Positive Community Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on the 4, 6 and 7 December 2018.

Positive Community Care Limited is registered to provide two registered activities from the same location. At the last inspection on 27 June 2017 we inspected the regulated activity of accommodation for persons who require nursing or personal care and rated the service good in all key questions. At this visit we inspected the second regulated activity of personal care in Positive Community Care Limited domiciliary care agency. The service in relation to personal care relates to people living in their own houses and flats in the community and specialist housing. The service is for older people who may be living with dementia and younger people with mental health and/or other disabilities.

This personal care service provided care and support to people living in 18 supported living settings so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The supported living settings were situated across five local authorities.

Not everyone using Positive Community Care limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection a service was being offered to 73 people however, only 5 of those people were being offered the regulated activity of personal care.

The registered manager had left the service in September 2018. 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 provider had recently recruited an area manager who was intending to register with the CQC.

Whilst staff were offered an induction and shadowed experienced staff they were not always being supported to complete their training in a timely manner. Therefore, we could not be assured people living in some of the services were being supported by staff equipped with all the necessary knowledge and skills.

Although there was evidence of robust risk assessment in more established settings we found in a 'newer' setting that the risks to people had not been thoroughly identified and therefore measures to keep people safe were not in place and accessible for staff reference.

The provider was not always working in line with the Mental Capacity Act 2005 as they had not always taken the necessary steps to ascertain people's capacity about their finances and had not ensured relatives managing their money had the legal right to do so.

The provider had systems in place to audit the medicines, incidents and accidents, safeguarding alerts and complaints. However, the above concerns had not identified and addressed in a timely manner.

People told us staff were friendly and caring. In almost all instances staff interactions with people observed and heard were positive and kind. People said staff respected their privacy and people were supported to be as independent as possible to uphold their self-respect.

Staff supported people to undertake a variety of activities at home and in the community. People's diversity support needs were identified and they were supported in their cultural observances.

The provider assessed people's needs prior to offering a placement and people had person centred care plans that informed staff how they wanted to be supported.

Staff administered medicines in a safe way and people were supported to access appropriate health care for both their physical and mental health. People told us they liked the food provided and that they were given their choice of meals. Heathy eating was promoted in the services and people who had dietary care needs were being appropriately supported by staff.

The provider assessed staffing needs in the services and ensured staff were recruited using safe recruitment processes.

Staff told us how they would recognise signs of abuse and told us how they would report safeguarding adult concerns appropriately.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing and Good governance.

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?

Requires Improvement

Some aspects of the service were not always safe.

In some instances, risks to people had not been identified and therefore measures to keep people safe were not in place.

Staff demonstrated they could recognise symptoms of abuse and knew how to report safeguarding adult concerns appropriately. The management team reviewed accidents and incidents reports to ensure these were appropriately investigated and action taken to prevent reoccurrence.

Staff received training to administer medicines and medicines records were completed appropriately.

The provider had an ongoing programme of recruitment to ensure there were enough staff to meet people's care needs. They followed their recruitment procedures to ensure the safe recruitment of staff.

Staff received personal protective equipment to help prevent cross contamination and promote good infection control.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

Staff had not always completed their training in a timely manner.

Some aspects of the principles of the Mental Capacity Act 2005 had not been adhered to as required.

The provider undertook assessments prior to offering people a placement at the service to ensure they could meet their care needs.

People were supported to eat healthily and drink enough to remain hydrated.

Staff supported people to maintain their mental and physical well-being and to access the appropriate health care.

Is the service caring?

Good

The service was caring.

People told us staff were friendly and caring. Most staff interaction we observed was positive and sensitive.

Care plans contained guidance for staff to communicate effectively with people so they could make choices about their day to day living activities.

Staff respected people's privacy and kept their personal information in a confidential manner.

Is the service responsive?

Good

The service was responsive.

People had person centred care plans that contained guidance for staff about how people wanted their care provided.

Staff supported people to be as independent as possible and encouraged them to participate in activities they enjoyed.

People were supported to complain and the CEO demonstrated they addressed complaints and put in place measures to prevent a reoccurrence.

At the time of our inspection the staff were not providing end of life care. However, some people were asked if they wanted to record what they would like to happen if they became very unwell.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The provider undertook audits and checks to ensure the quality of the service provided but these had not always identified the concerns we found or where these were identified, they were not actioned in a timely manner to make the necessary improvement.

The provider had systems in place that ensured people and staff felt able to voice their opinions and raise concerns.

The manager worked in partnership with several commissioning bodies and housing associations for the benefit of people using the service.

Positive Community Care Limited

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 4, 5 and 7 December 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to make sure the Chief Executive Officer (CEO) and the area manager would be in the office to meet with us. One inspector carried out the inspection.

The site visit took place on 4 December 2018 when we visited the provider's offices to speak with the management team and to review care records and policies and procedures. It ended on the 7 December when we fed back our findings to the CEO and the area manager. Our inspection included a visit to two supported living settings on the 5 December 2018.

Prior to our inspection we reviewed previous inspection reports and notifications we had received from the service. A notification is information about important events that the provider is required to send us by law. We took note of a quality alert shared by one local authority and we spoke with two commissioning authority.

During our inspection, we looked at five people's care records. This included their care plans, risk assessments and daily notes. We reviewed five people's medicine administration records. We observed and listened to staff interactions with people in the supported living services throughout the second day. We reviewed three staff personnel files. This included their recruitment, training, and supervision records.

During the inspection we spoke with four people who used the service, the CEO, the area manager, three team leaders, one senior support worker and three care workers.

Requires Improvement

Is the service safe?

Our findings

Whilst some people had a range of comprehensive risk assessments and management plans to mitigate risks, we found that two people did not have risk assessments in place and their living environment had not been adequately assessed by the provider to ensure their safety.

One of the two people had as described in their hospital notes, a skin condition. There was no assessment that stated the level of risk to the person and to stress to staff the potential seriousness of this health issue. There were some actions identified within their care plan to provide care for this condition but there was no means for new or temporary staff to read through and understand the risks to the person in a comprehensive way. We brought this to the attention of the team leader and area manager who explained these people's care plans had been completed using "the old documents."

In this setting there was not an assessment of the risks to the two people living in the premises by the provider. We were shown a risk assessment undertaken by the Housing Association who provided the property that did assess both health and safety and fire risks that the people might face. However, this did not contain an assessment of risk specific to the individuals living in the premises. For example, upstairs windows did not have window restrictors in place and windows could be positioned as wide open. The risks that this could pose to people living in that setting had not been assessed. In addition, the provider had not considered if staff should be fully trained, for example in the use of fire extinguishers so they could help ensure the safety of people in the event of a fire.

We brought this to the attention of the team leader and area manager who explained they had identified health and safety risks to the people at the service two days prior to our inspection and they had purchased fire blankets and would assess if there was a risk to people from the lack of window restrictors.

People told us they felt safe using the service. Their comments included, "Yes I feel safe," and "I'm looked after here," and "I get looked after perfectly well. Things are just floating along in a normal fashion. Everyone gets on." Staff could tell us what actions they would take to safeguard people. Their comments included, "I would report it to the manager if other staff weren't doing things properly or if I saw bruises or marks," and "Safeguarding training is mandatory, we look for signs of people being withdrawn or dishevelled or not wanting to spend money, [because of financial abuse.] They continued to describe they would whistle blow if there were unaddressed concerns, "I would talk to the line manager or go above and talk to the directors or go to the CQC."

The Chief Executive Officer (CEO) and the area manager described how they supported team leaders to review all people's records and to ensure that all safeguarding concerns were reported appropriately. They had an oversight of safeguarding alerts through an electronic tracker and monitored all types of incident and accidents and the outcomes. One team manager had a designated responsibility to champion safeguarding and had reported concerns to the local authorities and had notified the CQC appropriately of the said concerns. The CEO told us how they learnt from incidents and safeguarding concerns. They gave an example of putting in place protective measures and providing re-training for staff in one supported living

setting following a safeguarding concern. They described how they were taking the learning from this incident to inform changes in their process when setting up new services.

Staff told us there were enough staff employed to support people in a safe manner. Their comments included, "Enough staff yes, we manage, good communication is the key," and "There are enough staff, when someone is off sick they call in an agency staff. We give them an induction, we handover and show them the care plans and tell them how to support the client." Staff told us that they did not work for long periods without a break. One care worker said, "We all have a break each week, we work more than 37 hours a week, but no way they will not allow too much, as we all need breaks and no one works very long hours." Team leaders told us when they needed to use agency staff they requested staff from a specific agency that they found had a good track record and they tried to get staff who were familiar with their service.

The CEO told us that they recruited staff on an ongoing basis to ensure they had enough staff to meet the needs of the service. They described they read through each application form with a HR officer and asked prospective staff to interview. The interview panel was usually made up of two members of the senior management team and often included a person who was using the service. They explained the panel members asked potential staff questions that evaluated their aptitude for the caring role. The CEO said that whilst experience and qualifications were important they looked for people who were motivated and had a passion to care for others.

We checked a sample of staff recruitment records and found that the provider had taken good measures to check staff identity and when appropriate confirmed their right to work in the UK. Criminal record checks were carried out and references sought from previous employers to ensure staff were of good character and safe to work with people.

We checked people's medicines administration records (MARs) and found that these were being completed appropriately at the time of the inspection. We noted that in one supported living setting medicines administration was not being appropriately recorded but this had been identified by the provider prior to our inspection. There was a plan in place to address the shortfalls.

Daily checks took place by the shift or team leaders to check MARs were completed appropriately and the medicines were 'tallied' each time they were administered to ensure no errors had been made. Staff administering medicine could tell us what medicines were used to treat and there was guidance for staff to support them to monitor for any side effects. Guidance for staff was clear and for example, one person's records contained an action plan for staff monitoring medicines with instructions to record and report any changes. Staff liaised with this person's psychiatrist and their medicines were reviewed every six months.

The two settings we visited were both clean and well maintained. There were hand washing materials provided for care staff, people and visitors. Staff were provided with personal protective equipment such as gloves and aprons to ensure they practised good infection control.

Requires Improvement

Is the service effective?

Our findings

During our visit we found that training was not being completed by staff in a timely manner so they had the skills and knowledge the provider had identified for the staff to fulfil their roles. We spoke with staff who confirmed they received an induction and ongoing training. We noted that some staff referred to training from previous employment rather than current training. We asked staff about the training they had received at Positive Community Care. Their comments included, "Still got a bit to do, maybe about four left to finish. Managers give us support to do it. At the beginning there was no support but we complained and got support. [New team leader] is very strict and checks, they are spot on, so it has been better the past few weeks," and "Training is supportive and helpful. It helps me do the job. I did medicines training two weeks ago. I'm Studying Health and Social Care at college [Own funded training]. I wanted to work in mental health. We are all supervised. I am supervised by [Team Leader]. They are very supportive and [Senior support Worker] is lovely. They don't mind us asking questions" and "I've had safeguarding, health and safety and medicines training and more is booked."

We reviewed a sample of staff training records and found that two staff who had commenced their role in July 2018 had received an induction to the service that included shadowing experienced staff and reading through policies. They were in the process of working through their online training. These staff records showed that whilst they had begun their training some key topics such as infection control and prevention, safeguarding and Mental Capacity Act 2005 (MCA) were begun but were overdue and flagged in red to be completed. For example, for one staff who commenced their role in July 2018, we saw that 'understand your role' was in progress, 'equality and diversity' and 'personal development' were almost completed, safeguarding adults training was completed apart from the test and the course work was completed for the MCA training but the test was still in progress. Infection control and prevention had been started but not completed.

Following our inspection, we requested a copy of the training matrix. We saw gaps where staff were not marked as having received training in key areas. For example, the setting we visited that was opened in August 2018 contained a lot of gaps with only one staff out of the seven staff marked as having completed MCA, duty of care, working in a person-centred way, infection control, and communication training. Only two staff were marked as completed awareness of mental health, dementia and learning disability. The other staff were not marked with a cross or 'in progress.' We were not assured therefore that staff were receiving training in a timely and appropriate manner to equip them to undertake their role.

Some people's care plans referred to staff needing to be familiar with the MCA and to support the person's decision making process through one to one sessions. Out of thirty eight staff only ten staff had completed or were in the process of completing MCA training. Although eighteen of those staff had completed or were in the process of completing deprivation of liberty training. We did not feel assured their training in MCA was sufficient to support them to understand the legal requirements of the MCA.

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

We brought our concerns about the training of staff to the CEO's attention and they told us that they had identified that staff were not always completing their training and managers had discussed this in staff meetings. It was, they described, "work in progress" and the senior management were working with team leaders to encourage them to give staff time before and after a shift to complete their course work. They also said they were in the process of considering employing a manager specifically to concentrate on learning and development.

The CEO also told us they had provided training in services were a person might have specific support needs such as having a behaviour that challenged the service. They had also provided 'Breakaway' training and positive behavioural support to staff in September 2018 in two services where people had those support needs. After noting the success of that training they had decided to roll out this training to all staff so they could understand and utilise de-escalation and breakaway techniques when necessary.

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. We checked whether the service was working within the principles of the MCA.

Some people's care plans contained clear information that demonstrated the provider was working with people in line with the MCA. For example, there was information in some people's care records as to how their finances were managed on their behalf by a court appointed guardian. However, we reviewed two people's records that stated a relative managed their finances. There was no mental capacity assessment that stated they could not manage their own finances and no evidence that demonstrated the relative had a legal right to manage these people's money on their behalf. The team leader told us they had recognised that there was no clarity about these people finances and as such had started to investigate this further with the family members and professionals so the necessary improvements could be made.

Prior to people being offered a service senior management undertook an initial assessment by meeting with the person, their family members and professionals. A team leader told us, "The assessments are good so we know who is coming and if they are compatible." Some people's records contained their initial assessment undertaken by the provider and we noted that people's care plans were person centred and contained details obtained through the assessment process. The CEO described how they worked with the commissioning authorities and housing associations to identify suitable housing options and provide appropriate care to people in areas they wanted to live in.

People told us that they liked the food they were offered. One person said, "We have sandwiches, roast chicken, rice and pizza sometimes." Other people confirmed they were given their choice of food, "If I ask for my choice I get it," and "I would like chicken and rice. I would be able to have it. I would have to say and they do it. I enjoy the food. I get a choice at breakfast, bacon and beans, or shredded wheat, I would be able to have it."

People's care plans stated what they would like to eat for example, "Fruits and chocolate!" and "Likes Meat /chicken/ biscuits etc." When people had dietary requirements their care plans stated what support they required from staff. For example, one person had diabetes and their care plan reflected this and gave guidance to staff that their diabetes was diet controlled. Staff were able to support them to go for walks and provided healthy eating literature around the house. There was also a cookery book with meals that were

appropriate for diabetics. In addition, their weight was monitored so action could be taken where required to support the person.

In one service people were being encouraged to be healthier and eat fruit instead of biscuits and there was monthly weighing for one person who was experiencing a loss of appetite. Some people's care plans contained guidance for staff to prompt fluids stating for example, "Encourage to drink water or juice." To support some people living in one service who had health conditions associate with the misuse of alcohol there was a ban on the consumption of alcohol in the premises. This was clearly stated as one of the displayed house rules. We observed people were offered frequent hot and cold beverages and staff made people drinks when they asked for them or people were supported to make drinks for themselves.

Staff had supported people to access the appropriate health care for both their physical and mental health. There was evidence of people being supported to see the GP and referrals to specialist clinics were requested in a timely manner. People's records indicated they had been supported to attend various hospital and community health professionals for reviews and follow up appointments.

Good

Is the service caring?

Our findings

People told us they liked their staff and found them kind and friendly. Their comments included, "They [staff] have become friends," and "Yes I like the staff, they are good, they take us out."

Apart from one incident all staff interactions observed were positive, caring and polite. For example, we heard staff chatting with people and asking them if they had enjoyed their trip out and having gentle 'banter' with people. Staff knew people well and we heard and observed them talking about topics they knew people enjoyed talking about.

In one supported living setting we observed a staff member not interacting with the people they were supporting. The people were watching the television and the staff member had closed their eyes and was in the process of falling asleep. We brought this to the attention of the team leader who was also present in the room. Once spoken to by the team leader the staff member interacted with people appropriately. The CEO later told us that this matter was addressed with the relevant staff member.

We asked the team leader in one of the supported living setting how they monitored the way staff engaged and interacted with people. They explained they were present on approximately four days in the service and gave an example that they had noted some staff had become, "complacent" and they had addressed this with the staff team and they were actively monitoring staff performance. This was confirmed by a care worker who described the team leader as having a positive role in addressing poor practice in the setting.

There was a keyworker system in some the settings. A keyworker is a staff member who has a responsibility for a particular person and is the point of contact for family and professionals. A team manager described they matched the staff member with the person and would ask the person how they felt about a staff member to ascertain if it was the right staff for the person. This helped staff build a strong rapport with individual people.

People's care plans described how they communicated and understood what was being asked of them. For, example, when addressing [Person] use simplified speech for better understanding," and another plan gave guidance that included, "Staff to be attentive when I am communicating with them" and "When staff are speaking to me they need to use simple sentences and speak slowly and clearly and give me time to respond." Another person's care plan gave guidance to staff to use the person's memory book as this facilitated the staff and other people living at the service to communicate with the person more effectively.

Staff told us how they gave people choice in everyday life. Their comments included, "When it's dinner time we call them and they pick out what they want. We get in a selection of food including Halal food from the supermarket and the butchers." And "I offer three choices for breakfast and ask what would you like? I show them how to cook and they stand next to me. I help them choose recipes from the internet. If we haven't got the ingredients we go and get them."

People confirmed that staff respected their privacy. Their comments included, "My room is comfortable, yes

it's big enough, enough privacy, there are no problems there." And "I like my room I like all the staff here." Staff described how they respected people's privacy by knocking on doors before entering. A team leader told us they shared the Dignity and Respect Policy in staff and resident's meetings. They explained they gave examples to both people and staff that they must not, "barge into other people's rooms" and must respect other people's privacy. In addition, they confirmed that they kept people's personal information in a confidential manner in a locked cabinet.

Good

Is the service responsive?

Our findings

People had person centred care plans that contained information about their social history and important events in their life. This allowed staff to understand people within the context of their life and gave them an opportunity to understand what was important to the person. Care plans stated people's diversity information such as their religion, culture and gender and if they followed any religious or cultural observances. Staff told us how they supported people to ensure their diversity support needs were met. One of the services had employed a staff member who could converse in a person's language of choice and we saw that key information had been translated for this person so they could understand what was being displayed.

The CEO told us that they asked staff at interview about their feelings around diversity to ensure they employ staff who could work with a diversity of people. They explained at the initial assessment they talk with people about their diversity support needs. If for example, they want to go to church or the mosque. They continued to explain that the organisation holds cultural days to promote different cultures and will for instance offer foods from that culture. The CEO explained they supported people from the Lesbian, Gay, Bisexual and Transgender plus (LGBT+) community and held discussions with staff about supporting people's sexuality and being tolerant of people's preferences and wishes. They said, "We promote a tolerant culture."

One of the aims of the organisation was to assist people to rehabilitate and to become as independent as possible. Therefore, care plans stated what support people required but also stressed what they could do for themselves. One person told us, "I clean everywhere, the bedroom, the kitchen and hallway." We observed them sweeping the floor and they took pride in looking after their home. People told us they were supported as they wanted to be by staff. One person said, "Yes they give me my medicines and they help me wash and shower. Yes, I am happy now." Care plans gave staff person centred guidance as to how to give the support as people wanted it to be provided.

People told us that they were supported to undertake activities and go out. Their comments included, "Yes enjoyed myself out today," and "They take us out, to the shops, we went just now, not to the park, but we go to the library on the bus, there's music there. We like the music and dance as well" and "Yes, buses and shopping sometimes we do the shopping or the staff do shopping. You can go out as much as you want, yes every day." People's care plans informed staff what they liked to talk about, what activities they preferred to do and how to support them safely in the community.

One setting had a senior care worker who had a specific responsibility for activities. They arranged a variety of activities for their setting which could also be accessed by people in the other settings. Recent activities included visits to see Christmas lights, and to Harrow for sausage rolls at a café. In the summer there are visits to the Lido and football sessions in the park. Indoor activities in the services included playing cards, creative writing and for those who wanted it, going to other services to learn about cooking and bible study. One day a week there was coffee morning at a central location. There was a Christmas tree decorated by people in the lounge and a Christmas party was planned. The senior staff member explained they had a

video blog about the different activities they did and this was used to further engage people using the service and to create an online activity.

In another setting that we visited, activities were not so varied but people were going out and about in their daily life and there were arrangements for them to attend a local college and football activity in the new year. This was in line with the people's care plan review and their aims and goals. Two people in this service invited us to see their bedrooms and they both told us they were happy with their rooms. However, we brought to the area manager's and team leaders attention that although their bedrooms were well maintained there was little in terms of personalisation of the bedrooms. There was no memorabilia or photos, or any items associated with their interests or background. This did not demonstrate a person-centred approach in this one respect.

People were supported to make complaints. There was easy read and written information provided so people had all the necessary information to make a complaint. In one service the complaints procedure was provided in a person's language. People were encouraged to speak with their keyworkers and raise concerns if they were not satisfied with an aspect of the service. The area manager had visited all the services and spoken with people so they could raise any concerns they had. Some had indeed raised concerns and we saw a recent concern had been dealt with appropriately. The CEO demonstrated they had logged people and relative's complaints. They had acknowledged the complaints and had investigated these before responding and apologising to the person complaining, where required. They had an oversight of complaints so they could recognise trends in the service.

At the time of our inspection the CEO confirmed that no one was receiving end of life care. There was a section in people's care plans for their end of life choices to be recorded but in the records, we reviewed people had chosen to decline this. The CEO explained that, "We ask but we haven't got anyone at that stage now. We do help people to find a suitable solicitor support with their wills. Sometimes people do not want to talk about end of life. In particular, younger clients don't want to discuss it." The CEO told us that in the event of someone requiring end of life care they would talk with them and their family and GP about their preferences for care. They also said they would provide the necessary training to staff to be able to care for people at the end of their lives appropriately.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found a number of concerns that showed that the provider's quality assurance processes and systems for auditing and monitoring the quality of the service were not identifying the shortfalls we found at this inspection. The majority of the concerns were focussed on one supported living setting we visited that was opened in August 2018 and was therefore one of the provider's more recent services. Concerns associated with this service included a lack of robust risk assessments that included not identifying the level and likelihood of risks and not providing appropriate guidelines to mitigate the risks to staff and others. Risks associated with the environment where people lived and staff provided care had not always been assessed so any risks were identified and appropriately mitigated.

Whilst in the more established settings the principles of the MCA had been considered and were being implemented, we noted that in the recently opened setting this had not been considered when people were placed at the service. We indeed found that the MCA principles were not always being adhered to. Whilst this concern had been identified by the team leader who had been put in post two weeks before the inspection it was not timely and was still not addressed when we visited. The above was an indication that there had not been a robust senior management oversight of this supported living setting.

In addition, in the whole service there were gaps in some staff training and there was a delay in newer staff completing online training that meant that in some services we could not be assured that staff knowledge and expertise was of a good enough standard to ensure people receive safe and appropriate care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, the CEO and senior management team audited, checked and tracked safeguarding adult's alerts, complaints and accidents and incidents and reviewed people's care plans on a regular basis. Team leaders audited medicines and daily records on a weekly basis in the services and fed back to the area manager and the CEO.

The staff told us they felt well supported by the provider at the time of our inspection. We met several staff who had progressed through the service and their skills had been recognised and encouraged by the provider. All team leaders spoke positively about their commitment to the people using the service and their desire to work with their staff teams to provide a good service. They were knowledgeable about people in their care and demonstrated they reflected on the care given and sought to continually improve.

The CEO had oversight of the service. There had been some changes in the senior management team following the registered manager leaving in September 2018. The person who had initially came into the post had to leave shortly afterwards. The recently appointed area manager stated they intend to apply with the CQC to become the registered manager. The team leaders were each responsible for several supported living settings that were identified by location and size. This was described by the area manager as a, "newish structure." They had visited all the supported living settings and had held a team leader staff

meeting on the 1 November 2018. They had plans to hold quarterly meetings thereafter to support the team leaders and to visit all supported living settings on a regular basis.

The CEO told us there were good lines of communication with people using the service. There was a keyworker system so people built a rapport with their allocated staff who held one to one sessions where people could raise any concern. Within the services there were resident's meetings where 'house rules' were discussed, activities planned and concerns could be raised.

Team Leaders told us they spoke with people at least several times a week to check they were happy with their care. The area manager undertook planned visits to supported living services and planned to undertake at least two unannounced visits to each service annually to speak with people using the service. We noted that they had already visited one service and had identified and reported a safeguarding alert by listening and acting on the person's concern.

There was a resident's feedback sheet that was in a pictorial and easy to read format. Surveys were completed using these and the results were analysed and responses fed back to staff so improvement could be made where this has been identified. The CEO told us they were looking at ways to improve communication with family members and were exploring the use of a communication portal whereby family members could log in and raise concerns, feedback information and complete surveys etc. This was 'work in progress' at the time of our inspection. In addition, there was a quality action group planned but it was not up and running yet. It was referenced in the service users guide and was planned for the new year. As such the provider was proactively working with people and families to ensure their feedback was received and acted on.

The provider worked in partnership with a number of commissioning bodies and housing associations to identify suitable accommodation and support for people to enable them to live in an area of their choice with support tailored to their needs.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality of the services provided to service users. Reg17(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff were supported to undertake training and learning in a timely manner. Regulation 18(2)(a)