

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](http://www.craegmoor.co.uk)

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

The inspection took place on the 7 and 9 November 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 six 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. At the time of this inspection 31 people were using the service. 25 people lived in shared accommodation and six people lived alone in their own home. The number of people using the service had increased since the last inspection. Two of the shared homes were formally residential services within the providers group; they had de-registered in July 2016. People from these homes now received support with their personal care from Craegmoor Supporting You in the South East.

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. The regional manager was managing the service until a new manager was employed.

The service was last inspected in February 2016 where eight breaches of our regulations were identified. The safe domain was rated as inadequate and an overall rating of requires improvement was given at that inspection. The breaches of regulation related to notifications of incidents, person centred care, obtaining peoples consent, medicines, risk assessments, safeguarding, recruitment, leadership and staffing. The provider had made minor improvements, but more were needed in a number of areas, and not enough improvement had been made regarding keeping people safe and the management and leadership of the service. We found some new breaches of our regulations at this inspection.

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

The provider's processes for recording and responding to safeguarding incidents were not robust. Some incidents had not been reported to the correct professional bodies for further investigation.

People did not always receive all of their one to one hours of support; this meant they had been restricted in going out to pursue their outside interests.

The provider had not always appropriately checked new staff were competent to complete their roles

effectively before allowing them to work alone. Agency staff worked alone with people and had not been given enough information to understand their individual needs which impacted on the care that was provided. Staff did not have clear guidance to support people with their individual behaviour needs, this left people and staff at risk of harm.

Some staff training had lapsed or had not been completed. This meant people were not supported by staff who had the most up to date knowledge and skills to meet their needs. Staff had not received regular supervision to support their roles. The provider could not be assured that people were being supported well by staff as competency checks had not been conducted to assess this.

Peoples care plans did not always contain up to date information regarding their health needs, people had not been supported well with their weight management. People had been supported with the management of their other health needs such as attending outside health care appointments.

Staff were unable to deliver support to people in a person centred way because they had not been given up to date guidance or information. People were not always supported by staff who understood their interests or personal preferences well. During the inspection some people were not engaged in any activity and staff were not engaging or communicating with people.

Care plans were not up to date and lacked important information to help staff understand how to support people. Not all care plans had been reviewed and updated to reflect people's current needs. Some documentation gave good detail about how staff could help support people with their basic needs and situations. Some people were consulted about their care plans and how they wished their care needs to be met.

Communication between staff was inconsistent, there was little handover between staff at one shared house unless staff arrived early for shifts. This was of a greater impact if the staff member taking over a shift was a new agency worker, lone working with unfamiliar people.

The provider lacked oversight of the service, some of the concerns found at the previous inspection continued to be areas of concern at this visit. Record keeping was poor in areas such as complaints, care planning, and continuous improvement of the service. Whilst some improvements had been made there continued to be breaches of regulations that should have been identified by the provider.

Staff did not understand the ethos of supporting people in their own homes rather than in a residential service or how independence could be promoted. Staff had not been well consulted by the provider. Staff lacked understanding about the support they provided people and asked us for advice about how they should support people with specific areas of their life.

Recruitment processes were in place to ensure only suitable staff were employed. Checks made prior to new staff beginning work included references, health and appropriate identification checks to ensure staff were suitable and of good character.

People were supported to take their medicines safely; medicines were administered by trained staff.

Staff demonstrated they respected people's individual likes and preferences, they understood people's preferences and communication needs well. Staff engaged with people in a caring manner. People's privacy was respected; staff knocked on doors before entering people's homes and asked people if it was okay if we looked in their bedrooms.

The provider had a system for managing complaints. Although the provider had responded to complaints, the outcomes to these complaints had not always been recorded so it was not possible to see how complaints had been resolved to the complainant's satisfaction.

The regional manager had restructured the management of the service appointing three locality co-ordinators. This new structure had been in place for three weeks at the time of the inspection and staff reported positively about the change although it was too early to analyse how successful this was.

The regional manager had conducted some of their own internal audits since their appointment and had improved some areas. This included obtaining additional hours for locality co-ordinators to do paperwork, more staff being deployed to meet the needs of people in some of the shared houses and booking training for some staff in a specialised area.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in 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?

**Inadequate** ●

The service was not safe.

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

The providers systems for responding to safeguarding incidents were not robust.

There were not always enough staff to support people with their outside interests.

People received their medicines safely.

The provider's recruitment process ensured suitable staff were employed to deliver the care and support people required.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Some staff training had lapsed or had not been completed. The provided had not assessed the competency of staff.

Staff had not received regular supervision to support their roles or development.

Peoples care plans did not always contain up to date information regarding their health needs.

People had been supported to attend health appointments when this was necessary.

### Is the service caring?

**Requires Improvement** ●

The service was not consistently caring.

People were not always supported by staff who understood their interests or personal preferences well.

People did not receive support in a person specific way because information was lacking for staff to refer to.

Staff engaged with people in a caring manner, people's privacy was respected.

### Is the service responsive?

The service was not consistently responsive.

Care plans were not up to date and lacked important information to help staff understand how to support people in a person centred way.

People did not always have enough support to be able to do the activities they chose.

The provider had a complaints system in place and acted on complaints which had been made, but outcomes had not been recorded.

**Requires Improvement** ●

### Is the service well-led?

The service was not well led.

The service lacked oversight; staff did not feel well consulted by the provider and had not been provided with enough information to complete their roles effectively.

Internal systems for monitoring the quality of the service had highlighted failings but little action had been taken to improve areas of concern.

The regional manager had started to take action to improve the service but it was too early to tell if this had been effective.

**Inadequate** ●

# 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 the 7 and 9 November 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 on the first day and one inspector on the second day.

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. The provider had not had the opportunity to complete a Provider Information Return (PIR) as they had not received this document before the inspection. 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 collected this information throughout the inspection.

We visited 17 people who used the service in four of the shared locations. We spoke to 11 staff, three agency workers, and the regional manager. Before the inspection we received feedback from one healthcare professional. Not all people were able to express their views due to communication difficulties; 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, accident and incident records and quality assurance information.

# Is the service safe?

## Our findings

A person told us they felt things were going better but they did not go out that much because they had lost their confidence following a fall. Up until the last few weeks the only vehicle to take them out had a broken step which made them feel unsafe. Another person told us staffing was getting better but if only one or two staff were available they could not go out. They wanted to go out more but this was dependent on the availability of staff.

At our last inspection in February 2016 we found that people had not been protected from abuse and safeguarding incidents had not been reported appropriately which was a breach of Regulation 13 of the Health and Social Care Act 2008.

At this inspection we found safeguarding incidents were still not being reported to the local authority. Incidents related to people being either verbally or physically abused by other people using the service. Staff did understand the process of reporting incidents of abuse, however the provider had not ensured information which had been reported had been passed on to the appropriate professional bodies for investigation and notification. The regional manager said the unreported incidents had not been correctly analysed. Although the incidents had been recorded on the provider's internal system, the incidents had not been reported to the local authority which had been an oversight.

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

At our last inspection we found that action to protect people from known risks had not been taken which was a breach of Regulation 12 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

Three people had mobility issues and sometimes required staff support to help them move. Staff did not have adequate risk assessments to follow when assisting people and had not been trained in the practical elements of moving and handling. Staff told us they assisted one person by lifting them under their arms which was the incorrect way to help someone move and could cause them injury. We raised this as a concern with the regional manager who was unaware this was happening. They said they were going to take immediate action to retrain staff and implement updated risk assessments. This person should have had specialised equipment to help them move. Staff told us the equipment was not used to help the person to move and they did not know where it had gone.

One person's care plan had been updated in October 2016. They had mobility problems and had an upstairs bedroom; staff said the person had previously had a fall down the stairs. No risk assessments had been implemented to reduce the risk of this happening again. There was no instruction to tell staff if an ambulance should be called or if the person could get themselves up again if they fell. The regional manager told us they did not know about this incident and risk assessments needed to be implemented and

updated.

Staff did not have a clear understanding of how people should be supported to minimise risk to themselves and others. For example, an agency worker told us that one person who always needed support when going out would tell them when they were going to the shops alone. There were no guidelines or risk assessments in place for staff to follow. This person had been involved in an incident whilst they had been out shopping on their own.

Another person displayed behaviours that meant they were at risk of harm from the environment. Staff were aware of this however we found that this person had access to areas of their home that required repairing and could pose a risk to their safety. Staff told us that they had been told various things by different managers and were not sure what the correct guidelines were when supporting people.

Some people needed help and assistance to leave their home in the event of an emergency. Individual personal emergency evacuation plans (PEEPS) should establish people's support needs and how they may respond to an emergency situation. Five PEEPS lacked enough information to inform staff how people should be supported in the event of a fire. One person's assessment stated, '(Person) is likely to refuse to leave if scared. It may be essential to use manual handling to ensure (person) leaves the building. This may result in (person) becoming aggressive due to panic and fear'. There was no further information of what manual handling meant or how staff could specifically support the person which placed them at risk.

One person's care plan stated they should have the bottom of their feet checked every day so referrals to the doctor could be made if any areas of concern were found. A staff member said the person had been refusing to have checks on their feet for about a month. Although the person was due to attend their doctors the following day no further action had been taken to monitor this since the person had started to refuse support. The last recorded check of the person's feet was 3 December 2015.

The provider was still not properly assessing or mitigating risks to people's health and safety. There were ineffective reporting and recording of accidents and incidents. This is a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not ensured that staff were deployed effectively which had impacted on people's ability to leave their home when they wanted to. This was a breach of Regulation 18 of the Health and Social Care Act 2008.

At this inspection we found that staff numbers had improved in some of the shared houses although people in other shared homes did not always have enough staff to support their social needs. The provider had deployed additional staff at three of the shared houses which was an improvement from the last inspection when only one staff member was available at specific times throughout the day. The regional manager said they allocated staffing numbers by counting the one to one hours and shared hours people were commissioned for. In one shared home people did not always receive their one to one hours because only one staff member was deployed through the day and night and supported other people. A staff member said, "If (person) decided they wanted four hours to go to Canterbury for their one to one they wouldn't be able to because I couldn't leave the other person at home alone, they would have to come too and they don't always want to do this".

Staff did not understand what one to one or shared hours were specifically for and were unable to tell us exactly how many individual hours' people should receive every week. It was difficult to understand how peoples one to one hours were allocated at three of the shared houses because only one rota was used to

deploy staff. The rotas did not specify when staff were providing people with their own specific hours of support.

The regional manager said there was a mixture of shared hours and one to one hours but the only way to track if people had received their specific one to one hours was to read their individual daily reports. We tracked one person's weekly planner which outlined when they should receive their allocated one to one hours to do activities. On the 27 October 2016 their planner stated they were going on a trip to Hastings. Daily records confirmed this outing had not happened and it was unclear how the person got their unused hours back. At another shared home people's freedom to leave their home was restricted because only one staff member had been deployed to support people. Staff said it was not always possible to support people with their chosen outside activities due to other people refusing to attend.

The provider had not ensured that there were sufficient numbers of suitably qualified, skilled and experienced staff deployed to fully meet people's needs. This is a continued breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection people were not protected as recruitment procedures were not robust. The provider had taken action to improve this and recruitment was no longer a concern at this inspection. Recruitment processes were in place to ensure only suitable people were employed. Employment gaps had been explored, references and photographic identification obtained and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with adults. Permanent staff renewed their DBS checks every three years so the provider could be assured they continued to be suitable for their roles. Other checks made prior to new staff beginning work included references, health and appropriate identification checks to ensure staff were suitable and of good character.

At our last inspection we found that not all staff had been trained to administer medicines. There was insufficient guidance available to inform staff how people should receive their medicines safely which was a breach of Regulation 12 of the Health and Social Care Act 2008. We found that improvements had been made in this area and was no longer a concern at this inspection.

Some people could independently manage their medicines whilst other people required support from staff. Daily and weekly audits were conducted by staff and the locality co-ordinator, this ensured all medicine was accounted for and safely administered. Regular audits monitored errors and temperature checks to ensure safe storage of medicines had been completed. Since the locality co-ordinator had taken up post they had begun to competency check staff that administered medicines. One person had been bought paracetamol by staff for minor pain relief. This had not been prescribed by the person's GP and no guidance was in place to tell staff when the person should be given this. This was an area that required improvement.

## Is the service effective?

### Our findings

A staff member said, "I have done half my training and have six more to do. I have completed Mental capacity training, fire, cyber security and IT safety. I think I need to re-book on to medicines but I've been competency checked. The locality co-ordinator is doing my supervisions".

At the last inspection we found that not all staff had received all of the required essential training to meet people's needs. New staff had not completed all essential training and staff had not been regularly competency checked to ensure they supported people appropriately. This was a breach of Regulation 18 of the Health and Social Care Act 2008. Staff training and supervisions continued to be a concern at this inspection.

There were 10 vacancies in the staff team with four new staff currently going through the recruitment process. Gaps in shifts were being covered through the use of agency staff. Where possible only agency staff familiar with the service were used but this was not always the case. One person told us they were not happy with the number of agency staff used and they did not like a "Stranger" sleeping in their house. Some agency staff worked alone with people and had not been given enough information to understand their individual needs which impacted on the care that was provided.

The provider had not always appropriately checked new staff were competent to complete their roles effectively before allowing them to work alone. A staff member told us they had been given a two day induction before beginning to work on shift, they had passed their probationary period after three months but had not received any formal supervisions or competency checks before the probationary review had been completed. New staff completed the provider's in house induction workbook as part of their induction when beginning employment with the service. The workbook was signed off by a senior member of staff; staff were also supposed to complete training which was essential to their role throughout their induction although this had not always happened. New staff were completing the Care Certificate to supplement the provider's own induction. The Care Certificate is an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

Some staff training had lapsed or had not been completed. This meant people were not supported by staff who had the most up to date knowledge and skills to meet their needs. Only two staff had received basic life support training. The provider had booked some staff onto a basic life support course and emergency first aid training in January 2017 but all other staff were untrained in this area. Although some staff had received theory training in moving and handling people they had not been practically trained to support people appropriately. Staff told us they used moving and handling techniques that were unsafe and could cause harm to people.

Some people had specific conditions such as epilepsy, diabetes, mental health issues and Prader-Willi syndrome (PWS). PWS is a rare genetic condition that causes a wide range of problems including a constant desire to eat, and behavioural problems. Not all staff had received training that was relevant to the people they were supporting. For example only three staff had received mental health training, and six staff had

received epilepsy training. There were no recordings of staff receiving any diabetes or PWS training although a staff member said they had attended PWS training but a long time ago and another newer staff member said they were attending diabetes and epilepsy training as part of their induction.

Staff had not received regular supervision to support their roles. Five staff had received one supervision in 2016, three staff had received two and six staff had received three supervisions. The provider's policy stated that staff should receive supervision at least every eight weeks. Staff did not have daily contact with senior management so regular supervisions were vital to allow them the opportunity to discuss their roles and development. The provider could not be assured that people were being supported well by staff as competency checks had not been conducted to assess this. Most staff had received their annual appraisal in 2016. Some staff said they felt well supported whilst others, who mostly worked alone said they had been left without much support or guidance and needed more.

Staff did not have clear guidance to support people with their individual behaviour needs, this left people and staff at risk of harm. One person had an incident in October 2016 of verbal and physical aggression towards other people and staff. There was no available behaviour support plans in the persons care file to direct staff of the intervention strategies they should take. Agency staff frequently worked alone with the person. Another person's care plan said they had been known to self-harm in the past and staff should check the person regularly for any signs of this. The guidance document had not been dated or signed by any staff to demonstrate it had been read. The document stated, 'Staff should check the person daily after their hygiene routine in the morning and evening'. One staff said they did not do this but checked the person after their medicines, they did not think other staff followed the guidance. The staff member told us that although the person had not self-harmed for a while a particular object should not be made available to the person. The care plan made no reference to this and agency staff lone working with the person would be unaware unless verbally told by permanent staff.

The provider had not ensured that staff were suitably qualified, skilled and experienced to fully meet people's needs. The lack of adequately trained staff is a continued breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were encouraged to gain qualifications in health and social care while working at the service. 16 staff had obtained a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

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. At our last inspection we found that capacity assessments had not always been made. Where people lacked capacity the MCA had not always been followed appropriately.

People's capacity had been assessed and best interest decisions had been recorded to demonstrate how people were being restricted in the least restrictive way. One person did not have access to their medicines which only staff were able to access but no assessments or best interest decisions had been documented. This was fed back to the regional manager who said they were going to review this and take the necessary steps to comply with the Act; this is an area that needs to improve. There had been some good work

completed when people chose to take risks and people were given information to make their own informed choice. For example one person's risk assessment said they had made a decision to smoke. They were aware of the risks and were supported by staff, their GP and nurse to understand the consequences this could have on their health. Staff understood that it was the person's right to accept certain levels of risk and would support the person to understand the consequences of their actions.

At the previous inspection the provider had been in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. People had not been well supported to manage their health needs. This continued to be a concern at this inspection.

One person had declined a check-up with their optician in June 2016; there were no records of any further appointments being made for the person. Some people had healthcare passports which gave a good description of people's basic needs. However, one person's healthcare passport did not fully contain up to date information. The healthcare passport said the person required no support to manage their continence although staff told us they were sometimes incontinent at night and required support with this.

One person was very low in weight although staff did not know their exact current weight because weight checks had not been made. This placed the person at risk because any further weight they lost was not being monitored. A senior staff member told us the person had always been of a slim build but this had not been reflected in their care plan. Staff said the person had seen a dietician but had not been prescribed any food supplements. Staff did not have a good understanding of how they could provide the person with additional calories to reinforce their daily food intake and asked us what this was. This did not demonstrate the provider had a good oversight of supporting people with their weight management; this is an area which requires improvement.

People had been supported with the management of their health issues. Staff told us that previously people had missed some of their healthcare appointments due to the number of staff available, but since more staff have been deployed people were always able to attend their planned health appointments.

The regional manager said they had been trying to embed a more independent way for people to have control over their meals. At some of the shared homes people still ate their meals together although they had been recently given their own food cupboards so they could manage their own meals.

## Is the service caring?

### Our findings

A person said, "I like going on trips and outings, I like the staff but they don't always help when they are busy". A staff member said the felt things had greatly improved for people since becoming a supported living service. Staff had been trying to support people to do more for themselves such as bringing their laundry down, helping prepare meals and being involved in administering their own medicines.

Staff were unable to deliver support to people in a person centred way because they had not been given up to date guidance or information. This was a particular concern at one of the shared homes where people were frequently supported by agency staff who worked alone. People were not always supported by staff who understood their interests or personal preferences well.

People had not always been supported well when they expressed an interest or wish. For example a person's care file had documented in April 2016 that the person wanted to make a memory book to put photos of their family and other memories into. The person had not been supported to achieve this aspiration although their relative had given them photographs. There had been no follow up recorded as to why this had not been achieved. During the inspection some people were not engaged in any activity and staff were not engaging or communicating with people. This is an area that needs to improve.

Other staff demonstrated they respected people's individual likes and preferences. One person enjoyed to do art work which staff helped them with, other people and staff sat together talking in a relaxed way. Staff demonstrated they understood people's preferences and communication needs well, staff engaged with people in a caring manner. For example, one person sat at a table with their personal items around them. Staff assisted the person to communicate with us; they encouraged the person to do this independently but intervened when it was unclear what the person was trying to tell us. Staff explained the person liked to look out the window and watch what was happening outside while writing in their books, listening to their CD or watching specific programmes on the television.

One 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. One person said they wanted to go to the shop with staff and other people. A staff member told the person there was no rush and to finish their cup of tea first. The person said they were happy, and staff supported them well.

People were supported to make their own choices and decisions, for example one person said they wanted to purchase a new CD player, the locality co-ordinator said that was not a problem and they were going to help the person to achieve this. People's privacy was respected; staff knocked on doors before entering people's homes and asked people if it was okay if we looked in their bedrooms. Staff waited for consent before entering people's personal space. People were able to freely come to the office to talk to the senior staff when they wished. People were supported to obtain advocates when they needed help with specific or complex decisions.

## Is the service responsive?

### Our findings

One person told us they were a lot happier and were getting more attention from staff. They could help around the house, do some cooking, help with laundry, go to the cinema more, have takeaways and were now going to table tennis which was something they really wanted to do previously. Staff talked with them about their care plan and they enjoyed having more staff available and doing more things. They said agency staff had been good, and they felt able to raise issues if unhappy. A staff member commented, "Life is absolutely better than before, people did nothing then and only went to the company day care".

At the previous inspection the provider had been in breach of Regulation 9 of the Health and Social Care Act 2008. 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. The provider had not ensured people's social needs had been assessed or met. The provider was still in breach of this regulation.

Agency staff did not have up to date guidance in the care plans to follow to be able to support people with their needs well. Documentation was inconsistent in its quality, an agency worker said, "I can't rely on the support plans as they are out of date. There are no risk assessments around (persons) money or going to the shops. I haven't had any guidance; I do the best I can". Another staff member said, "(Person) can make some loud noises which I know are not anything to worry about but it's not in their care plan to inform other staff". Agency staff frequently worked alone with this person. Care plans were not up to date and lacked important information to help staff understand how to support people in a person centred way. One person had mental health issues, their care plan lacked information of how this affected them and what action staff should take to support the person in the most appropriate way. The impact this had on the person was minimised as staff who usually worked with them understood them well. The regional manager had started to improve care plans and had allocated specific time for the locality co-ordinators to review and update documentation. Some care plans had been reviewed and updated, others had not been reviewed or updated to reflect peoples current needs and were a work in progress.

Not all people were able to independently leave their home to pursue their interests, and needed staff to support them to do this. Opportunities for people to attend outside activities were restricted at some of the shared locations because there were not enough staff available. During the inspection some people were supported to go to the bank, have lunch out, and attend a day centre.

Some Care plans and guidance documentation lacked sufficient detail to inform staff of how people required support to meet their needs and reflect their personal preferences. People could not always pursue their outside interest because there were not enough staff available. This is a continued breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication between staff was inconsistent. In some of the shared locations staff did not use a diary or communication book to keep track of when people's appointments had been arranged, when people expected visits from outside healthcare professionals or any other important information staff should be aware of to help support people. A staff member told us that they had left a note for agency staff that lone

worked outlining the things they needed to know but this had gone missing. There was little handover between staff at one shared house unless staff arrived early for shifts. This was of a greater impact if the staff member taking over a shift was a new agency worker, lone working with unfamiliar people.

Some documentation gave good detail about how staff could help support people with their basic needs and situations, such as personal care, social interactions, hobbies, key skills and personal preferences. For example in one person's file it stated the person did not like their birth name and preferred to be called by a different name which staff were aware of and respected. Some people were consulted about their care plans and how they wished their care needs to be met.

The provider had a system for managing complaints. When concerns or complaints were made these were recorded. Although the provider had responded to complaints the outcomes to these complaints had not always been recorded so it was not possible to see how complaints had been resolved to the complainant's satisfaction. A complaints policy was available for people to use if they were unhappy with any aspect of the service; an easy read format was available for people who may need it. People were encouraged to express their views and provide feedback so the service could continuously improve. People had 'My meetings' where they could discuss any problems they may have or what they wanted to change to make things better. One person had raised concerns about rubbish that had been left in the garden and about the bathroom facilities. Although action had been taken to try and solve the issues raised the person had not been supported to report their concerns using the formal complaints process. This is an area that's needs to improve.

## Is the service well-led?

### Our findings

A staff member said, "We need a manager here, the regional manager is only a phone call away but if you want to discuss something trivial or run something past them you tend not to. You can raise issues with the locality co-ordinators but they are new in post and cannot do much so I don't bother to raise some things".

At the previous inspection the provider had been in breach of Regulation 17 of the Health and Social Care Act 2008. The systems for assessing and monitoring the quality and safety of the service provided was not always effective.

The provider had not taken enough action to improve this. In August 2016 an internal inspection had been conducted by the provider. A report was produced to outline what improvements the service had made and what areas of improvement were still required. The report highlighted that risk assessments and care plans were insufficiently detailed. People's weight had not been monitored and additional health tools had not been used as per the company policy to monitor people with risks relating to their weight. Quality assurance systems were seen to be lacking at the service and evidence was not seen that unannounced visits had taken place and feedback had not been obtained from the people that use the service, and their family. The regional manager said this had been improved and people now received 'My meetings' but action had not been taken when issues were reported. Surveys had not been given to relatives or outside professionals to complete. During this inspection we found the same concerns. Little action had been taken following this report, and the areas identified as a concern remained so.

The provider lacked oversight of the service, some of the concerns found at the previous inspection continued to be areas of concern at this visit although the provider had made improvements in other areas such as medicines and recruitment. The registered manager left the service in September 2016 and the regional manager had been appointed to manage the service in October 2016. Because of their other responsibilities they could only visit the service twice a week. They were available by telephone should staff need to contact them for advice or support. The regional manager had restructured the management of the service appointing three locality co-ordinators. Locality co-ordinators were assigned specific shared homes to be in charge of which provided staff with improved support. This new structure had been in place for three weeks at the time of the inspection and staff reported positively about the change although it was too early to analyse how successful this was.

Staff did not understand the ethos of supporting people in their own homes rather than in a residential service. Staff had not been well consulted by the provider when the residential services had ceased to operate and peoples support packages had transferred into this service. Staff had not grasped how support should be delivered to people to promote their independence. A staff member said, "I asked if we were going to have training in supported living. I don't have a great deal of knowledge about supporting living". Staff lacked understanding about the support they provided people and asked us for advice about how they should support peoples with specific areas of their life. For example a staff member asked if they were allowed to leave a person alone in their home. They had been told by a senior manager they could but felt the person was at risk so were not comfortable doing this. Another staff member said, "I've been totally

confused, each manager has told us different things". A staff member said, "It's a lot better now the locality co-ordinator is here, before it was down to me and supervision had not happened much". Not all staff within the service had benefited from regular team meeting. One staff told us that staff meetings were infrequent and they were not consulted by the management about changes. Record keeping was poor in areas such as complaints, care planning, and continuous improvement of the service. Whilst some improvements had been made there continued to be breaches of regulations that should have been identified by the provider.

Although the provider had internal processes for recording and reporting incidents this had not always been followed and incidents had not been reported to the appropriate professional bodies. Internal systems had failed to identify the unreported incidents, which had been uncovered at this inspection. The provider had failed to inform CQC of notifiable incidents involving people who used the service.

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

The regional manager had conducted some of their own internal audits and had identified that positive behaviour training was needed for some staff who supported a person with specific behaviours which had become more challenging towards others. They had booked the training through the provider and were awaiting a start date. The regional manager had negotiated specific weekly office hours for the locality co-ordinators so they could concentrate on updated the care plans. They had also arranged additional staff to be deployed to meet the needs of people in some of the shared houses. The newly appointed locality co-ordinators had started to conduct weekly checks on medicines, moneys, rotas and hours, and staff knowledge although it was too early to assess what positive change this had made. A locality co-ordinator said, "Before, the staff were not recording money properly so it looked like money was tampered with but the recording were just bad".

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>Some Care plans and guidance documentation lacked sufficient detail to inform staff of how people required support to meet their needs and reflect their personal preferences. People could not always pursue their outside interest because there were not enough staff available Regulation 9(1)(2)(3)(a).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider was not properly assessing or mitigating risks to people's health and safety. There were ineffective reporting and recording of accidents and incidents Regulation 12(1)(2)(a)(b)(h).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider did not have an effective system in place to ensure incidents of abuse were handled and investigated Regulation 13(3).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had not ensured that there were sufficient numbers of staff who were suitably</p>

qualified, skilled and experienced to fully meet people's needs. Staff were inadequately qualified to provide support to people Regulation 18(1).

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 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 Regulation 17(1)(2)(a)(b)(c)(e)(f).

### The enforcement action we took:

A warning notice has been issued in regards to regulation 17. The provider has failed to ensure the service is well led and managed resulting in a negative impact on the people using the service.