Craegmoor Homes Limited

Craegmoor Supporting You in the South East

Inspection report

122 Coast Drive
Greatstone
New Romney
Kent
TN28 8NR

Tel: 01797361541
Website: www.craegmoor.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 12, 15 and 16 February 2016, and was announced. We gave '48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies.

Craegmoor Supporting You in The South East provides personal care and support to adults in their own homes. It provides care in four separate locations where people share a home together; and an outreach services to people that live alone. The service provides care and support for people living with a learning disability; it is registered to provide personal care. The service was last inspected in November 2013 and had met our standards of compliance. At the time of the inspection 22 people were using the service. 15 people lived in shared accommodation and seven people lived alone in their own home.

The service had a registered manager; however they no longer worked at the service and were in the process of de-registering. 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. A new manager was in the process of registering with the Commission and was present on all three days of the inspection.

The service had not safeguarded people from abuse. Several incidents had not been reported to the local authority for investigation or notified to the Commission. The provider had been unaware about the incidents until raised by the inspectors. Since the new acting manager had been in post safeguarding incidents had been reported following the correct processes to protect people from further harm.

Risk assessments had not been updated or introduced when people or others had been put at risk or suffered harm. The provider could not demonstrate that when risks had been identified additional measures had been put in place to reduce the likelihood of repeating incidents.

The provider's systems for reporting, recording and responding to accidents and incidents were ineffective. The provider had been unaware about numerous incidents where people had been placed at risk. When staff had reported incidents they had not been acted on appropriately by the management team.

People were not benefiting from staffing, which was flexible to their preferences and support needs, but were dependent on the availability of staff. At a location where people shared an environment insufficient staff numbers were deployed from Monday to Friday after 2:00pm. This impacted on the freedom people had to leave the service and when they could receive support with their personal care.

Staff had not completed their essential training before working alone. The provider had not checked staff's competency in their ability to work alone safely. Not all staff had received specialised training to support people with their individual needs. Staff lacked understanding and knowledge around fundamental areas, which were necessary to keep people safe, for example, safeguarding, diabetes and epilepsy.

Staff recruitment files lacked some information, which is a requirement of the regulations and needs to be obtained to ensure people are kept safe. This included photographs, exploration into employment gaps, reasons for the termination of previous employment and suitable references.

The provider was not fully complying with The Mental Capacity Act 2005. Restrictions had been placed on people, which had not been assessed as the least restrictive option available and best interest meetings had not taken place in line with the Act. Understanding around this important area was lacking.

The service was inconstant in meeting people's health needs. Some people had been supported well when they required specialist help with their health needs; other people had not been supported when deterioration in their health had been identified.

Some reports about people were not written in a respectful or dignified way. People's information was not always stored confidentially.

There were inconsistencies across the service with supporting people to access activities and social stimulation. At one of the shared locations the lack of staff meant people could not freely leave their home between specific times.

Care plans and daily notes about people were lacking in detailed information and were not personalised. Some documentation gave good information about how staff could support a person in specific areas.

The provider did not have good oversight of the service. Internal audits had failed to identify the areas of concern identified at this inspection and the provider was unaware about the incidents which had gone unreported. Staff felt the service was making improvements since the new manager had taken up post. They told us previously to this they did not feel well led or managed and had been given conflicting advice by different managers, which made their jobs difficult. The provider recognised they had areas to improve and had made an action plan with the acting manager to work towards. Since the acting manager had been in post most staff had received a supervision and appraisal, they said they felt better supported then previously and the service was turning around.

People had choice around their food and drink and were encouraged to make their own decisions around this. People were supported to prepare their own meals and have lunches out or takeaways if they wished.

Staff demonstrated they cared for the people using the service and wanted things to improve. Staff had caring interactions with people, which indicated they knew them well. If people were unhappy, there was a complaints procedure they could follow and people told us they knew how to complain.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end 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?

Inadequate

The service was not safe.

Safeguarding incidents had gone unreported and the provider was unaware about incidents, which had occurred.

Risk assessment was not adequate in reducing risks to people when potential harm was identified.

There were inconsistencies across the service of how people received their medicines safely.

There were not enough staff at times to support people to pursue activities and interests of their choice.

Safe recruitment practices had not been followed.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not following the requirements of the Mental Capacity Act 2005 and people were not always consulted about decisions.

New staff had begun to work alone before completing essential training. Staff had not received up to date training in specialist areas to be able to support people.

The acting manager had given most staff an appraisal or supervision, and staff felt supported.

People were encouraged to make decisions about their meals and have independence around this.

Is the service caring?

Requires Improvement

The service was not always caring.

Some language used in reports about people was not respectful or caring. Personal information about people had not been treated confidentially.

Staff demonstrated a caring attitude towards people and demonstrated they knew them well.

Staff interacted with people patiently and with compassion.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and daily records lacked detail and personalisation.

Some people were not always able to do the activities they wanted to do at specific times due to the number of staff deployed. Other people were able to access activities and social stimulation when they chose to.

The provider had a complaints policy which people felt confident to use. The provider had responded to complaints when they had been raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service lacked oversight; staff felt they had not been well-led or informed properly by management.

Internal systems had been unsuccessful in identifying areas the provider needed to respond to, to protect people.

Since the acting manager had taken up post some areas in the service had improved and the provider had identified further shortfalls and how they could be met.

Craegmoor Supporting You in the South East

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 inspection took place on 12, 15 and 16 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. The inspection was conducted by two inspectors.

Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The acting manager was also asked to send us some further information after the inspection, which they did in a timely manner.

We visited seven people who used the service in two of the shared locations as well as one person who lived alone. We spoke to eight people, one person by telephone after the inspection, seven staff, the acting manager, and the national operations manager. We received feedback from one health professional before the inspection.

Prior to the inspection we sent questionnaires to people, relatives, staff and community professionals about the quality of care at the service. We received six responses in total, five from people and one from a community professional.

Not all people were able to express their views clearly due to limited communication skills, others could, so during the inspection we observed interactions between staff and people. We looked at a variety of documents including seven peoples support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, training records, medicine administration records, and quality assurance information.

Inadequate

Is the service safe?

Our findings

One person told us they did not lock their room at night as they felt safe. We asked another person if they felt safe and they said, "Yes I do". Although people told us they felt safe, we found a number of areas in which people's safety had been compromised and this put people at risk of harm.

People were not protected from abuse. Safeguarding incidents had not been reported following the provider's own policy or to meet the safeguarding legal requirements of the local authority. People's money had gone missing, but this had not been raised as a safeguarding and reported to the local authority. A staff member said, "It was worrying, before (acting manager) came. Money had been going missing; we put safes in place for people. It wasn't reported to anyone apart from a manager". There were no incident reports or risk assessments to prevent further suspected financial abuse. Staff told us they had moved people's money to the staff sleep room to prevent further money going missing. No capacity assessments had been completed or consent obtained from people to do this. The inspectors raised this as a concern to the provider who was unaware of this incident. The provider later told us that people's money had been returned to them and they would investigate this further. Records confirmed other incidents of alleged abuse had not been reported including three incidents of physical abuse in February 2015, one in March 2015 and one in May 2015. Safeguarding and whistle blowing information was available for staff to refer to in the staff folder, which included contact numbers to call, but staff did not have a good understanding about the process to raise concerns about people's safety. Since the new manager had taken up post safeguarding referrals had been made appropriately. We raised the unreported safeguarding's to the local authority after the inspection.

The provider did not have an effective system in place to ensure incidents of abuse were reported and investigated. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had not been updated when people had been identified as being at risk. For example, a person had fallen down the stairs whilst having a seizure. The risk to the person had not been reduced and no action had been taken to implement measures to minimise the outcome of harm the person could suffer. Another person was attending outings alone. There had been a previous incident in the community which impacted on members of the public. This had not been updated in their risk assessment to minimise further occurrences of a similar nature. One person had several incidents of being physically abusive towards other people they lived with. There was no risk assessment in place to support this person with their behaviour, provide guidance to staff, or to protect others. One person's care plan stated they required staff to support them with breakfast, lunch and dinner because they were diabetic and were at risk of becoming ill if they did not follow a good diet: This person lived alone. The hours recorded on their weekly support and care record had several gaps and blank information so it was not possible to tell if this need had been met. Individual risk assessments were lacking in some of the care files in areas, such as money, road awareness and shaving. One person's care plan stated they would pick at their hands; no risk assessment had been made around this to help reduce harm to the person.

When people had accidents and incidents, the provider had not ensured they were protected from further harm. Staff reported accidents and incidents directly to the manager. Accidents and incidents were logged on the provider's compliance system, which was audited and analysed to identify reoccurring events or patterns. The system had not been successful in recording or responding to the unreported safeguarding incidents we found.

Not all staff were trained to administer medicines. People in one shared location had paracetamol in their personal medicine cupboard. It was not clear if people received this when they required it because staff were unaware if this was a prescribed medicine or a homely remedy. This was not documented on the medication administration record (MAR). A homely remedy is another name for non-prescription medicines available over the counter in community pharmacies, which are used for the short term management of minor, self-limiting conditions. e.g. toothache, cold symptoms, cough, occasional pain, etc. A prescribed cream had been left on top of a shelf in a person's bedroom. Staff told us they did not think this person would remember using it, which meant they could not be sure the person was correctly receiving their prescribed cream; the health needs of this person were not being met. A person was prescribed a medicine whose dosage varied. Although documentation was kept up to date regarding the dosage the person required, documentation lacked detail about the side effects staff should be aware of. Therefore, there was a risk that staff would not be able to respond appropriately if the person should need further medical help. Systems had been put in place to audit boxed medicines daily to reduce the risk of mistakes; however audits had not been consistently completed. The acting manager had completed a medication audit in February 2016, which had not identified these shortfalls. They told us, "I don't actually count meds when conducting an audit. I will now you've identified staff are not counting meds. I thought they were".

The provider had failed to properly assess risks to health and safety of people and mitigate such risks. The provider had failed to have proper and safe management of medicines; this is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required staff to support them to take their medicines and other people were encouraged to manage their own medicines, and risk assessments were in place to ensure this was safe. At another of the shared locations audits were being conducted effectively by staff to monitor the right quantities of boxed medicines were accounted for.

People were not protected from robust recruitment procedures. Staff had completed an application form and attended an interview where they were asked questions about their experience. Disclosure and Barring Service checks had been made. These checks identified if prospective staff had a criminal record or were barred from working with adults. There were no photographs included in all three staff files, which is a requirement of the regulations to ensure safe procedures were followed. One staff file had a three year gap in their employment history, which had not been fully investigated and the reason for previous employment terminating had not been explored. The provider told us that two references were required for each applicant, including a reference from the applicant's last employment to ensure staff were suitable and of good character. However, one staff file contained a reference from a person's relative and another staff file contained only one reference.

The lack of effective and safe recruitment processes is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff deployment was not centred on the needs of people. At one of the shared locations staff would lone work from 2:00pm onwards. Most people needed help with their personal care. A staff member told us, "If (person who is female) needs help with bathing, female (staff) from next door will come over". This meant

that people's needs being met would be dependent on the availability of staff from a different service already providing support to other people. All people apart from one at this shared location required support whilst out. The number of staff deployed to support people impacted on the freedom people had to leave their home at their leisure. At weekends two staff would be deployed so people would have more opportunities to go out if they wished. A staff member commented, "People can't go out when there's only one person (staff) here. It can get boring. If we had a car we could get people out; it's very repetitive for people". People were not benefiting from staffing, which was flexible to their preferences and support needs, but were dependent on the availability of staff.

Sufficient staff were not being deployed to meet the needs of people when they required it this is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Some people's health needs were not always responded to effectively. A person said, "I've been ill, been a bit better now. My carer helped me to go to the doctor". A staff member told us that they were concerned about the decline in a person's health. This had not been reported and referrals to medical professionals had not happened to ensure their good health. A health professional told us, "They appear to be quite good at adapting to people's changing needs due to aging, but on the whole they do not think creatively or out of the box to meet people's needs". A person who was diabetic required staff to help them manage this safely. Their care plan lacked information regarding the safe levels their blood sugars should be maintained at when readings were taken. The care plan said, 'Retest my blood sugar levels to make sure they have returned to normal levels'. A description of what 'normal' meant was missing. There was a good description of what signs staff should look out for if the person's blood sugar level was low. Staff were able to describe the signs and symptoms to look out for to recognise if this persons levels were unsafe, however, the lack of detail in the care plan could pose a risk to the person's health if supported by a new staff member or someone who was not familiar with them. The persons care plan stated: 'I need support with my diabetes, I need staff to monitor my diabetes, as I don't recognise when my blood sugar levels are low'. Evidence was lacking to show regular checks had been made, placing the person at risk. Some people had epilepsy, which was controlled by the medicines they took. Although people infrequently had seizures caused by their epilepsy, staff were not able to clearly describe the action they would take if this happened. One staff said, "I don't know what the care plan said to manage epilepsy". The care plan did contain guidance for staff to follow to support people with their epilepsy. The acting manager said staff needed to have more embedded learning about epilepsy management.

People were being placed at risk as health needs were not being consistently responded to effectively. This is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The provider had stated in their PIR that, "Staff have the basic understanding of the Mental Capacity Act and how they can support individuals to make a decision. However more work is needed around this". Some capacity assessments had been made, others were missing. When people were assessed as lacking capacity this had not been followed by a best interest meeting to document the least restrictive way the person would be supported. There was evidence that involvement from outside health professionals had been sought to be part of the decision making process, but the Act had not been complied with fully and restrictions had been imposed on people without assessing if this was in their best interest, for example people's money being taken away from them without their permission.

The provider had failed to comply with the requirements of the Mental Capacity Act 2005. This is a breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed a mixture of online and face to face training. Not all staff had received all of the required essential training to ensure they could effectively meet people's needs. One staff told us training was really good and they were waiting for first aid training. They felt it was easier to complete training online than going on courses. Another staff said, "Training is brilliant, but I would prefer more face to face training". Not all staff had received specialised training to be able to support people with their individual needs. In one person's care file it stated: 'I have a diagnosis of onset dementia, at times I can get confused and forget what I have done'. Not all staff supporting this person had received training in dementia. One staff said, "One staff could understand about (persons) dementia, but other staff don't know". Another person had been diagnosed with depression, but staff had not received specific training to help support the person with this. First aid and diabetes training had not been kept up to date meaning staff would not have the most up to date knowledge and skills to support people.

All new staff were required to complete an induction at the start of their employment. A staff member had shadowed more experienced staff for three weeks, but had started to work alone before completing their care certificate induction training, first aid or medicine training. This staff member had not received a formal supervision and had not had their competency checked by a manager before working alone. The acting manager had provided most staff with a supervision and appraisal since they had taken up post, before this, supervision was infrequent. One staff told us that they had received a supervision from the acting manager, but previously had not received much at all. Staff competency checks were not recorded or evident meaning it was not clear how the provider could be sure staff supporting people were able to effectively meet their needs. The acting manager said, "I visit people in people's outreach and see staff then. I don't log the visits made to the staff who provide the support".

The lack of adequately trained staff is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had choice around the food and drink they received. At one of the shared locations people decided together what they would like on the weekly menu and meal choices were written on a white board in the kitchen. We observed staff offering people different food choices if they did not want what was on the menu. People were also supported to be involved in the preparation of their meals and the whiteboard indicated who would be in charge of cooking on specific days of the week. During the inspection one person told us they had ordered a Chinese take away with staff support which they had enjoyed. When people had difficulties around eating meals referrals had been made to the speech and language therapist (SALT) who supported the service to implement safe guidelines around the person's meals.

Requires Improvement

Is the service caring?

Our findings

Staff did not always demonstrate respect, privacy or compassion for people. Some language used in reports and documentation was not respectful. A staff member had documented, "(Person) has been to day care today, (person) has left early causing stress for support workers as (person) was causing up a fuss". We raised this as a concern with the acting manager who told us they had spoken to staff before about the language they used in reports, but this had not been effective.

A communication book was left in the shared lounge of one of the locations we visited, which detailed people's personal information and was accessible to anyone who came into the service, therefore compromising the confidentiality of information held about people. A health professional told us, "They do not seem to do much at the weekends. Staff appear to treat the flats as their own homes. The staff appear to be very laid back when it comes to providing support. They seem to be doing the bare minimum required, possibly not helped by not having a manager on site for a good deal of the time".

During the inspection staff interacted with people in a caring way. People were encouraged to be independent and improve their individual life skills. An example of this was when one person was being helped to read their book and write. Staff supported this activity patiently and attentively, and the person held the staff member's arm throughout. This person was later asked by the same staff member if they would like to count their own personal money. Staff sat with the person and supported them at a pace, which suited them and spoke kindly and respectfully to the person throughout.

People's individual likes and preferences were respected by staff and staff demonstrated they cared about the outcomes for people. One staff sat with a person who was looking through their magazine and talked to them about it. This interaction demonstrated there was good understanding of the person's communication needs and staff engaged with the person in a caring manner. This person had one of their favourite programmes on the television at the same time, which they were enjoying. Another person liked to stand outside in the courtyard, which they did throughout the inspection. Staff respected this choice and checked to see if they were okay, whilst given the person freedom to do this.

People were able to freely come to the office to talk to the acting manager when they wished. One person told us they liked their home, but would like to have their own telephone and more electrical sockets which is the responsibility for the landlord to respond to not the service. They came to the office and spoke to the acting manager about this who responded to the person in a kind and engaging way allowing them the time to express their wish and making an agreement together about how this could be actioned. When people required further support they were helped to contact advocates. An advocate came to visit two people during the inspection.

Requires Improvement

Is the service responsive?

Our findings

Not all people were able to independently leave the service to pursue their interests, and needed staff to support them to do this. One person said, "I don't go out if it's cold, don't like to. Would probably go out if there was a vehicle. I would like more to do indoors. I do gardening in the summer". Another person said, "I went to my day centre today and have been swimming". One staff said, "I think the service could improve by finding new activities to do". Opportunities for people to attend outside activities were restricted at one of the shared locations due to staff numbers, which were reduced to one staff member from 2:00pm onwards from Monday to Friday. When one staff member was on shift people could not attend outside activities. At another shared location staff told us it was difficult to do activities with people because of the lack of transportation and infrequent public transport. A health professional told us, "The service tend to access services that are within the Craegmoor umbrella". A staff member told us, "There are not specific activity logs, but there should be some".

The provider had not ensured people's social needs had been assessed or met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection people were supported to attend a day centre and another person was supported by staff to have fish and chips for their lunch whilst they were out. One person told us that staff would support them to go to the shops and they had been on holiday to Hastings.

A staff member commented, "The care plans are unfocused, the paperwork could be improved". People had a "My plan" document, which gave basic personal information about the person, a brief life history, description of likes and dislikes and religious beliefs. There was a brief description of how people needed support each day. Guidance was missing for people when they had a specific health need. Documentation identified that support was required for specific needs, but was not personalised to explain how this should be provided by staff to meet the needs of the person. For example, a person's health need checklist said: Do I have mood swings? And was answered: yes, slight. There was no description to say what slight mood swings meant or how staff could recognise this. Another person's care plan stated they were prone to leg ulcers and required support to manage this. The guidance was not personalised and it did not inform staff how to support this person consistently. There were no additional risk assessment in place for staff to follow to support the person with this health need.

Records lacked detail and clear descriptions of how people could be supported safely. Records had not been regularly reviewed to monitor this. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Documentation was inconsistent in its quality. When objects were important to a person this had not been mentioned in their care plan. For example, a person liked to carry a soft toy with them to relieve their anxieties. There was no mention of this in their care file, which meant new staff or staff unfamiliar with the person would be reliant on being told this by other staff. Plans lacked personalisation and further detail to understand more about the person's other interests or goals. This meant people would be reliant on staff

who understood their needs and wishes well. Daily care records were brief and lacked enough detail to understand the support people had received throughout the day. For example, one person's day logs said, Monday: 'AM arts and crafts, PM did washing, had a shower'. Tuesday: 'AM karaoke, lunch, PM line dancing', and Wednesday: 'went to the shop, watched DVDs, went to bed early'.

Care plans and guidance lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences. This is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some documentation gave good detail about how staff could help support people with their basic needs and situations, such as personal care, communication, tenancy support, medication, eating and drinking, keeping myself safe, health and wellbeing, shopping, and managing my money.

One person told us, "My carer helps me, I have no complaints. I can talk to (acting manager) if I'm not happy. I have nothing to complain about". The service had a complaints policy, which included an easy read version for people. The policy gave timescales and details of who people could seek further help from should they be unhappy with the response they received from the service. A process checklist was also included to help people understand how complaints would be handled. One person said, "I can tell staff if I'm not happy". Another person said they would tell the manager and if the manager was not available another staff member whose picture they pointed to in a folder. People were given the opportunity to raise any concerns or complaints at their 'Your voice' meetings. People had documentation in their care files that gave details of how they could complain and who to in an easy read format. The provider had responded to complaints when they were raised and had investigated and sent outcomes of their investigation to complainants.

Requires Improvement

Is the service well-led?

Our findings

The provider did not demonstrate they had good oversight of the service. When shortfalls were highlighted at the inspection this was blamed on staff who no longer worked at the service. A health professional told us, "The service was very good up until the last 'long-term' manager left. Since then I have seen the service quality decline and there has been a rapid turnover of managers". The acting manager said that since they had taken up position things had been challenging and the paperwork in the office was taking time to get back in order. They commented, "I think there are things I can improve, there are some things I can't that have happened in the past. I think I've fallen down in educating the staff and making sure they understand. We need to educate ourselves". A staff member told us that they felt the service had not been well led and the safeguarding's found should have been reported. They said they had been given conflicting advice by different managers. Another staff member said, "There's been a lot of changes, which makes our job harder. Everyone has changed the way that we work. Things seem to be settling down now".

Leadership was lacking particularly at one of the shared locations we visited. A staff member told us, "I'm glad you're here, things will get better. I've been left alone before (acting manager) got here". Numerous incidents had gone unreported and people left at risk of repeating incidents. The provider had their own internal procedures for reporting incidents and we were shown evidence that they had discussed this with their management teams. However, internal systems had failed to identify the incidents, which had been uncovered at this inspection. Since the acting manager had been in post from January 2016 there had been an improvement, and incidents had been reported following the correct processes.

The provider had failed to notify the Commission of incidents which had resulted in harm to people. This is a breach of regulation 18 of the Health & Social Care Act 2008 (Registration) Regulations 2009.

Internal auditing had failed to identify the inconsistencies and missing information regarding the hours people were receiving and the lack of information in people's daily record logs. It was not clear if people were receiving the one to one staffing hours they were allocated as recorded logs were missing and inconsistently completed. The one to one staffing hours the provider gave us did not reflect what was stated in people's care files, and documents were conflicting. In one of the shared locations people's one to one hours were combined with shared hours, records did not show how people had received their own hours, which were allocated to them. Daily notes were not detailed enough to understand how people's one to one hours had been used. For example, one person's daily notes stated Monday: '(Person) has had a quiet day in their room', and Tuesday: '(Person) has been helping around the house today'. There were no further details about their day recorded. The acting manager said people may save hours for special occasions or holidays, but this was not recorded. On the second day of the inspection the acting manager showed us folders she had made to improve the way in which one to one hours would be logged. One staff member had been using a person's weekly support and care record to log all of their own weekly hours not the one to one hours the person received. This demonstrated that staff lacked understanding about how records should be kept and the provider had failed to identify this.

Clear systems for staff to report accidents and incidents had not been embedded. The service was working

towards a more inclusive culture with shared values. Currently this was lacking, a staff member told us, "My values are to provide a good service to the people living here, these are my values, don't know what the values are of the service". A senior manager said, "We acknowledge things are out of date, paperwork. There's a lot of issues with rotas, daily notes need a high level of recording. We are getting external supported living training and working on capacity and consent. We have a clear action plan about how to improve. We are trying to embed the values of independence and building up staff confidence which has been knocked".

Senior management conducted monthly service reviews to highlight areas that needed to be improved. An action plan had been made in January 2016 to address areas that were in need of improvement and efforts had been made to tackle this. These included the acting manager applying for registration with the Commission, which they were in the process of doing, updating all staff files, ensuring staff do not work with individuals who have specific support needs without undertaking training, supervision and appraisals, and arranging team meetings. Staff recruitment files had been updated, but some gaps remained and most staff had received a supervision and an appraisal. The provider had not put measures in place to reduce the risk of staff who were lone working without the essential training to complete their role effectively. Staff from a neighbouring service were relied on to complete these tasks. This had an impact on people because responding to needs would be dependent on staff who were already providing support to people at another service.

The systems for assessing and monitoring the quality and safety of the service provided was not always effective. This is a breach of regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had 'my meetings' with staff, which encouraged them to have a voice about the service they received. Recordings of these meetings had been made, but lacked information when things were achieved when outlined as an area of improvement. The acting manager told us, "The staff just do it. You may be able to see from goals and aspirations, but we only started that this year". The provider's internal audits had highlighted the need to complete monthly audits of handover notes to ensure that recordings of all activities that individuals participated in, life styles, hobbies and interests were documented. Action was still needed to improve this further and the acting manager said following their action plan she needed to update the documents.

The provider had put in place a system for offering additional support to the acting manager. Senior management had booked dates to visit the service and be available to the staff team. One staff said, "We have staff meetings. I feel well informed about things". Another staff member said, "I feel well supported now, it's been difficult last 12 months but getting better". One staff commented, "(Acting manager) is good, no one has anything bad to say about them". There was an on call system for staff to use out of hours or when extra support and guidance was required. The provider employed a quality lead to visit the service and report on areas which required improvement. The provider had sent surveys out to staff in February 2016 to ask for their feedback about the service and how things could improve. People had been asked to complete questionnaires and results had been analysed in June 2015. Examples of questions people were asked included, "I am happy with the way staff help me", I can choose how to spend my time", and "I feel safe at the home".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the commission of incidents which had resulted in harm to people. Regulation 18(2)(e).

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were being placed at risk as health needs were not being consistently responded to effectively. The provider had not ensured people's social needs had been assessed or met. Care plans and guidance lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences. Regulation 9(1)(2)(3)(a).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to comply with the requirements of the Mental Capacity Act 2005. Regulation 11(1)(3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

There was a lack of assessment and records about how to keep people safe from individual risks, and unsafe medicine practice. There were ineffective reporting and recording of accidents and incidents Regulation 12(1)(2)(a)(b)(g).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have an effective system in place to ensure incidents of abuse were handled and investigated Regulation 13(3).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems for assessing and monitoring the quality and safety of the service provided were not always effective. Records lacked detail and clear descriptions of how people could be supported safely; records had not been regularly reviewed to monitor this. Regulation 17(1)(2)(a)(c).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There lacked effective and safe recruitment processes Regulation 19.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staff were not being deployed to meet the needs of people when they required this. Staff were inadequately qualified to provide support to people Regulation 18(1).