Living Ambitions Limited

Living Ambitions - Newcastle

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

Summary of findings

Overall summary

We last inspected Living Ambitions – Newcastle ('Living Ambitions') on 11 April 2017 and found it was meeting all legal requirements we inspected against. We rated Living Ambitions good in all of the key questions at that time.

Living Ambitions provides personal care and social support to people living in their own homes in Newcastle and Northumberland. At the time of our inspection there were 54 people with a learning disability and/or a mental health related condition receiving a regulated activity from the service, mostly on a 24/7 basis. Not everyone using Living Ambitions 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.

This inspection took place on 6 and 13 February 2019, with further phone calls with relatives and external professionals on 15 and 18 February 2019. The inspection was unannounced.

The service had a registered manager in place. 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 service was not well managed. The registered manager and supporting leadership staff had not ensured a move to the new office and the implementation of new records had been managed well. There was lack of oversight regarding core processes and information, such as care records and medicines administration.

Medicines were not always managed in line with good practice guidelines and staff competence regarding medicines administration was not consistently assessed.

Service managers and team leaders had not carried out effective spot checks of support workers to assess their competence and the accuracy of care records.

In depth risk assessments were not always complete following an initial general assessment of risk. Staff knowledge of the risks people faced was good but there was evidence of some risks not being assessed appropriately.

Financial management arrangements in place were not always flexible enough to meet people's changing needs and preferences.

People's goals were not clearly documented or acted on. We have made a recommendation about this.

A range of training had been delivered to staff on joining the service, with regular refresher training provided.

There were improvements to be made to the efficiency of the system used to remind staff to complete training and the provider was a aware of this. We found instances where staff required specific training to support people and had not had this training. Staff had however been working with a suitably experienced member of staff, reducing the level of risk.

People spoke highly of the staff who supported them to live at home. They told us they felt safe, respected and comfortable. Policies and procedures were in place to safeguard people from harm and the staff we spoke with understood their responsibilities. Lessons however were not always learned following incidents to ensure the service made improvements on an ongoing basis.

Care plans were not always person-centred and required review. At times, person-specific information was difficult to access. New paperwork had been introduced and it was evident staff were not yet comfortable or confident in new ways of recording people's needs and goals. People's personal sensitive information was not always kept safe.

Recruitment processes continued to be robust and staff were safely recruited. An induction process was in place and staff training was up to date.

Staff told us they received supervisions and team meetings were held within each household. This however was dependent on the availability of senior staffing.

We found staff understood the principals of the Mental Capacity Act (2005) and their responsibilities. Documentation relating to decisions that were made in people's best interests were at times incomplete or inaccurate.

People told us the staff supported them to maintain a balanced diet. They said their support workers made good meals and always offered them a choice. People told us that their support workers understood their likes and dislikes and staff we spoke with demonstrated this.

Everyone we spoke with and their relatives felt they were treated with dignity and respect.

An annual satisfaction survey was used to formally gather opinions about the service.

The service was not working to principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around consent and 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

The service was not always safe.

Risk screening documents were in place but these had not been translated into accessible, clear risk assessments to guide staff.

Staff skills had not always been assessed to make sure staff could administer medicines safely.

People felt safe and had long established support workers who knew their needs well.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received the relevant training to ensure people's needs could be met effectively.

Documentation relating to people's ability to make informed choices was not always complete or accurate.

People had access to external health services.

Is the service caring?

Requires Improvement

The service was not always caring.

People's personal sensitive information was not always securely stored.

People were treated with dignity and respect.

People had formed strong bonds with staff they had known for a number of years.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always up to date and accurate.

Management of people's finances was not flexible enough to enable people to live their lives the way they wanted.

Staff demonstrated an in depth knowledge of people's preferences.

Is the service well-led?

Inadequate

The service was not always well-led.

Auditing and governance procedures had not effectively identified or remedied the problems we found during inspection.

There had been high levels of staff turnover at service manager and team leader level, which had disrupted the service.

The provider reacted promptly when areas of concern were identified and shared.

Living Ambitions - Newcastle

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 prompted in part by concerns received by CQC from an anonymous source about the standard of management of the service.

Inspection site visit activity started on 6 February 2019. We visited the office location on this date to see the manager and office staff. We also began visiting people in their own homes on this date to speak with people and to review care records. We visited more people who used the service on 13 February 2019 and made additional phone calls and emails to people's relatives and external health and social care professionals on 15 and 18 February 2019.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by CQC, and previous concerns shared with us. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams and safeguarding teams.

During the inspection we spoke with six people who used the service. We observed interactions between staff and people who used the service. We spoke with 13 members of staff: the registered manager, two area managers, two service leaders, six support staff and two office administration staff. We looked at six people's care plans, risk assessment information, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. Following the inspection we spoke with three social care professionals and two relatives.

Requires Improvement

Is the service safe?

Our findings

Risks were not effectively or safely managed. The provider had in place a 'Risk screen' document which set out in basic terms the risks people faced. These documents had been introduced since the provider took over from a previous care company and were intended to set out where further risk management work was required. They were a logical starting point for risk assessment but we found several instances where identified risks did not lead to comprehensive risk assessments. For instance, one person who was a clear risk of falls had this documented in the 'Risk screen' but staff supporting them were unaware of a specific falls risk assessment. When we reviewed the person's care plan we saw there was relevant information about how the risk of falls could be minimised. This was not easily accessible and staff we spoke with were unaware of where it was kept. The registered manager and senior staff had implemented new care documentation but had not ensured staff understood the new system. This meant staff were unable to easily locate risk assessments and new staff may not have access to them.

Staff told us, "We used to have risk assessments we understood," and, "They used to be separate – they are archived away." It was evident staff were not confident in using the new risk assessment documentation. The majority of staff we spoke with had been caring for the same people for a number of years and were able to demonstrate a good knowledge of the risks people faced. There was however a danger that, given the relatively high turnover of staff recently, that newer staff would not be aware of the levels of risk people faced, and would not be able to rely on the information in people's homes because it was not up to date or accurate.

For instance, where one person required a specific type of diet this was not well documented in the care file and it was not apparent that the information had been reviewed recently. Staff ensured the person ate in line with the most recent advice they had access to and did demonstrate a working knowledge of the person's needs. There was however a risk of the person receiving the wrong type of diet due to the inaccuracy of records. The provider ensured this person's care records were reviewed immediately and a review of the advice in place from speech and language therapy team completed, with an additional up to date review put in place.

The administration of medicines was not always safe and in line with good practice as set out by the National Institute of Health and Care Excellence (NICE). For instance, whilst the provider could demonstrate staff had been trained in the safe administration of medicines, arrangements for assessing the ongoing competence of staff in this regard were not clear. Some staff could not recall having their competence assessed and, when asked about the level of scrutiny and supervision their practice was subject to, this varied depending on the service manager or team leader at that location. This meant we could not be assured that staff practice was consistent and observed by the provider to be in line with good practice. This put people at risk of harm. We found instances of poor medicines administration practice with regard to topical medicines (creams). There were no body maps in place and no detailed description of whereabouts on the person the cream should be applied. Again, people's safety was dependant on staff knowledge and was not supported by clear record keeping.

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

When notified of these risks the provider took prompt action to ensure the poor standards of documentation did not have a practical impact on people's wellbeing. They updated the documents immediately and put in place additional staff training regarding people's medicines.

Safeguarding training was in place and staff were aware of their safeguarding responsibilities. There were on-call arrangements, should staff have concerns out of hours.

Lessons were not always learned at a managerial level when things went wrong. For instance, we found one example of a person being put at risk through the conduct of a member of staff. This was not reported in a timely manner. This delay had not been addressed by managerial staff at the time of inspection and meant there could be a risk of repetition. When we raised this with the provider they ensured refresher training was put in place.

People we spoke with told us, "They look after me well," and, "I am always safe and secure." We observed relaxed, amiable interactions between people who used the service and staff. External professionals we spoke with expressed confidence in the ability of core, experienced staff to keep people safe and to ensure their needs were met. They also however acknowledged an ongoing issue with staff turnover. This meant people who used the service were more at risk through information not being effectively shared between staff.

Pre-employment checks were in place, for example references, identity checks and Disclosure and Barring Service checks. These ensured prospective staff did not present a risk to vulnerable adults.

Appropriate infection control policies were in place and staff confirmed they had all the necessary personal protective equipment they required.

Staffing levels were appropriate to the needs of people who used the service and the rota was planned such that people were not at risk of missed calls. The majority of the support in place meant staff were with people for a number of hours at a time and there were no short calls. Staff voiced concerns about how well rota planning and management was communicated.

Requires Improvement

Is the service effective?

Our findings

Staff received a range of training the provider considered mandatory to ensure they were given the skills to meet people's needs. This included moving and handling, safeguarding, first aid, food safety and fire awareness. The provider was in the process of moving all staff training records onto a centralised system at the time of inspection, in order to improve the way they recorded and managed staff training. They hoped this would improve their ability to ensure staff received the appropriate refresher training at the right time. At the time of inspection, 71% of staff were fully up to date with training. We found some instances of staff not having received training in a timely manner. One member of staff supported a person with a specific type of rescue medication, but had yet to receive the appropriate training. Whilst the provider could confirm they had only ever worked whilst being supported by an experienced, suitably trained member of staff, they acknowledged the staff member required this training.

Where initial training had been provided but ongoing assessment of competence was required, this was not always clearly recorded. For instance, one person had to have food and fluids administered via a Percutaneous Endoscopic Gastrostomy (PEG). A PEG is a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Staff had received initial training in this process but there was no evidence to demonstrate ongoing competence assessments by a clinical practitioner. The provider rectified this as soon as was practicable.

Staff feedback was mixed about training, with the majority confirming there was a practical balance of face to face and online training. Some staff were concerned they had to travel greater distances to attend training workshops than they would have done previously, though this was not a consensus view. One new member of staff told us, "There has been lots of training and then hands-on support. I've always been with experienced people and always supported." A more experienced member of staff told us, "I don't think there's anything else we need – they always remind us when it's time."

Staff gave mixed feedback about levels of formal support they received. One stated, "I know who my manager is and we have regular supervisions," whilst another said, "Managers are coming and going and we are left in the middle." We found the majority of support staff did not have confidence in the current arrangements in place for their immediate line management and the support and direction they received. This was directly linked to the high turnover of staff at team leader and service manager level, which the provider acknowledged as a destabilising factor.

Staff confirmed they did not receive a specific amount of handover time between shifts, with one staff member starting at the same time the previous one finished. This meant all important information needed to be handed over quickly, or else effectively and efficiently documented in paperwork.

We received mixed feedback from external healthcare professionals about how well staff liaised with them in order to meet people's needs. One professional told us, "There are often things that don't get communicated well – they hold back a bit, I feel." Another said, "They have always been responsive and have got on top of things straight away."

People were supported to access primary and secondary healthcare through the support of care staff. For instance, people attended GP appointments, annual health checks, eye check-ups and chiropody. Likewise, people's social appointments were documented, for instance hair appointments and visits to family.

We received positive feedback from people who used the service about how well they got on with experienced staff and how well these staff met their needs. External professionals confirmed there were a number of people who benefitted from stable staff teams who knew their needs extremely well. Where there had been staffing turnover and a lack of local management, they did not feel assured that people's needs were consistently met.

People we met were supported to make their own meals or, where they were unable, staff would do this, adhering to their likes and preferences. One person told us, "They do a mean lasagne," whilst another person enjoyed the cake their support worker had made for them.

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.

Due to the poor standard of record keeping it was not always possible to establish if people's best interests had been considered in the planning and review of their own care. Capacity was not well documented. For instance, two capacity assessments we reviewed contained other people's details on the forms and it was unclear who had been involved in the decision. When we spoke with staff it was evident their understanding of capacity was specific to the person and each decision they may need to make, but records did not reflect this. There was no clear understanding by staff regarding who should complete these assessments and when. The provider took urgent action to involve people's advocates and address this matter following our inspection.

The system in place to help people manage their money did not enable people to be independent and make choices. The system was slow and overly complicated. The service held the position of financial appointee for a number of people who used the service. This meant they controlled the person's benefits. Currently, staff had to request money for people via the office, which then had to generate a cheque to access the money. Relatives and staff both agreed that people's finances were more flexibly managed and person-centred when people had their own bank cards. Office staff told us the plan was to move to online banking, as per the provider's policy, but they were unsure when this would happen. This current system was dependent on staff at each person's home helping them plan ahead and did not allow for as much flexibility as people had enjoyed previously.

One relative told us, "I feel the financial arrangements are for the benefit of the organisation, not the people." The provider told us they were in the process of reviewing each person's appointeeship and involving those who knew them best to decide what would work best for them in future. Records of financial expenditure we saw were accurate but records of people's individual budget planning, as with the rest of the records we saw, were incomplete and had not been reviewed. The provider had written to each person using the service regarding the change from the old system to the new, but had not given people the option to retain their old bank accounting preferences. This was clearly restrictive.

This arrangement did not support the ethos of supported living schemes or of encouraging individual independence. The MCA states that people should be assumed to have capacity (until established

otherwise) to manage their own lifestyles, including their finances and medicines. If these restrictive practices were in people's best interests, mental capacity assessments should have been carried out and recorded on their care files. Records around consent and capacity were incomplete and there was no clear indication that people understood and were happy to consent to these practices.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were not always appropriately supported to make choices about their care needs and lifestyle.

Requires Improvement

Is the service caring?

Our findings

People's involvement in their own care planning and review was not always clear, as records were not always updated. We spoke with people who evidently did feel included by their support workers in day to day decisions. Less clear was how they were supported to be involved in more comprehensive reviews of care. The provider told us formal reviews should take place annually and more often if people's needs changed. We found this had not happened in some cases. The provider took immediate action to ensure each person's needs were reviewed and updated where necessary. Our observations showed staff interacting with people well with a view to them playing a part, for instance helping to check their own medicines and talking through the administration procedure with staff.

External professionals we spoke with felt people were supported by staff who knew them well. They confirmed, where there was a stable staff team, there was confidence in the ability of staff to ensure people were involved in all aspects of care planning and to play and active role in their care. Where there was a high turnover of staff, they had concerns about the provider's ability to ensure these staff were fully aware of people's individualities. We found this to be the case, with some people who used the service expressing concern about the level of supervisor and/or management turnover.

Some documentation had been updated without proper planning or checking and, as such, incorrect information was contained in people's care records. On occasion this included the names of other people who used the service. This meant records were not always stored and handled sensitively.

People who used the service were generally happy with the service provided and the level of support offered by staff. The majority of people we met had evidently formed longstanding bonds with core members of care staff, with whom they displayed warmth and affection. We saw this was reciprocated by staff who, where they had been at the service for a number of years, had got to know people well. Relatives confirmed, "One member of staff has been there for 25 years, a rarity in care. They know [person] so well."

People were treated with kindness and compassion. They told us, "Staff look after us," "We are well looked after," and, "I love my [support workers]. They are brilliant." People who were unable to speak with us indicated they were comfortable in the presence of staff through smiles, signs of affection and the sharing of jokes. People were made to feel valued and respected through the thoughtful interactions of staff. Where people valued relationships with family members staff helped people visit them.

Relatives told us, "You can't fault the care staff at all, they look after people very well," and, "The staff in people's houses are fantastic." One social worker said, "The staff there are very person-centred and know absolutely everything about them."

Staff understood people's communicative needs and made sure they were involved in day to day decisions through tailoring their means of speaking accordingly. People's dignity was maintained and they were helped to achieve outcomes meaningful to them. One person showed us how they had been helped to have a bath seat fitted in their home. They said, "I love baths, I have them all the time and this helps me do that."

They also showed us the board they used to plan meals and activities, and large display clocks which also had the date on. They told us this helped them keep a track of the day and time and feel more in control of their life.

Requires Improvement

Is the service responsive?

Our findings

Staff agreed that records were not fit for purpose, for example saying, "If there was a new starter they'd struggle. They'd be dependent on shadowing and these records wouldn't be good enough." We did see some positive instances of new approaches being implemented, for instance one person's Positive Behaviour Support (PBS) plan. This however did not align to the person's other care records. PBS is a means of improving a person's quality of life through detailed planning based on their known behaviours. This was not representative of the service though and there were other instances where people's views had not been properly consulted. For instance, one person's support hours had significantly reduced but this decision or the impact of it had not been communicated to them, nor was there evidence they had been involved in the decision.

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

People who used the service had access to a range of activities meaningful to them, facilitated by staff who understood what was important to them. We found some positive instances of staff teams understanding people's needs extremely well and ensuring they were protected from the risks of social isolation through taking part in various activities. One person regularly went to a Zumba class, a disco, visited their relative and went on holiday. They were currently planning their latest holiday and were extremely excited about this. Other people told us, "I like going on the bus to Newcastle," and, "I love going shopping." Two people showed us their new ipads and how they liked to spend time on them. One person enjoyed old films, another swimming. We saw evidence of these activities happening regularly.

At times people were not always treated as individuals. People who lived together and did not always share the same interests at times felt they had to undertake the same activities and were not treated as individuals but as a collective. Staff needed to take care to treat them and their interests as individuals, and not assume they should undertake the same activities. This had happened on occasion. We fed back to the provider who agreed to review this situation and make improvements.

People's likes and dislikes were well understood by staff who cared for them, for instance their dislike of a type of food, or their love of a type of old film. As with other aspects of care planning, this was rarely well documented. We saw the provider had introduced new care plan documentation but this had not been completed properly. For instance, each person had a document which was intended to set out their goals and monitor their progress towards these goals. The majority of care files we looked at contained blank copies of these documents and staff told us they were unclear on when or how to fill them in. People's level of independence had not been meaningfully reviewed and assessed to see if these tools were appropriate to their needs. Additionally, there was evidence in people's daily diaries and other records of them achieving independent goals. This meant, whilst people were achieving some positive outcomes, this wasn't well planned or documented. The provider needed to ensure any new implementation of documentation was relevant, fit for purpose and, most importantly, fit for the needs of people who used the service.

We recommend the provider review the documentation and processes in place for recording and planning towards people's goals and ensure this is appropriately shared with staff, with sufficient oversight in place.

Where there was a consistent staff base and a continuity of care, external professionals had more confidence in the service. Where there was a high turnover of staff, whether at support worker level or at the team leader or service manager level, there were concerns about people's needs not being met through poor communication and governance. We found this to be the case in the care documentation we reviewed and conversations we had with staff and people who used the service.

No one using the service was in receipt of end of life care at the time of inspection; the provider had an appropriate policy in place.

General documents like the service user guide were available in easy read format but there was no evidence of accessible documentation being used to facilitate people's involvement in their own care planning and review. This is contrary to the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The provider had sought people's views, and the views of relatives, in the previous year, via surveys. Only 14% of surveys were returned. Whilst the vast majority of responses were positive, the registered manager had not worked to ensure those people who may not be able to, or would prefer not to, complete a survey, has other means of contributing feedback.

Staff had liaised with external agencies to meet people's needs and there was some evidence of multi-agency working. There was however no clear lead at the service who took responsibility for ensuring these meetings or advice were well embedded into practice and care documentation. This meant we could not be assured people received responsive, person-centred care. Relatives we spoke with confirmed they did not have a clear point of contact at the service for when they had queries.

Inadequate

Is the service well-led?

Our findings

Auditing and governance systems were in place but they had not proved suitably effective to identify the underlying problems we found on inspection. Oversight was poor and there was a lack of effective prioritisation. The registered manager told us they planned to have cross-site auditing in place where service managers would review the records at different locations. This had not happened yet due to the high turnover of staff at that level.

We met a range of staff who were committed to the needs of the people they supported but unclear about how to implement the new documentation and systems in place. They were not well led at a local level because there was significant turnover at service manager and team leader level, and because these staff were not given clear responsibilities with regard to the rollout of the new systems.

Morale was low and a number of staff felt they were undervalued and not communicated with well. We experienced examples of this during the inspection, for instance one member of staff receiving an instruction via text message to attend a training event, but without detailing the nature of the training. There was a consensus of opinion that there was a considerable gap between office staff and care staff, the result of which were poorly managed systems and a lack of oversight. The provider had done little to counter this, for instance offering shadowing across the job types to ensure staff had mutual respect for each other's roles, or holding more regular meetings.

At the last inspection we commented on the positive atmosphere in the office and the vibrancy brought to it by people who used the service visiting, as well as staff. The provider had since relocated the office and we found visitors were few. One person who used the service told us how they missed the interactions they used to have with office staff and said, "It's all different now, I don't see them. I used to know the managers. I want to move." The level of staff turnover at leadership level was having a demonstrable negative impact on people's confidence in the service.

Where people had an established team leader we found these working relationships were positive and a management presence was a regular occurrence at people's houses. There remained however a lack of effective oversight regarding each person's care records and documentation as there was no clearly established accountability. Staff were unclear on their role in terms of completion of records, whilst team leaders and service managers similarly were not clear regarding who was responsible for updating and checking care plans and related information. As such, we found a number of instances of poorly maintained records and incomplete or inaccurate information in people's care records.

Again, opportunities were missed at all leadership levels to ensure people's records were appropriately updated (or to effectively raise the problems we had encountered). Effective auditing would have identified the incomplete, inaccurate and out of date information we encountered on the inspection. As such, any new staff would be working to information that was outdated and put people at potential risk of harm. These risks pertained to the day to day risks people faced, diet, medication and capacity and were directly linked to the poor standard of record keeping.

External assessment by the authority who commission services had previously demonstrated that there were a number of gaps in the provider's documentation and policies. These had not been sufficiently addressed. The registered manager had been in place for a year and, given the relatively small size of the service and appropriate corporate level support in place, should have ensured improvements had been made. The provider acknowledged there were shortcomings in the management of the service.

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

Staff we spoke with did not at the time of inspection have the confidence to raise these issues formally. Feedback from them about the support they received from their managers was inconsistent. The provider stated they intended to hold a number of staff meetings to encourage and involve staff more. The provider took a range of urgent actions immediately subsequent to the inspection to ensure people were safe and the process of making improvements could begin.

Relatives we spoke with expressed a level of anxiety in their dealings with the provider previously. One stated, "The care staff are great but when you try and get answers from higher up it's like pulling teeth." This was representative of the feedback we received regarding a service that was not well managed, and which relied on the knowledge of longer-term support staff to ensure people were safe.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's best interests were appropriately considered and documented. Practice was not in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure appropriate quality assurance and auditing processes identified errors and led to improvements. Records were not accurate, up to date and contemporaneous. Records were not fit for purpose.