management plans. Support plans were noted to contain personalised information and outlined people's needs, their short and long-term goals and the required interventions by staff.

Supporting documentation such as personal profiles, personal emergency evacuation plans, daily record sheets, food diaries, activity planners, incident records, health information and miscellaneous records were also in place. Systems had been established to ensure support plans were kept under review and to confirm people using the service had agreed the content recorded.

At our last inspection on the 12 and 13 March 2018, we also found a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014 relating to 'receiving and acting on complaints'. This was

because the registered person had failed to establish and operate effectively an accessible system for identifying, receiving, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach.

The registered provider had a complaints, suggestions and compliments policy and procedure in place together with a complaint procedure for service users. A large print accessible version entitled 'speaking out' had also been produced to help people with communication needs understand the information and ensure the service complied with the Accessible Information Standard (AIS). The AIS requires that all publicly funded adult social care and care provided by social care services must identify and meet the information and communication needs of those who use their services.

We requested to view the complaint records for the service and noted that a system had been established to track and log the details of any complaints and to provide details of the action taken, lessons learned and outcomes. Records indicated that there had been two complaints from one person using the service since our last inspection and that these had been appropriately acted upon. Outcomes had also been relayed to the complainant via a letter. One compliment had also been received.

No complaints, concerns or allegations were received from people using the service during our visit. People told us that in the event that they needed to raise a concern they were confident they would be listened to.

At the time of our inspection, none of the people using the service required the use of assistive technology products. The manager told us that assistive technology would always be taken into consideration subject to people's needs and support requirements.

The service did not provide end of life care but had a policy and procedure to follow in the event of the death of a person using the service.

Requires Improvement

Is the service well-led?

Our findings

We asked people who used the service if they felt the service was well led. People spoken with told us that the manager of the service was approachable and supportive and we received comments such as: "I know X [the manager] he's great. He comes to see me. He listens" and "I see the manager. He is nice. I like him".

Likewise, staff spoke positively about the manager. We received feedback such as: "When I look back to how the service was it's 100% better. He [the supported living manager] is brilliant. Things are where they should be"; "The service is improving all the time. It has changed for the better" and "I have no concerns now. It's much improved. Service users are well looked after".

At our last inspection on the 12 and 13 March 2018, we found a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to 'good governance'. The was because the registered person had failed to ensure that effective systems were in place to assess, monitor and improve the quality of the service.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach.

The rating in this domain is requires improvement. To improve the rating from 'requires improvement' to 'good' would require a more consistent track record of good practice.

As a result of our last inspection, the provider had revised its governance policy and framework.

The revised governance structure incorporated a schedule of meetings throughout the organisation for the combined audit and governance committee; executive management, senior management and mental health management teams and dedicated meetings for staff working within and people receiving support from the supported living service.

A suite of new audits had also been introduced. For example, we noted that the Business Development Director had routinely undertaken comprehensive audits of key operational topics within the supported living service. Following each audit, an action plan was produced and performance results analysed. Key performance indicators were also monitored.

Furthermore, the Chief Executive Officer had completed file audits to check and review the content of each service user's file and other records required for the regulated activity. Action plans had been produced in response to the findings and progress was noted in all areas.

Since our last inspection, the former Chief Executive Officer and Business Development Director had left employment with the provider. We were informed that a new Operations Director and a Compliance Manager had been appointed following a restructure and were due to commence employment with the company soon.

The manager informed us that the audits previously completed by the former Business Development Director and the former Chief Executive Officer would be continued by the newly appointed Operations Director and also a Compliance Manager to ensure continuity.

Additionally, the provider had introduced a new dedicated supported living service audit tool that was divided into four sections. The audit was completed in stages by the manager on a monthly basis for each person receiving support from the service. This tool provided a comprehensive framework to ensure important areas such as medication, health and safety, accidents and incidents, complaints, safeguarding, environmental issues, records and people's health and wellbeing were monitored. We could see that actions plans were also reviewed and that progress had been made in improving standards as summary analysis reports were generated from the data recorded.

Electronic management information systems had also been developed to ensure staff training, staff personnel files, supervisions, audits and meetings were checked, up-to-date and kept on target.

Additionally, a staff survey had been completed in May 2018 and a service user survey had been completed in June 2018. Following the service user survey, a summary report was produced which indicated that four people (65%) had completed a survey. All participants reported that they were happy with staff and that staff arrived on time and stayed for as long as they should or were needed for. Areas for development included activities, involvement in writing care plan and risk assessments, contact with the office and engagement with management. An action plan was included within the summary report and this provided details of action the provider proposed to take to improve the experience of people supported by the supported living service.

At our last inspection on the 12 and 13 March 2018, we also found a breach of Regulation 18 (1) (e) of the Care Quality Commission (Registration) Regulations 2009 relating to 'notification of other incidents'. The was because the registered person had failed to notify the Commission without delay of any incidents of abuse or allegations of abuse in relation to a service user.

At this inspection we found the registered provider had met their legal requirement and that action had been taken to address the breach. Records confirmed that the manager had notified the Care Quality Commission of events and incidents that occurred in the supported living service in accordance with statutory requirements.

The registered provider (Krinvest Limited) was owned by one individual who was listed at Companies House as the sole director of the company.

A senior executive management team had been established which had overall responsibility for the operation of the organisation. This consisted of an Executive Chairman and Managing Director; a Head of Development; Head of Business Administration; Head of Finance; Head of Clinical Research and a Head of Commercial Strategy.

We noted that the registered provider had developed a strategic plan for the organisation and had published information on the organisation's vision on its website. This stated that the provider's vision was "Quality assurance, choice and positive risk taking, to ensure each person we support lives the life they choose."

Since our last inspection, a new manager had been appointed for the service. We noted that the manager had applied to register with the Care Quality Commission and that they attended a fit person interview with

a registration inspector during the second day of our inspection. We received confirmation upon completion of our inspection that a decision had been made to approve the application.

The manager told us that they had gained prior experience in the operational management of a supported living service for people living with acute mental health needs and had undertaken a range of training relevant to their role and responsibilities.

Through discussion and examination of records, it was evident that the manager had developed a good understanding of the supported living service, the needs of people using the service and the staff team who delivered care and support.

The manager engaged positively throughout the inspection process and was helpful, transparent and efficient in responding to any requests for information. It was also clear that the manager was passionate about the design, development and delivery of a person-centred service.

We noted that the registered provider had purchased a range of policies and procedures for use within the service from an external supplier. The policies were readily available in the office for staff to view. The manager told us that a policy review plan had been developed to ensure key policies were updated by January 2019 to ensure they were more bespoke to the supported living service.

Ratings from the last inspection were displayed in the foyer of the supported living service office as required. The provider's website also reflected the current rating of the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services and the public with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.