Optima Care Limited

Manston

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on the 6 and 7 April 2017 and was announced.

Manston is a service registered to provide personal care to people living in their own homes. People were all living in supported living services, and had their own tenancies. The service supports adults who have learning disabilities, physical disabilities and mental health needs throughout East Kent. At the time of the inspection seven people were receiving a personal care service.

We last inspected this service in August 2016. We found significant shortfalls and the service was rated Inadequate and placed into special measures. The provider had failed to inform CQC of notifiable events. Suitable means of communication were not provided for people on a consistent basis. People's care plans did not contain ways of maintaining or increasing their independence. People and their relatives were not involved in updating their care plans or making decisions around their care. People did not receive care that reflected their preferences. Staff did not have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and had made decisions on people's behalf without seeking their consent or a less restrictive option. Care and support was not provided in a safe way to people. People were not receiving their medicines safely and in line with the prescriber's instructions. Complaints were not investigated and necessary and proportionate action had not been taken as a result. The provider had failed to assess, monitor and improve the safety of the service. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each person. The provider had failed to seek and act on feedback from relevant persons. There was a lack of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This service was placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us regular information about actions taken to make improvements following our inspection. At this inspection we found that improvements had been made in many areas, however there were still areas where improvements were required.
There was a registered manager in post. They had been employed since our last inspection. 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.

Staffing levels had improved since the last inspection, and some people now received consistent support from the same permanent staff. However, there were a large number of staff vacancies so the provider used temporary staff from another agency to cover the shortfalls. Some people regularly received support from temporary staff from a different agency. Incidents had occurred when people were being supported by these temporary staff and people's behaviours that challenge had escalated. The incidents had not been

managed effectively by staff. Staff had called the police for support during some incidents rather than try to prevent the behaviour occurring using techniques of positive behaviour support. There was guidance in place to assist staff with supporting people with behaviours that challenged. Other risks relating to people's care and support were now managed effectively.

There was a lack of oversight of the temporary staff being used to support some people. One person received support almost entirely from the temporary staff; they had not been consulted about or supported to change their support provider. The registered manager told us they regularly spoke with this person about the support they received but these conversations were not recorded and no formal quality assurance was carried out.

Some people required emergency medicine to be administered if they had an epileptic seizure. Staff had not all been trained in how to administer this medicine and people were regularly being supported by staff working on their own who had not had this training. There was a risk people would not get their medicine when they needed it to stop their seizures. The registered manager arranged training on the second day of the inspection and subsequently confirmed people were only receiving support from staff trained to administer their medicines.

Relatives and social care professionals told us they had raised concerns about the consistency of staffing and a lack of activities for some people, but there was no record of these complaints or the action taken. The registered manager told us that these complaints had not been recorded as they had not been raised as formal complaints and they would meet with relatives that had concerns.

Checks and audits had been completed but they had not identified the concerns that we highlighted at this inspection.

When people received consistent support there was a positive, person-centred culture and staff were kind and caring. People received the assistance they needed to access the activities of their choosing and staff supported people to use a range of communication methods to help them make their needs known.

Staff had the induction and training needed to carry out their roles. Staff had received training in how to manage people's behaviours safely, and how to prevent behaviours from occurring. Staff met regularly with their manager to discuss their training and development needs.

Staff had sought advice and guidance from a variety of healthcare professionals to ensure people received the best care possible. People were supported to prepare a variety of different meals.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). In supported living applications for DoLS are made to the Court of Protection. DoLS are a set of checks that are designed to ensure that a person who is deprived of their liberty is protected, and that this course of action is both appropriate and in the person's best interests. The registered manager had made some applications to the Court of Protection but these had not yet been authorised. Staff had up to date knowledge on the Mental Capacity Act 2005 (MCA) and DoLS. They supported people to make their own choices.

Both people and staff told us they thought the service was well led. The registered manager was experienced in working with people with learning disabilities and providing person centred care. The Care Quality Commission (CQC) had been informed of any important events that occurred at the service, in line with current legislation. Staff were recruited safely. The registered manager had reported any safeguarding

concerns to the local authority and these had been investigated fully.

Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of regulations .The service will therefore remain in special measures. We will continue to monitor Manston to check that improvements continue and are sustained. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

Temporary staff were being used to cover shortfalls, however, they did not know people and their needs well.

People received inconsistent support to help manage their behaviours and this had resulted in incidents occurring.

Staff had not been trained to administer people's emergency medicine.

Staff knew how to recognise and respond to different types of abuse. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received induction, training, and supervision to support people effectively. However, not all staff had the skills needed to give people effective consistent support.

Staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to make day to day decisions about their lives.

People were supported to see a variety of healthcare professionals.

People were supported to plan and prepare a variety of different meals.

Is the service caring?

Good

The service was caring.

People said staff were kind and caring.

Staff knew how to communicate with people and supported them to make their needs known.

People were treated with dignity and respect. Staff knocked on people's doors and always asked them if they wanted support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Access to activities was inconsistent and varied depending on if staff knew people well.

Care plans had been updated and were person-centred.

Some relatives had raised concerns but these had not been responded to fully.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and staff told us the service was well-led but it was too early to see that improvements had been embedded or sustained.

There was a lack of oversight of temporary agency staff providing support to people. Checks had not highlighted the issues we identified at this inspection.

The Care Quality Commission had been notified of important events within the service, in line with current legislation.

Staff were aware of the provider's values to provide person centred care.

Manston

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 6 April 2017 when we visited people in their homes, and on 7 April 2017 at the registered office of the domiciliary care agency (DCA). The provider was given 48 hours' notice of our visit to the DCA office so that someone would be available to help us access the records required.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received from the local authority and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

At the office of the DCA we spoke with the registered manager, one senior member of staff and the human resources manager. We also spoke with one team leader, six members of staff, three people and one relative.

We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance audits. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experience of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

After the inspection we spoke with the local authority safeguarding and commissioning teams. We spoke with one additional social care professional and three relatives about the service.

We last inspected this service in August 2016. Breaches in the regulations were identified at this inspection.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe when staff were in their homes supporting them. One person said, "There is staff here to keep me safe." Another person said, "Oh yes, I'm safe as I get help here in my flat." A relative told us, "I think [my loved one] is very happy and settled...I pick up [my relative] every other weekend and after their home visit they are happy to go back." However, a lack of consistent support staff meant that some people were not always supported in a safe way.

At our previous inspection, we found there was a lack of consistent staff which meant people did not always receive the care and support they needed to keep them safe. There was a high use of temporary staff from another agency due to the number of staff vacancies. Although at this inspection, some improvements had been made, and people living in one bungalow received consistent support from regular staff, other people regularly received support from another agency and incidents had occurred when temporary agency staff were supporting people and people had not received the right support. People had displayed behaviour that could be challenging and staff had not responded effectively.

One relative told us, "There is more regular care staff, but there is still quite a lot of agency…I'm not sure if some of the agency staff are skilled enough to manage." A staff member told us, "I don't like that it [the use of agency staff] does not give the consistency. It has improved, and I am sure it will continue to do so, but it is happening slowly."

One person received support almost entirely from another agency. Although the registered manager and their relative told us that this was the person's choice, and records showed that the other agency was providing consistent staffing, there was a lack of oversight of these temporary agency staff by the provider. The person had not been supported or consulted about liaising with the other agency directly.to change their support provider.

At our previous inspection, risks relating to people's care and support had not always been adequately assessed and clear and accurate guidelines were not always in place to help staff manage these risks. Some people did not have behavioural support plans in place so there was no guidance available for staff to follow to show what triggers to avoid and how to diffuse or divert situations before they happened. At this inspection, improvements had been made. There were now behavioural support plans in place for people who displayed behaviours that challenged. In one bungalow we observed people being supported positively. Staff acted quickly when people became distressed or anxious and offered them reassurance when necessary.

However, although there was guidance in place, people living in another bungalow did not always receive consistent support with their behaviours. Staff did not always respond appropriately to these people's behaviours and did not act quickly to diffuse or de-escalate situations. The police had been called on several occasions because agency staff had not responded effectively when a person had initially become distressed. On one occasion a person had become anxious because their gardening equipment needed replacing. Agency staff did not assist the person to go out and purchase new equipment. The person asked

staff supporting people living in an adjacent bungalow to assist them with buying new equipment. They were unable to and the person became so distressed they started throw stones at the window of the adjacent bungalow and at staff's cars. The police were called as a result.

One person's care manager told us, "I don't feel the service are doing enough to support [person] with their behaviour" and, "They need permanent staff who are appropriate, that can take people out on activities, and ensure they are engaged fully." A relative told us, "They are a specialist service dealing with more challenging people but where they have agency staff they are nothing more than babysitters."

When behavioural incidents occurred these were still not analysed fully to identify why they had occurred and if anything could be put in place to prevent them from happening again. There was a risk that people would continue to receive inconsistent support as a result.

Some people required assistance when they became distressed or anxious. There were clear guidelines for staff to follow using the least restrictive techniques to help people regain control of their feelings and the situation. Staff had to sometimes physically intervene to help keep people and other people safe. Staff explained how they prevented people from becoming anxious and how they responded if people became upset and emotional. There were clear guidelines in place for staff to follow to keep people safe but they had not always been followed. There was an incident where a staff member was injured. The registered manager had held a debrief meeting with staff to see what could be learnt from the incident. In other instances, agency staff had phoned the police when people became distressed, instead of following their guidelines. Staff said that it was necessary to work as a team, support each other and be confident. One member of staff told us, "We are constantly tested so you have to hold your ground and follow the plans."

People did not receive consistent support with their behaviours and these were not always managed safely. The provider had not ensured that people had support from trained, competent staff, This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks relating to people's care and support were now managed effectively. Some people had previously been in trouble with the police as they had difficulty understanding relationship boundaries. They were assessed as requiring one to one support when out in the community, and there were clear risk assessments and guidance to tell staff how to support people with understanding relationship boundaries. There was now a detailed 'risk management plan' that was specific to each person and staff. This covered a range of areas including fire, lone working and infection control.

At the last inspection, staff had not been trained to administer people's emergency medicine to help them recover from a seizure. At this inspection some staff had received this training, however there were still multiple instances when staff that had not been trained were supporting people on their own. People had been hospitalised due to prolonged seizures in the past, and there was a risk they may not receive the medicine they needed to prevent this from happening.

We discussed our concerns with the registered manager on the first day of the inspection. They changed the staff rotated to support people over night to ensure they were trained and competent to administer people's emergency medicine. On the second day of the inspection a training session was held for staff so more knew how to safely administer this medicine. The registered manager confirmed that people would only be supported by staff trained to administer their emergency medicine going forward.

People were at risk of not receiving their emergency medicine. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, there had been a number of medicines errors when staff had not given people the medicine they were prescribed and had not completed medicines records accurately. At this inspection, improvements had been made.

There were now appropriate arrangements in place for staff to support people with obtaining, recording, administering and disposing of prescribed medicines. One person told us, "I'm ok to swallow my pills on my own, but staff help me when I need them to." Medication Administration Records (MARs) were now fully completed, showing people received their medicines as and when they needed them. Some people had medicines on an as and when basis (PRN). There was clear guidance in place so staff knew when people might need these medicines and how much they should take.

At the previous inspection, we recommended that the provider review their recruitment procedures to ensure that staff they employed had any reasonable adjustments they needed and to ensure people had a say about who might support them. At this inspection some improvements had been made. Two recruitment files seen contained information about staff's medical history. However, two of the files seen contained a file note stating, 'meeting to be arranged to discuss adjustments needed.' We discussed these with the registered manager who stated they were not aware of the staff member's health declaration. The provider's human resources manager stated it, 'was on their list of things to do for next week.' A senior member of staff told us they were reviewing their HR processes to ensure individual managers had more control over staff processes. This is something we will follow up at our next inspection. People had been involved in meeting with potential staff and showing them their homes before they were recruited.

Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff knew how to recognise and report different types of abuse. They had received safeguarding training and information about abuse. Staff told us they would report any concerns to the registered manager. One member of staff said, "I'd talk to my team leader, then the registered manager. I could report it on the confidential phone line we have internally or go to the Care Quality Commission (CQC) or the local authority. Staying silent means you are just as bad [as carrying out abuse.]" Staff were confident that the registered manager would act on any concerns that were raised. The registered manager was aware of their safeguarding responsibilities. Referrals had been made to the local safeguarding authority when required and action had been taken to reduce the risks of incidents happening again.

Requires Improvement

Is the service effective?

Our findings

Relatives told us that people received effective care. One relative told us, "[My loved one] looks well cared for and healthy. They used to (have negative behaviours), but rarely does this now." People told us that staff accompanied them to appointments and supported them with their healthcare needs.

At our previous inspection, staff did not have the skills and competencies they needed to support people effectively and safely. Staff did not have the necessary knowledge or understanding about supported living and had not received training to enable them to carry out their role. Staff had not received necessary supervision and guidance from the provider. At this inspection, improvements had been made.

There was an ongoing programme of training which included face to face training and online training. Staff completed basic training in topics such as safeguarding, mental capacity and first aid. All of this training was up to date, and staff had been booked onto refresher courses in line with the provider's policy. Staff had also received training in topics specific to people's needs, such as communication and autism. Staff told us that the additional training they had received in communication had been extremely beneficial. When people needed assistance with their communication they now received the appropriate support. We observed staff using objects of reference and pictorial communication aids so people were able to say when they wanted to go out and what they wanted to do. People were now in control of their environment and staff encouraged people to do things for themselves, such as cooking and cleaning, rather than doing things for them.

Staff now had an increased understanding of supported living and could explain the difference between people living in their own homes and residential care. One staff member said, "We were misled in the beginning, we were told there was no paperwork and we should just leave people be, that's not the case, but it's about encouraging independence." Another member of staff told us, "Everyone is different so the support they need is different, but supported living is around encouraging people to do things for themselves."

However, although the number of temporary agency staff had reduced since the last inspection they were still regularly providing support to some people. The registered manager and the provider had no oversight over these staff and could not ensure they had the skills needed to support people effectively. Agency staff had been supporting people independently without being trained to administer their emergency medicine and incidents had occurred when agency staff had not responded appropriately to people's behaviours. For example, when people had become distressed and physically and verbally aggressive. The registered manager had not reviewed the agency staff's competency.

Staff now received regular supervision and met regularly with their line manager. They told us they felt well supported and could go to the team leader if they had any issues in the first instance and the registered manager if needed. Staff had all had an annual appraisal, where they were able to discuss their training and development needs for the year ahead.

New staff worked through induction training during their probation period, which included working alongside established staff. The provider had introduced the Care Certificate for new staff as part of their induction, which is an identified set of standards that social care workers work through based on their competency. Staff talked about the training and support they received when they first started working for the service. There was a folder of information about people's needs and preferences to tell new staff and agency staff what was essential to help them support people safely as they got to know them. Temporary agency staff were included in the training session on how to administer people's emergency medicine on the second day of the inspection. The registered manager did not offer supervision to the temporary agency staff providing support to people.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In supported living an application must be made to the Court of Protection. Some applications for people had been made to the Court of Protection, and these were waiting to be authorised.

At our previous inspection staff did not all have a clear understanding of MCA. Decisions had been made about restrictions on people's behalf without considering the least restrictive option. At this inspection improvements had been made. Each member of staff we spoke with had a clear understanding of MCA. One staff member told us, "We give people choices and they choose what they want to do and how to do it. We're here to support, not make decisions for people." People were supported to make day to day decisions about they wanted to eat, wear and activities they wanted to participate in. Staff were all able to tell us who had Deprivation of Liberty Safeguards applications pending.

At our previous inspection people did not always receive the necessary support to manage their health care needs. People had not been supported to manage their mental health effectively. At this inspection, some improvements had been made. Referrals had been made to relevant health care professionals, such as psychiatrists and psychologists to ensure people received clinical help when needed. People's support plans contained information about their health conditions and action staff should take if people became unwell.

People were supported to eat healthily and participate in meal preparation, menu planning and shopping for food. Some people needed assistance with their communication and there were photo cards of different meals and every week staff sat with people to choose the menu. Staff knew people's favourite foods and were aware of people's dislikes and about any food intolerances

There were clear guidelines for staff to follow about how to support people if they needed help to eat. Health professionals had been involved when needed to help write thee guidelines. For example, one person was at risk of choking so there were guidelines in place to prevent this from happening and what to do if the person did choke. Staff explained that they avoided having large stocks of sweet snacks and drinks because this had caused people to get anxious and be tempted to over eat. People were supported to choose healthy snacks and if they wanted a treat then they were supported to go to the shops to buy them. People were supported to plan and prepare their own meals. People had the opportunity to eat out and go out for coffee regularly.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "[Staff member] she is lovely, and [staff member] is a really great girl, and [staff member] he always has a giggle, and [staff member] is awesome, and [staff member] and [staff member] always have good laughs and [staff member] and [staff member] is brilliant." A relative told us, "The core staff do a good job making it feel homely," and "The core staff on the ground are doing the best they can and are kind and caring."

At the previous inspection, suitable means of communication was not provided for people on a consistent basis. People's care plans did not contain ways of maintaining or increasing people's independence. People and their relatives were not involved in updating their care plans or making decisions about their support. At this inspection, improvements had been made.

Staff knew how to communicate with people effectively. Some people had notice boards with photo cards and books with photos in so that they could point to activities or if they wanted a shower or a snack. People used a mixture of these aids and signs to make choices and we saw people were able to initiate activities as well as respond to what staff were offering. People looked confident and comfortable in the company of staff and there were numerous, natural interactions where people were able to make their needs known.

Staff explained that people's communication skills had developed. People were using objects to refer to what they wanted, pointing to the photos and taking staff to different parts of their home to show them something. A staff member explained that one person was starting to speak more and in the right context. They told us, "Now [person] takes the car keys and says 'car' and then we go out." Staff explained, another person who previously used one gesture for everything "Now uses a hand to mouth gesture for drink and a hand to hand gesture for food." Our observations confirmed the improvements in people's communication skills and the positive, encouraging responses people received from the staff.

There were now formalised plans in place to increase people's independence and encourage them to work towards specific goals. Goals were set depending on people's current skills so that the next step was worked on. These included participating in meal preparation, elements of their own care and interests. People had learnt to make drinks, cook pasta with support and hand over money to purchase items. These achievements were then reviewed and a new goal was set to ensure people were continually working towards doing something new.

One person had a goal plan to learn to wait calmly, to help ease their anxieties and there were set ways that this was supported throughout the day. The person's key worker explained that this had led to an increase in the person's opportunities, as they were able to go out and wait in queues calmly, so they had been able to use the slide at the swimming pool, which they thoroughly enjoyed. The person had also been able to go out for a drink in the pub and wait until they had paid for it, sit down and drink it at a sociable pace.

People were encouraged to develop their own routines and people's preferences were supported. One person wanted to get up later than usual so staff checked they were well and waited. When the person got

up, they immediately got ready and signed that they wanted to go swimming and the staff acknowledged this and they went out to the swimming pool.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially. When we asked questions about people, staff were respectful and discrete when talking or talked where other people would not be able to hear.

Requires Improvement

Is the service responsive?

Our findings

One relative told us, "The team leader is in regular contact with me and discusses [my relative's] progress and any problems. They send me photos of them taking part in lots of activities. They go swimming regularly which they love and go on a variety of outings."

At the previous inspection, complaints were not investigated, and necessary and proportionate action had not be taken to resolve complaints. At this inspection, some improvements had been made. The registered manager showed us a complaints file which contained one complaint from a relative of a person no longer using the service. This had been investigated and responded to in line with the provider's policy. However, when we spoke with social care professionals and relatives they told us they had raised complaints with the registered manager but there was no record of these concerns. One relative said, "I will raise things, and as nice as the registered manager is, I don't feel like they are fully addressed. They may say they will look into it, and even call me back half an hour later, but I don't feel that they have been addressed fully." We spoke with the registered manager about these concerns and they told us that they had not been recorded as complaints therefore, there had not been a recorded investigation or resolution in line with the provider's policy. They told us they would meet with the relatives to discuss their concerns.

Complaints had not always been documented, investigated and responded to. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, people did not receive care that reflected their preferences and they were not always able to access the activities they wanted. At this inspection, improvements had been made.

When there was consistent staffing in place people received the care and support they needed, in the way they wanted. Staff had spent time with people and got to know their likes and dislikes and how they wanted to be supported. Preferences, with regards to people's personal care and daily routine were documented in their care plan. Staff had step by step instructions on what people did each morning and evening. However, this was not the case when staffing was inconsistent and temporary staff were supporting people. For example, social care professionals and relatives told us that inconsistent staffing had impacted on people's ability to go out and participate in the activities that they enjoyed. One relative said, "We want [our relative] to be safe, happy and doing stuff. They need encouragement to do that sometimes, but staff should have the relationships with [person] to be able to do that. That is just not always the case."

Staff showed us a task list they had devised to assist some people with cleaning their communal kitchen. They told us it was beneficial so people knew what they needed to do before they left their home each day. However, there were multiple gaps on the form and staff told us, "When we [regular permanent staff] are not here and certain staff are, it is not being done." People could became distressed when their morning routines were not adhered to.

When people received consistent support they lead active lifestyles and participated in a range of activities. Some people needed additional support with their communication and routines to ensure they remained

calm. Staff used pictorial planners and photos were attached to each person's noticeboard, so that people could anticipate what was happening next. This helped them make the choices between activities. Staff said that people were less anxious because they knew they were going to do different things throughout the day and they had more control.

We saw staff point to the photos and people confirmed that they wanted to do the activity. People were able to choose to do different things spontaneously as well and make changes to the plans. During the afternoon two people indicated that they wanted to go to the local shop for a magazine so they all went out. Objects that were significant to a particular activity were used to assist people to say what they wanted and to know what was being asked of them. For example, one person had a particular bag they used for swimming which they had collected and used to initiate going swimming during the morning.

Activities were organised to give people the best chance of success to do the things they enjoyed. For example, one person went to a large indoor games and skating centre to carry out the sports activities they liked. However, at the entrance there was a drinks machine and snacks on show that they found distracting and put them off the activity. This led to anxiety. So the staff found an alternative venue so that the person could enjoy the activity without this distraction.

Routines were organised around people's interests and preferred lifestyle. One person liked to live an active life but also needed structured time that was less active to get the right balance and manage anxieties. Detailed guidance was in place to ensure staff were supporting people consistently to minimise their anxieties and any triggers for behaviours. Staff explained that since they had implemented this structured calmer time and the person knew that they would be going out more and had a regular activities plan, the person was noticeably calmer and incidents of behaviour that challenged had reduced.

No one had moved into the service since the last inspection. However, people's care plans had been reviewed and updated involving both them and their families. People told us that they had identified goals that they were working towards. One person wanted to go to the gym more often to help them manage their anxiety. Another person wanted to try cooking different meals. Goals were reviewed monthly and new ones were identified if they had been achieved.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection, there was no registered manager in place. There had been a lack of direction and guidance for staff and the management team had failed to identify the issues we highlighted. An independent consultant had carried out audits for the provider, but shortfalls they had identified had not been acted on. Some records were not accurate and not up to date, such as people's behavioural support plans and health action plans. Complaints had not all been investigated and responded to. Incidents and accidents had not been analysed to look for any similar themes or patterns in order to adjust support to reduce further incidents. At this inspection improvements had been made, however, there were still some shortfalls and some continued breaches of regulations which needed to be addressed.

People, their relatives and staff all told us that the new registered manager had made a difference to the service, and that they felt it was well-led. One relative told us, "The registered manager coming in has been good." Another relative said, "I'm much happier with this registered manager." People greeted the registered manager warmly throughout the inspection, and welcomed them into their homes. The registered manager had been in post for six months so it was too early to see that improvements had been embedded or sustained.

The culture in parts of the staff team and organisation had improved and was more person centred. We observed some good interactions between staff and people and staff were enabling people to have control over how they spent their time. However, staff, people and their relatives all fed back that the continued usage of temporary agency staff had an impact on the culture of the service and the quality of support provided to people.

One person received support almost entirely from another agency. A senior member of staff visited and provided support to this person once a week, however, the agency staff were working unaccompanied and as such there was a lack of oversight regarding the support this person received. The registered manager told us they spoke regularly with this person and there were no issues with the support being provided, however, there no records of these conversations and no formal quality assurance was completed regarding this person's care. We spoke with the person's relative and they told us they had raised issues in the past that the issues had not always been dealt with fully. Incidents had occurred when people were receiving support from agency staff and the registered manager had not supported and guided these staff members as they were managed by a different agency.

Several care packages had ceased recently before the inspection. Rotas showed that the amount of temporary agency staff being used was going to decrease. The registered manager told us that this should improve their oversight of the service.

Staff documented incidents and accidents when they occurred and most of these were reviewed by the registered manager. Some of the incident were in response to anxious and emotional behaviour that had been challenging. The registered manager had considered each incident and had responded accordingly in some cases but not all.

There was some collation of the type and frequency of incidents but the overall analysis was disconnected and incomplete. The registered manager's response to incidents focussed on stopping the situation rather than considering ways to develop people's skills to prevent incidents. For example, in one person's home the front door was left open and a person had walked out and went to the shops. They collected some items without paying for them and returned home. Usually the person was accompanied by staff when they went out to keep them safe and to assist with the parts of the activity that they did not understand. Making sure that the door was always shut and people were kept safe was addressed but there was no follow up with the shop keepers who had been affected and no plans to review and consider developing the person's life skills so they knew about how to pay for their shopping. This had limited people's opportunities to access and link in with the local community.

There were two team leaders who supported and mentored staff working with different people. They were regularly present when staff provided support and were able to monitor the quality of support that most people received. The team leaders and registered manager regularly checked the quality of completed paperwork, such as people's care plans, daily notes and medication records. The provider employed a consultant who carried out additional, independent audits on topics such as infection prevention and control and medicines. Any areas of improvement the consultant had identified were acted on. However, the checks and audits that had been completed had not highlighted the concerns we identified regarding the support people received when they were anxious, the high level of agency usage and staff not being trained to administer people's emergency medicines.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported by the registered manager who was skilled and experienced in providing person centred care. The registered manager had been a registered manager in other supported living services. Staff told us they felt well supported and felt comfortable asking the registered manager for help and advice when they needed it.

The registered manager understood relevant legislation and the importance of keeping their skills and knowledge up to date. The registered manager participated in a variety of events and forums with other managers that worked for the provider. Documents and records were up to date, readily available and were stored securely. The registered manager had notified the Care Quality Commission of important events as required.

Team meetings for staff were held every other month. They were held in different locations and on the same day at different times so that as many staff could participate as possible and still provide sufficient support to people. A range of different subjects were covered in the meetings and staff said they were encouraged to say what they thought about the service and offer ideas. However, the temporary staff from a different agency did not participate in these meetings.

Annual questionnaires were sent out to people, their relatives, staff and other stakeholders so they could give their views about the service. The responses were collated and action was taken when any areas of improvement were identified. Some relatives had suggested updates or changes to people's care plans and these were seen to be in place at the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive consistent support with their behaviours and these were not always managed safely. People were at risk of not receiving their emergency medicine.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not always been documented, investigated and responded to.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided.