Hestia Housing and Support

Colville Terrace

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2018 and was unannounced on the first day, and we informed the provider we would be returning the following day. This was our first inspection of the service since the provider registered with the Care Quality Commission (CQC) in June 2017.

This inspection was prompted by an incident we were notified of in March 2018. This incident did not directly have an impact on people using the service but it did raise some questions about potential risk which we wanted to follow up. Colville Terrace is a 10 bed supported living service that provides care and support for men and women with mental health needs. At the time of the inspection, nine people were using the service.

The property comprises self-contained studio flats with cooking and bathroom facilities. Communal areas include a lounge, a computer room, a laundry area and a courtyard located at the rear of the home. The building is owned by a separate landlord.

The service had a registered manager in post who was available during both days of our visit. 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.

There had been no safeguarding concerns and safeguarding processes were in place so staff knew how to report abuse if this was suspected and/or witnessed in the service. Staff were not always confident about how to report whistleblowing concerns. Staff had completed training in how to report unsafe practice. Risks were not always assessed and reviewed when people's needs had changed. Safety checks were not consistently carried out during the night to ensure people's safety.

Recruitment processes were followed and pre-employment checks were undertaken on staff before they began work. There was enough staff on duty to provide care to people who used the service. Staff were not provided with effective support and supervision to develop their knowledge, skills and practice. A programme of training was completed by staff that was reflective of the needs of people they supported.

People prepared their own meals. Staff encouraged people to eat a well-balanced diet and medical practitioners supported people to maintain good health. Medicines were not always managed safely. Staff had completed medicines awareness training.

People told us that staff were caring and listened to their views. Staff treated people with dignity and respect and understood their preferences, and how best to care for them. The provider worked with other agencies that provided specialist support and advice.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Care plans were not always reviewed to fully capture information about people's individual needs and how they had met their goals. People took part in activities that reflected their interests and hobbies. People and their representatives were provided with information about how to make a complaint if they were unsatisfied with the service.

The service was not well led. There was a lack of consistent leadership in the service that impacted on the service operating effectively. A comprehensive audit had been carried out by the provider to improve the standards of care, however this did not detect all the shortfalls we identified. Records were not always kept safe and secure in accordance with the Data Protection Act 1998 (DPA). People spoke positively about their experiences of using the service and their feedback was sought to improve how the service delivered their care and support.

We found three breaches of regulations relating to the management of risks to people's health and welfare, staffing and good governance. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Staff had completed medicines training.

Safety checks were not carried out consistently to ensure people's welfare.

Risks assessments were not always reviewed to reflect changes in people's needs.

Staff had completed training on whistleblowing but were not always confident about how to report unsafe practice.

People told us they felt safe. Staff had received safeguarding training on how to protect people from abuse.

Recruitment processes were followed to ensure that background checks were carried out on staff before they began work. There was enough staff to support people with their care.

Is the service effective?

Requires Improvement

The service was not always effective.

Regular supervision was not always undertaken to ensure staff received support with their skills and ongoing development. Staff had completed training that was reflective of people's needs.

People had access to their own cooking facilities and prepared their own meals.

Health professionals were involved in people's care to ensure their medical needs were met.

People were supported to make decisions regarding the care they received.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and listened to their views.

Staff knew people well and understood their preferences and dislikes.

People made choices about how they wished to receive their care.

Staff encouraged people to engage with agencies that provided advice, guidance and specialist support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans held information about people's individual needs and preferences, however these were not always fully reviewed to reflect changes in people's needs.

A programme of activities was available and people were supported to participate in these.

People knew how to raise a complaint and these were acted on and resolved.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

There was a lack of consistent leadership in the service, which had a negative impact on the service running effectively.

Systems of audits were completed to identify any shortfalls, however these did not detect all of the issues we found.

People spoke positively about how they were supported by the provider. Feedback was obtained from people about the quality of care they received.

Colville Terrace

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.

The inspection was carried out on 22 and 23 March 2018. We had received information of concern and as a result of this, we brought our inspection forward. The inspection was unannounced on the first day and we told the provider we would be returning to continue with the inspection the following day. The inspection team included an expert by experience on the first day and one adult social care inspector on both days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information that the Care Quality Commission (CQC) held about the service including any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider. We contacted the director of operations of the service who kept us up to date with information about the incident we had been informed of. We also called a representative of the local authority to obtain further information about the quality of care and support provided in the home.

During the inspection, we spoke with four people who used the service, one support worker, the team leader, the registered manager and the area manager. We reviewed three people's care plans and risk assessments, two people's medicines records, health and safety files, quality audits, minutes of meetings and people's daily records. We also checked six staff training and recruitment records, and some of the provider's key policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection, we had received a safeguarding notification about a medicines error identified by the provider's audit. This showed that two tablets in a person's blister pack were unaccounted for. The person's medicines records had not been signed to evidence they had taken their tablets. The provider assured us they had spoken with the person who told them they had taken their medicines, and that plans were put in place to mitigate any further risk. This included a review of the medicines procedures and additional training for staff.

People we spoke with told us that they took their own medicines and had no concerns. People had their own lockable medicines cabinets to store medicines safely. Despite this feedback, we found that medicines were not always managed safely.

Records showed that one person had moved into the service a week prior to our visit. Staff explained that they were having discussions with the person's GP about how to effectively support the person with their medicines. We asked for a copy of the person's medicines records to check if their medicines were being taken as prescribed. However, there were no written records to evidence how their medicines were being managed and what medicines the person had brought with them into the service. This meant we could not be assured this person was being appropriately supported to take their medicines safely.

We found inconsistencies in the recording of medicines temperature checks. Records showed there were gaps in the temperature recording of stored medicines over six separate dates. Medicines should be stored at the correct temperature to ensure the quality of medicines is not compromised.

Clear guidance was displayed on the medicines cabinet about the safe management of medicines. Instructions had been written to show there was a requirement for checks to be carried out daily on people's medicines and the temperature these were stored at, however we found this was not adhered to.

The above issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required support from staff to take their medicines and these were stored securely in the service. We checked their medicines and corresponding documents and found when people had taken their medicines the records had been signed by staff. There was a medicines assessment form for one person to assess if they could manage their medicines effectively. For example, staff had assessed if they had any difficulties remembering to take their medicines and if they knew how to locate the nearest pharmacy. The person had signed and dated the medicines assessment to show their understanding of this at that time. We observed a person being appropriately supported with their medicines by a member of staff when they asked for assistance. The procedure was managed correctly and records confirmed that staff had completed training in medicines awareness.

Prior to this inspection, we had been informed about a fire that had happened in a person's flat. This had

caused damage to the person's room and they had been rehoused safely in another service. The provider sent us information to show what action they were taking, such as updating the fire risk assessment and the refurbishment of the flat. During the inspection, we did not see sufficient evidence to demonstrate that robust fire procedures were followed to protect people from the risk of fire.

Weekly and monthly fire checks were meant to be carried out. This was to ensure fire checks were undertaken on the escape routes, and fire exit doors and that all extinguishers were in place. Visual checks needed to be undertaken on the fire panel. However, we found that records did not evidence that regular weekly fire checks were being carried out on the premises. Records showed the last weekly fire check was undertaken and documented on the 8 February 2018. Monthly fire safety checks were undertaken in February and March 2018 however, the records were not signed or dated by a manager to evidence these had been reviewed.

Although the provider's audit picked up there were gaps in records to show that regular fire checks were not undertaken, they did not pick up the further issues we found. Therefore, we could not be assured that thorough and regular checks were being done to protect people from the risk of fire.

The above issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We toured the building and saw that fire safety notices were displayed throughout the home. This provided information on what people, visitors and staff should do in the event of a fire emergency. There was an up to date fire risk assessment and the business continuity plan had been reviewed. Records showed that staff had completed training in fire safety.

People told us that staff regularly checked on their welfare. They told us that the staff knocked on the door twice a day to see if they were okay so they knew they were being looked after. We observed that when staff arrived on shift they checked the CCTV to review the footage of an accident that had occurred the night before. A night concierge was employed by an external organisation to carry out security checks in the building. The checks were carried out after staff had finished their shifts. Daily records showed these checks took place every three hours to check the security of the building and ensure people's welfare. However, there were no evidence to show security checks had been done over three separate dates in March 2018. This meant we could not be assured that security checks were carried out consistently in the service to ensure people's welfare and safety in the service.

Prior to the inspection, we were notified of an incident at the service that did not directly involve people using the service but may have affected their emotional wellbeing. During the inspection, we did not see sufficient evidence to demonstrate that people had been supported to address any feelings they may have had as a result of this.

People's risk assessments were stored electronically and contained information about how people should be supported to protect them from the risk of avoidable harm. For example, the risks associated with a person's medicines showed they were required to have regular blood checks to reduce the likelihood of harm to their health and this was acted on. A health and social care professional told us that people were being appropriately supported to stay safe, with the help of their social workers. The local authority told us they were keeping in contact with the provider about the incident and the provider confirmed this. Records demonstrated that people were to be supported to maintain their mental health and wellbeing. However, there was no evidence to demonstrate people's risk assessments had been reviewed to evidence how people were being supported to stay safe with the help of health professionals.

The above issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked if staff understood their responsibilities in relation to whistleblowing. Records showed that staff had completed online training on whistleblowing and there was an appropriate policy in place to support this practice. However, the staff we spoke with told us they were uncertain about what they needed to do when they had to report on wrongdoings in the work place. The staff acknowledged they did not follow the correct procedure when they had raised a whistleblowing concern and had learnt lessons from this. We spoke to the area manager who explained that the provider would be delivering more face-to-face training and reflective learning to ensure that staff were more confident on reporting unsafe practice if this was witnessed.

People told us they felt safe using the service. One person said they felt safe because the staff that supported them were "really nice". A second person commented that sometimes they did not feel safe. They explained this was not due to their environment but because their mental health made them feel that way. A third person explained that Colville Terrace was the safest place for them to live and they had no reason not feel safe.

Information was available in the service about what staff should do if they witnessed or suspected people were at the risk of abuse. Training records confirmed that all staff had received safeguarding training. There had been one safeguarding concern raised and this had been acted on. The registered manager we spoke with understood their responsibilities for reporting safeguarding concerns if these arose.

We reviewed the staff recruitment records and found the correct evidence was in place to demonstrate the provider's recruitment process was being followed. Background checks had been carried out and included an application form, references, photographic identification and a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Records showed that when potential candidates had information on the DBS disclosure a risk assessment was undertaken to decide whether to employ them. The provider used the employer checking service (ECS) to verify that staff had the right to work in the UK.

We observed there was enough staff to support people during our inspection. Rotas showed that staff worked in the service during the hours of 9am to 9pm. There were two permanent members of staff employed, however one staff member had taken planned leave. Agency and locum staff covered additional hours. The middle shift (10am to 6pm) was sometimes covered by agency staff, depending on people's assessed needs. The provider told us they were recruiting for a permanent member of staff to cover the middle shift. This was so that staff could spend more time with people supporting them outside of the home. A night concierge carried out checks in the service after care staff had gone off duty. There was an accessible on call procedure that people could use if they needed support and advice out-of-hours.

The area manager explained that the organisation's policies and procedures would be reviewed in light of the incident that happened in the service. The operations manager assured us they would carry out an investigation into the incident, led by an external organisation to ensure that lessons were learnt .They said we would be provided with a copy of the report when this was completed.

Requires Improvement

Is the service effective?

Our findings

People did not always receive care from staff who were adequately supported in their roles. Staff told us they were not always effectively supervised in their role or provided with sufficient opportunities to reflect on their skills and practice. They explained that due to changes in the management team there had been gaps in them being supported with regular one to one supervision. We asked the provider for staff supervision records and the appraisals for employees who had worked in the service for over a year. The area manager advised us that these would be sent to us but at the time of writing this report, we had not received these records. This meant that we could not be sure that staff were appropriately supported in their roles to ensure they were able to meet people's needs effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training was completed by staff to ensure they had the skills and knowledge required to meet people's needs. This comprised an induction and e-learning that was reflective of the needs of people who used the service. Records we checked evidenced that staff had completed up to date training on subjects such as child protection and emotional abuse, neglect and physical abuse, introduction to first aid, the recovery approach to mental health and mental health awareness.

People were supported using the Mental Health Recovery Star. This supported people to choose what aspects of their care they wished to be supported with and measure their own progress. However, we found that some of these outcomes had not been recorded to fully demonstrate the milestones that people had achieved. The provider's audit showed that this had been identified and staff had been given a deadline to complete these records.

People had access to their own cooking facilities in their flats to cook and prepare the meals that suited their dietary needs. One person explained that they did their own cooking and sometimes people got together in other people's flats to cook for each other. A second person said that they had independent living skills and ate a healthy balanced diet. A third person commented that they preferred to eat takeaway food and were able to make themselves a hot drink when they required this. Staff told us that people who used the service were fully independent and able to cook and shop for themselves. They encouraged people to eat nutritious meals and the records we checked confirmed this. Staff further explained that people could receive food donations from an external organisation that donated food items to those most in need, if this was required.

Medical advice was sought when people needed to access healthcare services. One person explained that they had a community practice nurse and a psychiatrist who they were very happy with. People were assisted by staff to arrange and attend their medical appointments where required. People accessed health facilities when they needed treatment, advice and support in relation to their physical and mental health needs. People attended meetings with mental health professionals and there was effective working with them to ensure their mental health needs were met. Health practitioner's recommendations and advice was taken into account and recorded in their care records during a review of people's health needs.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection no one was subject to a DoLS authorisation.

Best interests meetings were held in consultation with people and health and social care professionals to assess if people had the capacity to make day to day decisions about their care. For example, one person's mental health had deteriorated and the home treatment team had been contacted by the provider to discuss how they could effectively support the person during their mental health crisis. Where people had made decisions to consent to their care and support, records demonstrated how this was obtained. For example, one person had signed a consent form to agree they would collect their medicines from the office every morning and after midday to ensure that staff could observe they had taken their medicines as prescribed. Staff we spoke with gave us examples of how people consented to their care and records confirmed that staff had completed MCA training.

Good

Is the service caring?

Our findings

People we spoke with told us that staff listened to them and talked about the caring nature of the staff team. One person said, [Care worker's name] is very kind and caring and often I will have a chat with [them] about how I am feeling" and another person explained, "Generally everyone is nice and caring. The support worker is really good and we often have a cup of tea together."

The staff we spoke with understood people's needs and knew them well. One person had recently moved into the service, from the provider's other service. We observed a care worker who had supported them in their previous accommodation was assisting them. This helped the person settle in and ensure a smooth transfer between services. The person spoke about their interests and what they liked to do and there was a plan to give them an induction into the service. This demonstrated that support was planned in a way that provided consistency of care for people.

Residents meetings were held between people and staff to discuss their suggestions or concerns and they were informed about any changes in the service. Staff told us about the ideas and topics that were discussed, such as health and safety, activities, nutrition and wellbeing. Information about other external services people could access was displayed in communal areas and this was brought to the attention of people during residents meetings.

People were involved in making choices about their care and how they wished to spend their day. The majority of people who used the service were independent and made their own choices about their day to day routines. There were communal areas in the premises where people could socialise, attend activities or sit quietly and read the various books that were on display. One person told us they had made the choice not to engage with activities but did mix with the other people in the service, when they chose to.

People's dignity and privacy was respected. One person explained that staff were respectful and polite and listened to their concerns, and knocked on their door to see if they were alright. Another person said that staff knocked on their door and waited for permission to enter and during our visit, we observed this was done.

People were able to access advocacy and counselling services to ensure their views were listened to and to help with their emotional wellbeing. Staff explained that one person had been a close friend of a person who had died in the service and this had affected their mental health. As a result, staff had been closely monitoring the person's wellbeing. The person had been offered bereavement counselling and a health professional was booked to visit the person to ensure they had a full mental health check-up. This showed that the provider worked with other agencies that provided specialist support and advice when this was required.

Requires Improvement

Is the service responsive?

Our findings

People told us the provider responded well to their needs. One person told us that staff were really good and helped them and said the care workers kept them informed about everything they needed to know. A second person explained that their relative regularly visited them and was fully involved in their care and there was a good rapport between them and their care worker. A third person told us that they did not have any relatives but if a friend wanted to come and visit them there was no problem with this.

People's needs were assessed before they began using the service and care was planned in response to these. Care plans held descriptions of people's individual needs and included information about their health and social care needs. We saw written examples in care records of suggestions for care workers about how people wished to be involved in the care being provided to promote their individual lifestyle choices. The care plans produced comprised of information about people's mental and physical wellbeing, social interests and how they maintained their tenancy. However, some care plans required a more thorough review. For example, where people had not achieved some of their goals from the previous year, these had not been carried forward and updated during care planning reviews. Additionally, there were gaps in people's daily notes and therefore these did not always demonstrate if staff had supported people with their needs as required. These issues were highlighted in the provider's audit and timescales set for them to be addressed.

Staff assisted people to achieve their goals. When people expressed a wish to achieve a goal, staff worked with then to make this possible. A strengths and aspirations assessment was undertaken with people and showed the things they would like to achieve, for example, eating well and staying in physical shape. We noted that one person had bathroom scales in their flat. They told us that they wanted to weigh themselves, stepped on the scales and said they were happy with their weight loss goal. The person commented that they had been able to maintain their weight management because of all the exercise they did. Another person was being actively supported to bid for housing to secure independent living accommodation, as they were ready to live independently in the community.

Staff told us about people's lifestyles and circumstances and this demonstrated they understood people's needs and preferences well. They told us that the majority of people who used the service were able to complete some tasks independent of staff, and some people required more support with their daily routines. For example, staff helped people to maintain the cleanliness of their flats and explained this was beneficial to people's overall wellbeing.

People had opportunities to join in activities that reflected their interests. Planned activities had been arranged with people from another scheme in the local area. Activities that people could participate in included a computer workshop, movie evenings, walking groups, yoga and a nutrition workshop. One person told us how they had benefited from the workshops and said they had friends in the other service and joined in the activities that had been organised by staff. They told us that they had attended the swimming baths three times a week and the yoga workshops. Another person explained they were going to embark on a walk accompanied by a member of staff during the afternoon. Records showed that one

person participated in educational courses, such as a computer course and another person was seeking voluntary work. This showed that people were encouraged in engage in activities and maintain the hobbies and interests they enjoyed.

The provider had an equality and diversity plan in place and some parts of the plan had been implemented. For example, the recruitment practices were followed to ensure a female and male member of staff were employed who spoke different languages to meet people's individual needs. Staff had opportunities for leaning and had completed training on transgender awareness and modern day slavery so they had an awareness of equality, diversity and human rights.

People told us they knew how to make a complaint if they were unhappy about the service but said they had no concerns. One person said they knew how to raise a complaint and would feel comfortable raising any concerns. A second person explained if they had any complaints they would speak with the member of staff on duty about this. A third person told us they had no complaints about how the service was run and had nothing to complain about. Systems were in place for recording and managing complaints. Leaflets were pinned up on the notice board about how people could raise a complaint if they were unsatisfied with the service. Records showed there had been two complaints and these had been investigated and satisfactorily resolved.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection, we received information about an incident that evidenced that confidential data was not always handled appropriately in line with the Data Protection Act 1998 (DPA). We reviewed records to make certain that night time checks were being conducted in line with the provider's policy and in particular on the date of the incident we had been notified of. However, staff were unable to provide records to show when night time checks were completed or the outcome of these. Therefore, we could not be assured that appropriate monitoring was taking place at night to ensure people's security and safety. After the inspection, we spoke with the operations manager who told us they could not locate the records related to night checks and said they would request these from the external company that carried out the checks.

The provider had carried out an audit of the service in February 2018. This aligned with the Care Quality Commission (CQC) methodology and the outcome showed that the provider had rated the service as requires improvement in safe, caring, effective, and responsive and inadequate in well led. The audit report showed there was 322 areas that were quality assessed and identified 72 areas that required action. This included the titles of the staff who were responsible to ensure that the action plan was met and the deadline dates. The audit was comprehensive and identified some areas of improvement we identified during our inspection, including medicines, care records, health and safety checks and fire safety checks. However, it did not identify all the shortfalls we found including making certain that written records were in place to evidence how people's medicines were managed when they began using the service and the gaps found in the recording of medicines temperature checks. Risk assessments were not updated to reflect the changes in people's circumstances. The audit did not pick up the dates of the gaps we found with the fire checks. After the fire incident, we received information from the provider to show that a night concierge had been appointed solely for the project for enhanced monitoring. However, we did not find evidence to show these checks were being carried out consistently. There was no designated manager documented in the audit to show who was responsible to oversee the lack of staff supervision, their progression and recognition for the work they did.

There was uncertainty about what staff should do to when reporting unsafe practice. Information was not always managed in line with the Data Protection Act. Robust night checks were not consistently carried out. There was a lack of evidence to demonstrate that regular audits were undertaken and appropriately followed up by the provider. This meant that the service was not operating effective systems to ensure the quality and safety of people who used the service.

The above issues constitute a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

People's care records were stored electronically. Staff accessed people's records online using protected passwords to ensure the security and confidentiality of data and people's medicines records were held securely in lockable cabinets.

Before our inspection, we spoke with a representative of the local authority who explained there had been

quality issues in relation to the management of the service and that some of the outcomes for people were not being met. During our inspection, we found a lack of consistent and clear leadership which had a negative impact on the service.

The staff structure included two support workers, a team leader, a registered manager, an area manager and an operations manager. At the time of the inspection there was an interim registered manager in place who was covering the absence of the permanent registered manager. The interim registered manager was available during our visit; however, they had also taken leave and had recently returned to the service. They were available to speak with us during both days of our visit. We asked them about their knowledge of an incident that had occurred, and they explained they had limited information about any recent incidents since they had been on leave. They said they had a lot of admiration for the support workers who had contributed to providing a consistent structure for people who used the service.

We spoke with the team leader who had been in post since January 2018 and had previously worked for the provider in another service. They were knowledgeable about the processes of the organisation as a whole, but they explained were not given a good handover when they joined. They spoke positively about the staff team and told us they were on duty five days a week. When we asked for details about the fire incident, they were unable to tell us about what had happened, as this had occurred before they began working in the service.

The area manager was available during both days of our visit. We gave them feedback about the service and they spoke candidly about what had gone wrong in the service and what the service could do better. However, after the inspection, we were informed that the area manager no longer worked for the service and had moved on. The operations manager explained there was a plan in place to recruit an interim agency area manager. They said they were also ensuring that another interim service manager who had recently been recruited to oversee the other provider's homes that included Colville Terrace had received an effective induction.

During our inspection, it was evident that a permanent member of staff, who had been in post for approximately six months, had been running the day to day operation of the service whilst ongoing concerns were being investigated. People spoke favourably about the staff member and referred to how well they supported them during our visit.

The turnover rate for senior staff was high. Information about the service was not shared between line managers in the service. The provider was unable to demonstrate that regular staff team meetings had taken place to give staff the opportunity to express their views and involve them in the running of the service.

People told us they had positive experiences of using the service. Feedback was sought from people about how the service could improve in a variety of ways. This included staff obtaining feedback from people during their one to one meetings. People had been interviewed during the provider's audit in February 2018. This included questions on their safety, their employment, finances, medicines, staffing and if they were happy with their care and support. The results were positive overall. There was also a suggestion box that was used to collect people's ideas about the colour scheme used for the décor in a communal room. An annual survey was due to be undertaken and the provider explained this would be brought forward due to recent incidents. The provider worked jointly with other health and social care professionals to carry out planning and reviewing for people's care and support and to ensure they met their needs effectively.

Providers of health and social care are required by law to inform the CQC of significant events that happen in

the service and we had been kept informed of these events when they 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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks to ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (d) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided and did not always maintain records securely in relation to the management of the service. Regulation 17 (1) (2) (3) (a)(b)(c)(d)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met:

The provider did not ensure the staff received appropriate supervision and appraisals to enable them to carry out the duties they are employed to perform Regulation 18 (1) (2) (a)