Yarrow Housing Limited

Angela House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 January, 6 February and 16 March 2017. The first day of the inspection was unannounced and we informed the interim manager of our intention to return on the second day. The third day of the inspection was unannounced and was scheduled in order to gather further evidence following our receipt of information of concern. At our previous inspection on 29 October and 3 November 2014 the service had an overall rating of Good. We rated Safe, Effective, Responsive and Well-Led as Good and Caring was rated as Outstanding.

Angela House is registered to provide care and accommodation for up to a six adults with a learning disability or autistic spectrum disorder. At the previous inspection the accommodation was organised so that four people had a single bedroom and two people shared a bedroom. At the time of this inspection there were five people living at the service, each with their own bedroom. The accommodation comprises a communal lounge, kitchen diner, a sensory room, a small rear courtyard, and communal bathrooms and toilets. The bedrooms do not have ensuite facilities. The house is located in a central part of Hammersmith close to a wide range of amenities, public transport and a large park.

The service had a registered manager, who had worked at Angela House for nearly 25 years. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of the inspection the registered manager was on an authorised period of absence and had not been working at the service since May 2016. The service was being managed by an interim manager, who was an established manager from another local service operated by the provider.

Staffing levels did not demonstrate that sufficient staff were consistently deployed to ensure that people received their care and support in a timely manner. Observations during the inspection, discussions with different individuals and information sent to CQC signified that there was a distinct level of concern about the difficulties permanent staff encountered. This was due to the regular use of agency staff in an environment where people need consistency of care to meet their complex needs.

Staff were familiar with the provider's safeguarding policy and procedure, and understood how to protect people from the risk of abuse. Individual assessments were in place to promote people's independence and mitigate identified risks to their safety and welfare. Staff had been recruited in a detailed manner which ensured, that as far as possible, they were suitable to work with people who use the service. Records showed that staff had received medicines training and staff followed the provider's policy to safely manage people's prescribed medicines.

People were supported by staff, who had appropriate training to meet their needs. Newly appointed staff received induction training and their performance was formally monitored, in order to ensure they were suitable to permanently remain at the service. People's legal rights were protected as staff had a satisfactory

understanding of how the Mental Capacity Act 2005 (MCA) impacted on their role and responsibilities.

People were supported to make choices about their food and drinks, and their nutritional needs were monitored. Staff supported people to visit health care professionals, including GPs, psychologists, speech and language therapists and dietitians.

We observed that people had positive relationships with staff, who demonstrated their understanding of people's individual and complex needs. Staff understood people's likes and dislikes, and could explain people's life histories. People were spoken with and treated by staff in a respectful and kind manner and their privacy and dignity were promoted. For example, people were asked by staff if they were happy to show us their bedrooms and their wishes were respected. People were supported to eat a healthy diet that reflected their preferences and took into account any medical needs. The service had good links with local health care providers and professionals and people's individual files showed that their health care needs were regularly assessed and updated, with reference to the guidance and instructions from relevant professionals.

Staff supported people in a kind and compassionate way. They knew people well and understood their individual preferences. People's dignity and privacy was promoted by a caring staff team.

Individual care and support plans had been developed to identify people's needs and wishes, and explain how staff proposed to meet these needs. These care and support plans were regularly reviewed, involving people, their relatives where possible, and health and social care professionals. Relatives confirmed that they attended meetings and were asked to give their views. People participated in social activities at home and in the community, although this aspect of people's support did not appear as active as it was at the time of the previous inspection. There was an established system in place for informing people and relatives about how to make a complaint.

The interim manager was experienced and was described by external health and social care professionals as having a caring and knowledgeable approach. They were supported by an area manager, who was familiar with the service and knew the people using the service. The management team confirmed that there had been difficulties at the service with staff recruitment and retention, and environmental problems that had caused disruption to people and staff. We noted that staff had not been receiving individual supervision, and received information from other sources that staff did not feel supported by the management.

We found one breach of regulation in relation to not enough staff being consistently deployed. You can see what action we have 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?

Requires Improvement

The service was not always safe.

There were not enough staff deployed at all times to ensure people's safety and meet their needs and wishes.

Safe recruitment practices were operated to protect people who use the service.

Staff understood how to safeguard people from the risk of harm and abuse.

Risks assessments and accompanying guidance were in place to identify and mitigate risks to people's safety.

Medicines were safely managed by staff with appropriate training.

Is the service effective?

Good

The service was effective.

Staff received appropriate training in order to meet people's individual needs.

People's rights were protected as staff understood their responsibilities in regards to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

The choice of meals and snacks provided people with a balanced and nutritious diet. Staff provided support and assistance at mealtimes, in accordance to people's individual needs.

Staff followed guidance from health care professionals and supported people to meet their health care needs.

Is the service caring?

Good

The service was caring.

Health and social care professionals expressed that the staff team and the interim manager were kind and caring.

We observed respectful and friendly interactions between people and the staff.

People were supported with their personal care in a way that promoted their entitlement to dignity and privacy.

The service assisted people to access support from independent advocates.

Is the service responsive?

Good

The service was responsive.

Systems were in place to regularly assess people's needs and ensure that their care and support plan was up to date.

We observed that people were being supported to engage with activities in the community and enjoy local resources; however, we received comments that this was happening less due to staffing pressures.

Relatives were provided with information about how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Comments from different sources indicated that there was insufficient support for staff. We noted that staff had not received regular formal one to one supervision to support their practice and development.

Local health and social care professionals told us the interim manager was committed to meeting people's needs and had provided constancy.

There were procedures in place to monitor the quality of the service.

Angela House

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 checked 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 30 January, 6 February and 16 March 2017. The first day and the third day of the inspection were unannounced and we advised the interim manager we would be returning for the second day. The inspection team consisted of one adult social care inspector.

Before the inspection we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC and the report for the previous inspection that was carried out on 29 October and 3 November 2014. We also looked at a Provider Information Return (PIR) we asked the provider to complete prior to 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.

During the inspection we met and spoke with the five people living at the service. They were not able to tell us their views and experiences so 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. We also spoke with six support workers, the interim manager and the area manager. The records we looked at included two people's care and support plans, medicines records, staff files, health and safety documents for the premises, and records associated with the management of the service.

Following the inspection, relatives were contacted to check if they wished to speak with us and we received comments from two relatives of one person. We contacted nine health and social care professionals with knowledge and experience of using the service and received four comments.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had noted that the number of staff rostered for each day varied but was carefully calculated to ensure that people could be supported to attend day centres and appointments, and participate in community events and amenities. Staff had told us they were usually able to support people to go out daily if they wished to, which we had observed on both days of our inspection. The registered manager had regularly assessed people's dependency levels, which enabled her to make adjustments to staffing numbers and if required and request for people to be re-assessed for additional staffing hours from their placing authority. The rotas had showed that the service did not use agency staff but used a small number of regular bank support workers, in order to provide a consistent service.

On the first day of the inspection we noted that one member of staff on an early shift had been supporting a person with very complex needs during the night shift, although they had been rostered as a 'sleeping in' support worker. They had not been able to rest properly, as due to the exacting nature of staffing responsibilities, the 'waking night' support worker had needed their assistance. We were informed by the management team that staff were experiencing difficulties as people living at the service had complex needs and one person often needed an intensive level of support. The area manager was present at the service when we arrived and explained that she regularly spent a day at the service to support the interim manager and the staff team. We discussed staffing issues with the management team and were informed that the provider had appointed a new deputy manager in 2016, but this employee had chosen to stay for a short period and was no longer in post. The provider conducted recruitment interviews in 2017 in order to fill the deputy manager position but did not find an appointable candidate. The rotas showed that agency staff were used on a regular basis, although the provider endeavoured to use the same agency staff where possible, so that they had a better opportunity to become accustomed to people's needs and the established routines in the household. The provider confirmed that they were actively seeking to fill posts in order to reduce the use of agency staff.

Following the inspection visits to the service on 30 January and 6 February 2017, we received information of concern regarding how the provider's current use of agency staff was negatively impacting on the quality of care and support for people who use the service. These comments were received from different individuals. An external health and social care professional had observed that low staffing levels had caused problems with the effective application of professional guidelines to support a person and a relative told us they were in the process of discussing their concerns about their family member's care and support with the provider.

During the course of the inspection members of the permanent staff team told us there had been significant changes with staffing arrangements. Since the previous inspection the deputy manager and two support workers had retired, although the former deputy now worked a limited number of shifts at the service as a bank support worker. These staff had all worked at Angela House for nearly 25 years and we had observed their excellent rapport with people who used the service at the previous inspection. The staff we spoke with during this inspection stated that the retirement of two senior support workers, along with the retirement of an experienced former deputy and the current long-term authorised leave of the registered manager had negatively impacted on the stability of the service. Staff told us that it was now very stressful and difficult to

work at the service as there was an increased dependency on agency staff, who they felt did not understand people's unique and complex needs. We were given examples of when permanent staff worked long hours and covered additional shifts in order to ensure that people experienced continuity of care from staff they were familiar with.

Staff told us about the range of problems that had occurred since the retirement and authorised absence of key employees at the service, which had included the appointment of a permanent staff member who stayed in post for a week. Staff informed us that agency staff had found working at the service challenging as it took time to understand people's needs. This had resulted in permanent staff stating that they felt overworked, tired, disheartened and concerned for the wellbeing of people who use the service. Different sources told us that there had been an incident when a person did not receive a safe and hygienic standard of personal care from an agency support worker.

On the third day of the inspection we visited the service in the evening. We observed that there were three staff on duty; two support workers were permanently employed on a full-time basis and the third support worker carried out regular shifts at the service and was a member of the provider's own bank. (This is a team of staff recruited by the provider to facilitate cover for planned and unplanned shortfalls in staff). Staff told us that a shift covered entirely by employees occurred infrequently as they often worked on shifts with an agency support worker. On this evening, a member of staff finished their shift at their designated time of 7pm, which meant that the remaining two staff were required to support five people.

One person presented with behaviour that challenged the service and in line with the professional guidelines developed for the person they were given individual support by one member of staff. The person needed to receive their support in a sensory room on the first floor, which meant that one support worker worked on their own on the ground floor supporting four people. One person had not eaten well during the evening meal. The support worker was concerned that the person was hungry and prepared a separate meal for them. Other people needed support with personal care, encouragement to drink adequate amount of fluids, assistance to engage with meaningful activity and monitoring to ensure their safety. The support worker was experienced and well-organised, which enabled them to anticipate and meet people's varying needs. However, we noted that there was a potential risk that people's wellbeing and safety could be compromised and staff could experience fatigue.

The area manager contacted us after this evening visit to discuss our findings and we reported our observations. We were advised by the area manager that they would review staffing levels, taking into account that specific periods of the day were particularly busy. The provider informed us that a member of the staff team had been scheduled to work until 8pm on the third day of the inspection but had to leave the service at 5pm due to unforeseen circumstances. However, the rota for March 2017 showed that there were other occasions when only two members of staff were scheduled to work during the acutely busy period after people had been supported with their evening meal.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider demonstrated that rigorous recruitment practices were used, in order to ensure that people were supported by safely appointed staff. The provider checked any gaps in employment and we looked at evidence that Disclosure and Barring Service (DBS) checks were in place prior to any prospective staff being permitted to commence employment. (The Disclosure and Barring Service provides criminal record checks and a barring function to help employers make safer recruitment decisions). We noted that all other mandatory checks had been conducted, which included proof of identity, proof of eligibility to work in the

UK, health questionnaires, proof of address and at least two references. The human resources manager confirmed to us that the provider always asked for a reference from a candidate's most recent employer, or most recent educational establishment if this was more applicable to their circumstances. These records were held securely at the provider's head office, which we visited on the second day of the inspection.

People living at the service were not able to tell us if they felt safe with staff. We consistently observed that people appeared at ease and comfortable with staff, and we saw positive and happy interactions. Relatives told us that the permanent staff team were conscientious, committed to promoting people's safety and demonstrated a genuine fondness for people. A health and social care professional commented on the low number of safeguarding concerns at the service in comparison to similar care homes. Safeguarding training and refresher training was provided, and staff were able to discuss different signs of abuse and explain how they would report their concerns. Staff confirmed that they had received training and written guidance about how to whistleblow and understood that they could seek independent advice and contact relevant external organisations. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings).

Systems had been implemented to identify and minimise individual risks to people's safety and promote their independence. The care plans we looked at contained risk assessments, which provided clear information about the measures staff needed to follow in order to mitigate the risks. An external health and social care professional told us that the interim manager had a proactive style in regards to promptly informing members of the multi-disciplinary team if people's behaviours indicated that they needed a new assessment and possibly new professional guidance to ensure their safety, comfort and wellbeing.

Where required, the care plans and risk assessments provided specific instructions about how to support people with behaviour that may challenge the service. Staff told us about the actions they would take if a person became agitated or distressed, such as giving people time to calm down or offering them time to relax in the sensory room. We noted that there were clear guidelines in place for a person who responded to being offered a favourite activity. Staff had attended training about how to de-escalate behaviour that may challenge the service and promote positive behaviours. During this inspection we saw that staff regularly employed their skills in a calm and patient way.

There was up to date documentation in regards to accidents and incidents. Staff told us they recorded all incidents and accidents, which was then reviewed by the interim manager. This process enabled the interim manager and the staff team to look for any trends if applicable and address any issues of concern that negatively impacted on aspects of their daily living. We saw an example of where the interim manager had reviewed this documentation and advised a change to a person's risk assessment and associated care plan. Checks were in place to ensure that window restrictors were safely functioning and people had a Personal Emergency Evacuation Plan (PEEP) in place. (A PEEP is a bespoke 'escape plan' for people who may need help and assistance to leave a building in the event of an emergency evacuation).

The service had suitable practices to demonstrate that medicines were safely administered. Staff understood why people were prescribed specific medicines and we observed that staff assisted people to take their medicines in a reassuring and unrushed way. We looked at how the service stored medicines, including the record keeping for the safe disposal of medicines no longer required. We checked a selection of medicine administration record sheets (MARS) and found they were correctly completed in line with the provider's medicines policy. The registered manager carried out monitoring checks in order to establish that medicines were being safely managed.

Good

Is the service effective?

Our findings

Staff were provided with suitable training to carry out their role. During the inspection we spoke with members of staff with varying levels of experience about how the provider supported them with their training and development. A support worker told us they had been working at the service for over 10 years and felt that the training package was good as it was tailored to the needs of the people living at Angela House. The support worker explained to us that as an experienced and long-standing employee, they had undertaken national qualifications in health and social care and a specific training course focused on the needs of people with a learning disability some years ago. They confirmed they had completed the required mandatory and refresher training in line with the stipulations of the provider's training policy, which included health and safety, first aid, moving and positioning people, food hygiene, supporting people with medicines and infection control. Staff were provided with opportunities to undertake training that addressed how to meet people's individual needs and the support worker described their training from a speech and language therapist about how to support a person with their eating and drinking.

Another support worker told us they were within their first year of employment at the service. They confirmed that their probationary period had been subject to them demonstrating successful completion of the induction programme, periodic interviews to monitor their progress and other learning and development objectives set by the provider. The support worker stated they were working towards achieving a Care Certificate. (The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care service).

We noted that delays had occurred with staff receiving their annual appraisals. These are meetings in which an employee discusses their progress, aims and needs with their manager and receive feedback about their work performance. We discussed this with the area manager, who informed us this was due to the unforeseen change in management and advised us that this shortfall was being addressed.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the service was working within the principles of the MCA. We saw that people were asked for their consent for daily activities, for example people were asked if they wanted to go out for a walk and their wishes were respected. People's records evidenced that relevant parties, for example health and social care professionals and relatives had been involved when it was necessary to make decisions in people's best interests. Through discussions with the interim manager and by looking at documentation in people's files, we noted that there was a clear understanding as to when a DoLS application should be submitted to the local authority supervisory body.

We observed people being sensitively supported with their meals on two occasions during the inspection and systems were in place to ensure people's nutritional needs were understood and met. We saw that people were asked about what they wanted and consulted about portion sizes.
At the previous inspection we had noted that one person had a pictorial wall chart with menu choices and this system was still in use at this inspection. Other people were able to make their wishes known through either verbal or non-verbal communication. The activities schedule and people's daily notes showed that they were supported to go to restaurants and cafés. We observed people being accompanied by staff to visit local coffee shops and a staff member told us there was usually a trip to a restaurant approximately once a fortnight. People's care and support plans showed that their nutritional needs had been assessed and people were weighed once a month, or more frequently if this was advised by a health care professional. Staff told us they referred people to their GP if concerns arose about their weight. The interim manager informed us that there had been concerns detected that the service's bathroom scales had become inaccurate and we were shown documentation to confirm that new scales had been ordered.

People's health care needs were identified in their individual Health Action Plan. (This is a booklet for people with a learning disability about their health care needs and the support required in order to meet these needs). The care and support plans we looked at both had accompanying Health Action Plans, which had been reviewed or were in the process of being reviewed. The appointments sheet demonstrated that people were supported to access healthcare, which included visits to clinics and hospitals, and care and treatment from GP's, practice nurses, speech and language therapists and psychologists. The service used a specialist NHS dental team with expertise in supporting people with learning disabilities. We received a positive comment from a health and social care professional about how the service supported people to meet their health care needs and another professional comment that was complimentary about the approach of staff in regards to their commitment to meeting people's health care needs. However, the professional identified difficulties in sustaining health care guidelines, which they related to low staffing levels.

Good

Is the service caring?

Our findings

People using the service were not able to tell us their views about whether they were happy living at Angela House. During the inspection we saw positive interactions between people using the service and staff. We had noted at the previous inspection that people benefitted from having their needs met by staff that had worked at the service for many years and had developed a great understanding of people's preferences and behaviours, including how to recognise very subtle changes that could indicate for example that a person is unsettled, needs a drink or would like to be offered a favourite leisure activity. We received comments from different parties to state that the ambience and welcoming character of the service had now changed due to the absence of former staff who had been essential to the family-like experience offered to people. Although we noted that aspects of the staffing had changed, we did not see evidence that this had impacted on how staff supported people in a kind and compassionate way. During the two unannounced days and the one announced day of this inspection we met five staff who identified themselves as having considerably long periods of employment at the service, hence the homely feel of Angela House appeared intact. An external health and social care professional told us they had not observed any differences in recent months in terms of the respectful way that staff interacted with people.

Staff were knowledgeable about people's individual interests, hobbies, likes and dislikes. For example, one person liked to collect a particular item (a vintage toy) and had a nice selection of these items in their room. We noted that there was a discussion in a team meeting about how to support the person to add to their collection as popular styles from manufacturers had changed from when the person started their collection and now it was more difficult to obtain what they liked. Another person had a good awareness about bus routes in the area. A support worker initiated a conversation with the person about which buses we could use to local destinations, which enabled the person to demonstrate their knowledge and feel comfortable talking with us.

We observed that staff took appropriate actions to ensure that people's rights to privacy and dignity were met. People were consulted about whether they wished to speak with us and if they wanted to show us their bedrooms. Staff knocked on people's doors and bedroom and bathroom doors were kept shut when people were receiving support with their personal care. Staff supported people to maintain their independence as much as possible. People's care and support plans contained information about what people were able to do for themselves and the aspects of their daily living that they needed support. For example, we observed during a mealtime that people were encouraged to help with laying and/or clearing the table, if they were able to. This enabled people to maintain skills they had acquired and keep active alongside members of staff, if there were any concerns about decreasing mobility.

People were given information about the service and their rights in pictorial formats, for example there was a pictorial complaints leaflet and a pictorial contract. Information was made available by the provider about how to access advocacy services, and at the time of this inspection one person had regular contact with an independent mental capacity advocate. This meant that where people did not have the capacity to express their choices and wishes or experienced difficulties in doing so, they had access to independent support to assist them.

Good

Is the service responsive?

Our findings

At the previous inspection we had observed that people were given care and support that met their needs. We had noted that one person had been frequently presenting with behaviour that challenged the service and staff were working closely with a range of health and social care professionals, including a psychiatrist and a psychologist, in order to find ways to appropriately support the person. At this inspection we saw that staff were continuing to meet the varying complex needs of people who used the service. Comments from external professionals indicated that people's needs were generally met appropriately and comments from other parties indicated that the changes in staffing since the previous inspection had led to a decline in the quality of care and support.

The care and support plans we checked contained detailed information about people's needs and how to meet their needs. For people with complex needs there was written guidance for staff to enable them to identify the antecedents and early warning signs that people might present with behaviour that challenged the service. Staff also had guidance and training about how to re-inforce positive behaviours.

At the previous inspection we had noted that staff used different methods to find out what people liked and wanted to do, for example staff spoke with people where possible and talked with family members to learn about their preferences. At this inspection we observed how staff supported one person who liked to use the sensory room and found it relaxing to have frequent showers. The person sometimes chose to sleep in the sensory room so the service ensured that there was a suitable chair in the room to sleep in, which met the recommendations of the person's occupational therapist.

We noted at the previous inspection that the service had its own vehicle, which was used to take people on outings and for drives out to scenic local areas in Richmond and Kew. The vehicle was insured for staff to drive and enabled staff to more flexibly respond to people's wishes to go out. At this inspection we noted that there was no longer an available vehicle, which we discussed with the area manager. We were informed that the provider was planning for a new car to be purchased.

We received varying views about whether people were offered social activities. During the inspection we saw that there was an activities schedule for the week, although the daily shift planner did not always evidence that the activities took place. Some people attended local groups and day centres each week and we noted that this was continuing to take place as planned. We saw that people went out for walks, café lunches and trips to the park. There did appear to be less evidence of the type of outings we noted at the previous inspection, for example concerts, cinema trips and shows. We noted that one person used to attend a weekly class and was no longer attending due to health care reasons.

We looked at the complaints log, which showed that there had not been any complaints since the previous inspection. A relative informed us that they had concerns and had made arrangements to speak with the provider. Information from the local authority confirmed that they had not received any complaints.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection there was an interim manager in post, as the registered manager of the service had not been carrying out the day to day management of the service since May 2016. We noted that the provider had taken action within a reasonable period to place an experienced temporary manager at the service, following the authorised leave of the registered manager. The interim manager informed us that he was ordinarily based at Angela House five days a week.

The area manager was present at the service on the first day of the inspection. They informed us that they endeavoured to spend at least one day a week at the service, in order to support the interim manager. For this reason, the area manager had not been conducting unannounced monitoring visits at the service. We observed that they were up to date with the daily happenings that would ordinarily be checked during an area manager's monitoring visit, for example they were aware of which care and support files, health action plans and person centred plans had been recently reviewed and when other reviews, meetings, repairs and health care appointments were due to take place.

The interim manager and the area manager told us about some of the difficulties the service had encountered since May 2016, which included problems in appointing a full-time deputy manager to assist the manager with their role and provide support, supervision and guidance for the staff team. Staff who were undertaking their probationary period received one to one formal supervision once every two months. However, the interim manager acknowledged that most staff had not been receiving one to one formal supervision at least once every two months, in line with the provider's own policy. The supervision sessions enable staff to meet privately with their line manager to discuss positive achievements, highlight any concerns, and review their learning and development goals. As part of this inspection we received information from different sources that staff did not feel supported at work. Team meetings were taking place although the minutes we saw did not evidence monthly meetings, which was the usual frequency at the previous inspection.

We had noted at the previous inspection that the service sent questionnaires to people's relatives but the response level was dwindling. At this inspection the provider informed us that they contacted relatives; however, due to changes in people's family circumstances it was now the case that there were a limited number of people with a relative in a pposition to respond. We noted that the provider maintained active links with independent advocates, as there was a commitment to enabling people to have independent support.

At the previous inspection we observed that although the premises were clean, welcoming and homely, some communal areas looked faded and in need of redecoration and refurbishment. The registered manager had demonstrated that they had already discussed the need for improvements with the housing team that managed the property which is owned by Yarrow. At this inspection we noted that the building had experienced significant problems with flooding, which had caused structural damage. The interim manager and the area manager told us about the extent of the damage, which had resulted in the necessity to move people out of the premises for a few days last year so that repairs could be carried out. Due to the

significant problems at the premises, the provider was not in a position to progress with refurbishment plans but it was acknowledged by the provider that this should happen in the near future.

During the major repairs period people went to an activities based holiday chalet in a forest with pine trees, which was funded by the provider. Staff described it as being a beautiful setting to be in close to Christmas. However, further discussions with staff about the experience identified that they had worked very hard and put in additional hours to ensure that people were settled and comfortable in their temporary home, which unfortunately was not ideally suited for staff pushing wheelchairs uphill. We were informed that there were ongoing problems over the Christmas period with staffing, which resulted in some staff having to work extra hours again so soon after the extended work they carried out at the holiday centre.

There were systems in place to monitor the quality of the service for example, for example checks were carried out each day to check the safety and cleanliness of the premises and the interim manager checked that staff were up to date with care planning for the people that they were assigned as key worker for. The interim manager had also checked that health and safety inspections were up to date, for example gas safety, electrical installations and portable appliances testing. The provider understood their responsibilities in accordance to legislation to notify the Care Quality Commission of all significant events that had occurred.

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
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always deployed to meet people's needs.