Alliance Medicare LLP

Lighthouse Homecare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 May 2016. To ensure we met the provider and staff at the service's main office, we gave short notice of our inspection.

This location is registered to provide personal care to people in their own homes. The service provided personal care support to ten people in a supported living service. The premises consisted of individual rooms which people could lock and shared communal areas.

We are currently reviewing details of the service provision at the premises to ensure that the provider is registered for the correct regulated activity.

People who used the service were younger and older adults with either physical or mental health needs or learning disabilities and people with alcohol and substance misuse needs.

The service did not have a registered manager. 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 did not have a registered manager in place to ensure the effective operational management of the service. The provider had not ensured effective oversight of the service in the absence of a registered manager.

Staff had not received the relevant training or understood what processes they needed to follow to keep people safe from possible harm. Staff had not received training to meet people's individual care and treatment needs. Staff had not received training in the principles of the MCA (2005). Staff had not received regular supervision to address their training and development needs to ensure people received effective care.

Fire safety measures were not sufficiently robust to ensure people would be safely evacuated in the event of a fire. Health and safety assessments had not been completed to ensure the environment was safe for people.

There was an insufficient staffing level to meet people's assessed needs. The provider had not completed safe recruitment checks to ensure staff were suitable to care for people.

People had not consistently had access to appropriate health professionals to effectively meet their health needs. People's care and treatment was not routinely reviewed with the involvement of relevant health care professionals to ensure their health, safety and welfare.

Staff had not reviewed people's care plans and risk assessments regularly with their involvement. Staff followed care plans and provided care which did not reflect people's most current needs and preferences.

The provider had not encouraged people or explored different ways of giving people information about how to make a complaint. A complaints process was not in place to ensure service improvements were made.

The provider had not considered accessible ways to inform people about services available to them, to include advocacy. We have made a recommendation about this.

People's care plans were not personalised in all cases to enable staff to meet people's individual preferences. We have made a recommendation about this.

The provider had not notified us of significant events at the service. The provider had not demonstrated they understood their regulatory obligations to share important information with us to keep people safe.

The provider had not routinely consulted people or staff to obtain their feedback to influence how the service was developed.

A robust quality assurance system was not in place to effectively identify all service shortfalls and to ensure service improvements were made.

The service supported people to have meals that were in sufficient quantity, well balanced and met people's needs and choices.

People told us staff treated them with kindness, compassion and respect. People's privacy and dignity was respected by staff. Staff promoted people's independence and encouraged them to be as independent as possible. People were supported to take part in activities based on their needs and wishes.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate', and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Staff had not received the relevant training or understood what processes they needed to follow to keep people safe.

Fire safety measures were not sufficiently robust to ensure people would be safely evacuated in the event of a fire.

Health and safety assessments had not been completed to ensure the environment was safe for people.

There was an insufficient staffing level to meet people's assessed needs. The provider had not completed safe recruitment checks to ensure staff were suitable to care for people.

Medicines were stored, recorded and disposed of safely and correctly.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff had not received training to meet people's individual care and treatment needs.

Staff had not received regular supervision to address their development needs to ensure people received effective care.

Staff had not routinely obtained people's consent to ensure they received care in the least restrictive way.

People had not consistently had access to appropriate health professionals to effectively meet their health needs.

Staff supported people to have meals that were in sufficient quantity, well balanced and met people's needs and choices.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's views about the caring approach of the service were not routinely recorded as part of care reviews or other consultation processes.

The provider had not considered accessible ways to inform people about services available to them, to include advocacy.

People told us staff treated them with kindness, compassion and respect. People's privacy and dignity was respected by staff.

Staff promoted people's independence and encouraged people to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff had not reviewed people's care plans and risk regularly with people's involvement. Staff did not follow care plans which reflected people's most current needs and preferences.

People's care and treatment was not routinely provided with the involvement of relevant health care professionals to ensure their health, safety and welfare.

The provider had not encouraged people to make a complaint. A complaints process was not in place to ensure service improvements were made.

People's care plans were not personalised in all cases to enable staff to meet people's individual preferences. We have made a recommendation about this.

Is the service well-led?

Inadequate

The service was not consistently well led.

The service did not have a registered manager in place to ensure the effective operational management of the service.

The provider had not notified us of significant events at the service. The provider had not demonstrated they understood their regulatory duties to share important information with us to keep people safe.

The provider had not routinely consulted people or staff to influence how the service was developed.

A robust quality assurance system was not in place to effectively

identify all service shortfalls and to ensure service improvements were made.

Lighthouse Homecare

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 18 and 19 May 2016. To ensure we met the provider and staff at the service's main office, we gave short notice of our inspection. The inspection was undertaken by one inspector and a specialist advisor. The specialist advisor had professional experience of mental health and substance misuse services. We checked the information we held about the service and the provider. We reviewed notifications that had been sent by the provider as required by the Care Quality Commission (CQC).

The registered manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

During our inspection we spoke with five people. We also spoke with the provider, the deputy manager (who had been in post for one month) and three members of staff. We looked at eight care plans. We looked at three staff recruitment files and records relating to the management of the service, including quality audits.

Inadequate

Is the service safe?

Our findings

People said they felt safe with the staff that supported them. Nobody reported any concerns about their safety in respect of the service they received. People said, "I like it here. They [staff] keep me safe" and "It's nice here." One person talked about support from their key worker. A keyworker is a named member of staff that is responsible for ensuring people's care needs were met. They told us they were supported on visits outside the home as they did not feel safe going out on their own. However, people did not have access to accessible information about how to stay safe. Staff told us they had previously asked for DVDs to help people understand information such as keeping themselves safe from harm. The provider had not addressed this request.

Staff did not have the required training to identify safeguarding concerns and to confidently act on these to keep people safe. The deputy manager had arranged for staff to complete online safeguarding training. At the time of the inspection, staff had not completed training in this area. There was a whistleblowing policy in place. However, not all staff were aware of the policy or how to effectively report any concerns they had about potentially poor care practices. People could not be assured that they were safe from harm as staff had not had the training or knowledge of policies to keep people safe.

People were not always protected against the risks of potential abuse. Where people declined health care support and their health deteriorated, or when health care services had not provided adequate care, the provider had not referred their concerns to the person's funding authority in a pro-active way to ensure their health needs were met. Where people were inappropriately admitted to the service, sufficient action had not been taken by the provider to safeguard the well-being of the person, other people at the service and staff. The provider had not referred their concerns to the person's funding authority in a pro-active way to ensure people's needs could be safeguarded in their best interests.

The service did not always protect people and their belongings. People told us that their belongings including toiletries and food had gone missing. Staff told us the service had investigated these allegations and people had been reimbursed for missing personal items. However, the provider had not recorded information about the investigation or reported safeguarding concerns to people's funding authority and to CQC to ensure this was formally investigated.
The lack of effective systems and processes to protect people from abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recent safeguarding investigation identified that not all staff had been trained in medicines management. Staff had not received an adequate induction into how medicines were managed at the service. One person had not received their medicines in an appropriate and safe way. This contributed to a decline in their health needs which had led to a hospital admission. In response to this investigation, the deputy manager had booked staff on medicines management training on 07 June 2016. The deputy manager told us they had reviewed staff competence to give people their medicines. However, competence assessments for staff had not been recorded. At the time of the inspection staff had not received this training to ensure all staff were competent to give people their medicines.

Medicine Administration Records (MAR) had allegedly been stolen from the service and this formed part of a safeguarding investigation. We could not verify that people had received their medicines in a safe way prior to the date MAR were removed from the service. The provider could not update us on how the investigation was progressing. We have asked the provider to update us with the outcome of this investigation.

The lack of effective management of medicines is a breach of Regulation 12, 2 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had not always been assessed before they received support from the service. For example, where someone had behaviours which may challenge, a pre-admission assessment had not been completed. There was no information available to enable staff to effectively support the person, ensure their needs were met and support the wellbeing of other people at the service. People and staff told us this had a negative impact on the mental health and emotional well-being of people.

The lack of safe care and care planning is a breach of Regulation 12, 2 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have a good understanding of their responsibilities for reporting accidents, incidents or concerns to keep people safe. Records of accidents and incidents were kept at the service. When incidents occurred staff told us they completed incident forms, informed the deputy manager and other relevant persons.

People were not kept safe from the risk of emergencies. A robust fire procedure was not in place at the time of our inspection. People did not have an individual Personal Emergency Evacuation Plan (PEEP) in place. PEEPs identify people's individual independence levels and provide staff with guidance about how to support people to safely evacuate the premises. The last recorded fire drill took place in July 2015. It was not recorded how people would respond or how staff would ensure their safety in the event of a fire. The deputy manager acknowledged that more work was required to meet the required fire safety standards.

There was no business contingency plan in place that addressed possible emergencies such as extreme weather, infectious diseases, damage to the premises, loss of utilities and computerised data. Procedures were not in place to ensure continuity of the service in the event of adverse incidents.

People's home environment had not been adequately assessed for safety hazards. The provider had not completed health and safety assessments since July 2015, to ensure people lived in a safe environment. For example, one person's reported the lighting in their bathroom needed fixing in July 2015. This has not been repaired until April 2016. The posed a potential safety risk for the person. There were no clear guidelines in place for staff to follow to check equipment was fit for purpose. The deputy manager had identified this since starting in role. They had created an audit for staff to follow to ensure people's environment and equipment was monitored and tested regularly. This audit system had not started at the point of our inspection.

The provider had failed to ensure the premises were used in a safe way. This is a breach of Regulation 12, 2 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured they received their assessed support hours or that there were sufficient staff on shift to meet their needs. Each person had a number of individually assessed hours each week funded by the local authority to meet their support needs. However, records were not in place to demonstrate that people received their funded hours. The deputy manager completed staff rotas four weeks in advance. However,

there was no system in place to ensure staff were deployed to meet each person's support needs. The Local authority reported that people were not receiving the allocated hours they were being funded for. The deputy manager acknowledged they needed to record how people's funded hours were met to ensure people received appropriate support.

People were not able to have visitors to their home after 8pm. The deputy manager told us this was due to only having one staff member allocated on each night shift. People told us they did not agree with this blanket rule and felt it was not fair. This negatively impacted on their emotional well-being.

One person told us the service needed more staff. They said this was because there was only one staff member on a Sunday and it could get quite busy. They told us, "I tend to stay in my room even if I have something to get off my chest because it is too busy." Another person who was assessed as needing one to one support did not have this required support on a Sunday due to the lack of available staff.

We observed on the second day of our inspection that there was one member of staff on shift in the morning. They needed to manage medicines for everyone who required this. Whilst they were supporting one person with their medicines, an argument was taking place outside the staff office between three people. The staff member needed to stop what they were doing to support people and manage the situation. One person became upset and needed support from the staff member. An additional staff member was required at this peak time to ensure medicines could be completed safely, whilst other people's needs could be met as required.

The lack of adequate staffing is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not follow safe recruitment practices to ensure staff were suitable for their role. In two out of three staff files, employment references were not available. Criminal record checks had not routinely been made with the DBS to make sure people were suitable to work with vulnerable adults. Some staff applications had gaps in previous employment history that had not been explained. The provider was not able to assess whether there had been legitimate gaps in staff employment histories. The deputy manager acknowledged that staff files did not always demonstrate that safe recruitment practices had been followed.

The lack of suitable staff recruitment checks is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. Risk assessments in place took account of people's levels of independence and of their rights to make their own decisions. For example, one person was supported to keep safe when they went out on their own. The person took their mobile phone and let staff know where they were going and spoke with staff when they returned. The person had police contact details in their phone in the event of an emergency. They pre-planned long journeys with staff to ensure they had correct travel details and sufficient money. The person told us they enjoyed being able to go out on their own, visit places of interest and meet with their friends.

Inadequate

Is the service effective?

Our findings

People spoke positively about staff and told us they were skilled to meet their needs. One person talked to us about how staff helped them select health food to maintain a healthy diet, "We decide on different types of food, so I have healthy meals" and "Staff know when things are difficult for me. They check on me."

However, people were supported by staff that did not have access to a range of training to develop their skills and knowledge. Training records were out of date. The provider and previous manager had not monitored staff training needs or scheduled training courses for staff. The new deputy manager had identified this shortfall. They had enrolled staff on online training courses in all mandatory training subjects, such as fire safety, safeguarding and first aid. However, at the point of the inspection, staff had not completed training in these areas to ensure they had the required training to effectively meet people's needs.

Staff did not have the required training to effectively carry out their role and meet people's individual needs. For example, the service provided care and support to people with mental health needs or behaviours which may challenge. However, staff had not completed training to effectively support people with these needs. For example, where people did not accept staff authority or overstepped acceptable boundaries, staff told us they were not clear how to support people consistently or effectively in these situations. They told us they could benefit from training in these areas.

The provider had not supported new staff to complete an effective induction programme before working on their own. Induction records were not in place for staff at the service. The deputy manager acknowledged the previous induction process did not meet staff needs. They had recently implemented the new 'Care Certificate' training to be used with all staff. Three staff had started the Care Certificate at the point of our inspection. This is based on an identified set of standards that health and social care workers adhere to in their daily working life. Staff competence in meeting the requirements of the Care Certificate was to be assessed by the deputy manager. Staff had started to record information on all aspects of their care practice to enable them and staff to discuss good practice and any areas for improvement. It was too soon to assess the effectiveness of the new induction process.

People were supported by staff that had not completed regular supervisions (one to one meetings) or annual appraisals to discuss any training needs or concerns they had. The new deputy manager had identified this shortfall. Staff had attended one supervision session with them since they started in role. It was too soon to assess whether the new supervision sessions were effective in meeting staff needs.

This lack of appropriate staff induction, training and systems and lack of support supervision and appraisals is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the deputy manager and staff. 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 signed consent forms for their care and support needs, for example sharing information with other professionals and tenancy agreements. Staff had not completed training in the Mental Capacity Act 2005 (MCA). This training provides staff with guidelines about seeking people's consent, assessing people's capacity to make decisions and what to do in the event people may not have capacity to make decisions. Staff were not able to confidently explain how they applied the principles of this Act when supporting people to ensure decisions were made in people's best interests and as least restrictive as possible.

People had a tenancy agreement in place. However people told us that they did not know what it meant. One person said, "I know I have signed this, but I don't understand it." Some people at the service had learning difficulties. Tenancy information was not provided in an accessible way to help people understand their rights and make informed decisions when consenting to the terms of their tenancy agreement.

The local authority reported to us that someone had requested to have their medicines administered in their bedroom rather than the office. The provider had not obtained the person's consent as to how they wanted support with medicines or met their preferences and choices.

People's consent had not always been obtained which is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had health care plans which detailed information about their general health. People were supported to attend health appointments where needed. However, records of visits to healthcare professionals were not routinely recorded in each person's care plan. People's health care needs were not always met effectively. Where people had a recent decline in their health and required rehabilitation, or where people declined to attend appointments to meet their on-going health needs, this information was not routinely recorded in their care files.

People's care plans were not routinely reviewed where necessary with relevant health and social care professional's involvement. For example, one person had gained significant weight and was not routinely taking their required medicines. Staff had referred the person to relevant health care professionals to support their health needs. However, the person had declined to attend appointments. Staff had not reviewed the person's health needs, in light of their on-going refusal to attend their treatments or take their medicines. No clear objectives had been set to support the person to manage their health needs. Clear guidance was not in place for care staff to follow on how to support people with their individual health needs or when they declined to attend appointments. Staff told us they were not sure of the best way to help the person and needed more guidelines to support the person manage their health needs responsively. Where concerns were identified, the provider had not pro-actively referred concerns to people's funding authority to ensure people's needs were met in their best interests. People were at risk from long term health risks as their needs were not being addressed. We referred one case to the person's funding authority to ensure the person's needs were reviewed as a priority by the person's funding authority.

This lack of effective health care support is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where one person's health had changed it was evident staff had worked with other healthcare professionals. Staff had supported them to attend G.P. appointments. They had recently had a review of their medicines

and were due to have tests to assess their change in their needs. They had been offered a referral to the Occupational Therapy (OT) service to review how they could be supported to maximise their independence with cooking. The person declined a referral to the OT service. Before their change in health need, they had enjoyed cooking independently. However their independence level had reduced. They told us that they cooked meals that were easier to prepare and staff supported them to do this.

Staff were aware of people's dietary needs and food preferences, and acted in accordance with people's choices. People's needs and preferences were clearly recorded in their care plans. People were able to make choices about what they wanted to eat. People were supported to have a meal of their choices by staff. One person told us they were eating a healthy diet and chose what they wanted to eat. They were trying to eat healthily and that staff had advised them about what was best to eat. They said, "I have healthy meals and have brown bread and rice. I have cut down on potatoes. I am having curry tonight." One person had specific health needs staff supported and encouraged them to maintain a low sugar diet. We observed staff discussing pudding choices with someone. They talked about making a low sugar version of a pudding that someone wanted. People chose their own meal options and were supported by staff to shop for food items and prepare their own meals.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care they received. One person said, "I get on with the staff. They are kind and friendly" and "I like the staff they don't put me down and they are non-judgemental." We read letters from people and their relatives. Comments included, 'You are a brilliant member of staff. Thank you for caring so much' and 'Thank you for caring for X. X loves you all. You are very special for looking after X so well.' We observed that people were treated with respect. Their needs were met in a friendly and unhurried way. People appeared happy and relaxed when talking to care staff. People told us they were happy with how staff cared for them.

The deputy manager told us advocacy services were available to people at the service. However, people did not have access to accessible information about how advocacy services could support them or how to contact them. It was not clearly recorded how staff ensured people were informed of their rights and supported people to access this service to make independent decisions about their care and support needs. Advocacy services to include as access to Independent Mental Capacity Advocates (IMCAs) or Independent Mental Health Advocates (IMHAs) help people to access information and services; be involved in decisions about their lives; explore choices and options; defend and promote their rights and responsibilities and speak out about issues that matter to them.

We recommend the provider reviews how people access information on advocacy services.

People were supported to develop and maintain relationships with people that mattered to them and avoid social isolation. People told us they visited friends and family and friends came to see them. Where people wanted to maintain relationships with important people, this was written into their care plans. However, people were restricted from having visitors to their home after 8pm. This meant that people's needs were not fully met in this area.

We recommend the provider reviews the visitor's policy.

People's dignity was respected by staff. Staff talked to us about methods they used to sensitively prompt people to manage their personal hygiene. For example staff suggested people may wish to freshen up before going to appointments. Staff said, "I knock on people's doors and I wait to be asked in. I respect people's wishes. For example, one person likes to talk with staff but sometimes they like to be alone. I respect their wishes and give them privacy." We observed staff treated people with dignity and respect. When staff supported people to take their medicines they ensured the door was closed to give people privacy. They talked calmly and respectfully with people asked how they were feeling, answered their questions about medicines and had positive banter with people. One staff member reminded someone calmly and respectfully to consider putting on a dressing gown to promote their dignity and respect for others in the communal area. People's care plans gave guidance on how people should be treated to ensure their dignity was upheld. Respectful language was used throughout care plan records.

People received care and support from staff that had got to know them well. People were treated with

kindness and compassion in their day-to-day care. One person told us about certain dates that held difficult memories for them. They told us, "Staff try to cheer me up. They check in with me." Staff were aware of these and provided appropriate emotional support at those times. One person liked to talk to staff at night. A specific staff member was placed on night shift who they had a good rapport with to support them. Staff supported the person to complete a course in 'mindfulness' to support their well-being needs and coping strategies. People's care was not rushed enabling staff to spend quality time with them.

Staff talked to us about how they supported people when their mental health declined. They told us they provided one to one support to talk to people and listen to their needs. Where people may be at risk of harming themselves, they had developed positive and honest relationships with people. People disclosed to them when they felt at risk and staff ensured they had access to their allocated health care professional to keep them well.

One staff member told us about techniques they used to manage possible conflict and keep people calm. They said, "It's about using an appropriate tone of voice and language. I try to be on people's level and see things from their point of view." One person's care plan file contained information on how staff should support them when they became upset or frustrated. Records showed that on one occasion when the person's mental health had declined, they were offered a respite service to give them a break and help them recover. The person declined and their choice was respected by staff. We observed staff talking with them when they became upset about something. Staff were responsive, listened to them attentively and calmly and discussed possible solutions with them to resolve their concerns.

Staff knew people's individual communication needs. Information on people's communication needs was recorded in their care plans. One person's care plan had recorded for example, that they had difficulties with hearing. Staff told us they had recently decided to attend a lip reading course to further their skills in this area. We observed staff communicated with them clearly and maintained good eye contact to support effective communication. New staff completing their Care Certificate had completed work around how to support people with effective communication. One staff member said, "I use good eye contact. I clearly pronounce words and write things down if people need me to" and "I use uncomplicated language to explain things and give people clear and simple instructions they can follow."

Staff told us that people were encouraged to be as independent as possible. We observed in the handover meeting staff understood people's independence levels. They discussed and recorded where people were able to take their medicines independently and make their own meals. People's care plans indicated people's abilities and independence skills for example, 'X can self-medicate' and 'X has a handrail in the shower room [to support them to manage their personal care].' Staff told us about how they supported someone to increase their independence skills. Their goal was to move into their own flat and live independently. The person had met with their social worker to discuss suitable housing options.

Requires Improvement

Is the service responsive?

Our findings

People were not routinely involved in developing their care, support and treatment plans. People did not regularly take part in their care reviews. We asked people whether they had a care plan. One person said, "If I have, I haven't seen it." Staff had not recorded people's views about how their care should be provided.

People's needs had not been reviewed regularly and as required. For example, one person had an initial care plan for the first four weeks of their admission to the service. After this period there was no recorded evidence that the person's needs had been reviewed. The person required support to 'regain their independence', 'keep mobile' and 'gain an increased understanding of how their health needs affected them.' The person's care plan did not provide evidence as to how staff supported them to meet their care and support needs. Staff told us they had ideas about how to support the person's independence to include making meals; however this had not been implemented in practice. The deputy manager told us they were in the process of reviewing people's care plans and would ensure they were reviewed every month. It was too soon to judge whether this system was effective.

People's care plans were not personalised in all cases to enable staff to meet people's individual preferences. The deputy manager had identified that improvements were required in this area. For example, some people's care plans did not include a section called 'All About Me'. Care plans did not contain sufficient information about their personal history, choices or describe how they wanted support to be provided. People's goals were not routinely recorded to ensure people received support to meet their individual goals. For example, one person's long term goal was to live on their own. However, it was not clear from their care plan whether they had the required independence skills and how they could be supported to achieve their goal. Another person's goal was to have support with cooking and regain independent living skills to enable them to move on from the service in the future. There were no records to demonstrate how staff had supported the person to meet their goal.

People's needs had not always been assessed before they received support from the service. In three cases, there was no pre-admission care plans and risks assessment in place. Staff did not always have the information they needed and were not always made aware of people's individual needs before they came to the service. The provider had not routinely completed compatibility assessments to ensure people moving to the service were compatible with other people living there. People and staff told us this had a negative impact on the mental health and emotional well-being of people.

The lack of up-to-date care plan and review records and lack of person centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been encouraged to make a complaint where required. The provider had not explored different ways of giving people information about how to make a complaint in accessible formats or support people to make a complaint when required. People were not always aware of how to make a complaint. Some people told us they did not have cause to complain. One person told us," I've never made a complaint. I wouldn't know how to make a complaint"

No complaint had been recorded in the last twelve months. There was no evidence of a complaints process in place. We received a complaint about the service prior to the inspection. The complainant told us they had referred their concerns to the provider. There was no recorded information about this complaint. The provider could not demonstrate they responded promptly and appropriately to any complaints reported since the service started in March 2015. The provider could not demonstrate that they had learned from complaints reported to improve service quality. The provider had a complaints policy which had not been followed. The deputy manager told us they were due to implement a complaints process and encouraged people to make complaints. It was too soon to assess the effectiveness of this new system.

The lack of complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a range of activities they could get involved in. People were able to choose what activities they took part in and suggest other activities they would like to do. For example, one person liked to attend a running group, liked food and exploring new recipes and watching films. They also liked to have a joke with staff. We observed humorous banter and jokes between them and staff. We observed them talking to staff about a chocolate cake recipe they wanted to try.

People were supported to follow their interests and take part in work opportunities. One person told us they were going to work which was something they enjoyed and they had their bus pass to get there independently. They told us about a recent trip they had taken to Folkestone which they really enjoyed. Another person told us of their plans to meet with a family member and go shopping with them, which they were looking forward to. Some people attended day services where they met with friends and took part in activities of interest to them. Each person had a monthly activity planner in place which reflected their preferences on activities they wanted to get involved with.

Inadequate

Is the service well-led?

Our findings

There had been a period of management instability at the service. Two managers had left the service since December 2015. A new deputy manager had been in post for four weeks on a part-time basis. People were satisfied with the new management of the service. People and staff had confidence that the deputy manager would listen to their concerns and they would be received openly and dealt with appropriately. For example, one person requested that a spotlight was placed on the outside door and a railing added down to the basement where people did their laundry. The deputy manager had addressed this. People told us that things had improved with the new deputy manager in place. One person told us, "The deputy manager is very nice. I get on easily with her. Her door is always open and she makes me a cup of tea" and "I like the new management. It is much better."

The deputy manager told us they considered they were approachable and wanted to nurture people's ideas to improve the service. One staff member told us, "The deputy manager is managing the home well." Another staff member said, "The new manager is more engaged with people. There is more of a team effort. This is a much happier place now." Another staff member said, "The atmosphere is so much better here. I feel supported. I only have to pick up the phone at any time." They told us the previous night someone was unwell and they had needed some guidance in the early hours of the morning. The deputy manager was available on the phone and offered to come in. They felt supported and told us they had arranged for the person to see a healthcare professional to support them with their health needs.

The service did not have a registered manager. 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 deputy manager worked on a part time basis and told us they worked around the needs of people at the service. There was an on-call system so that staff could call a duty manager to discuss any issues arising. The provider was actively recruiting to a full time manager's post. However, they had not found a suitable candidate at the time of the inspection. There was no full-time registered manager present on site to manage the daily operational running of the service. The provider had not demonstrated they understood when CQC should be made aware of events and the responsibilities of being a registered provider. They had not notified us of all significant events at the service. For example, the provider had not notified CQC by sending formal notifications for the absence of managers.

Failure to notify CQC of the absence of a registered manager is a breach of Regulation 14 of Care Quality Commission (Registration) Regulations 2009.

The provider had not demonstrated they understood their legal duties and the conditions of their registration or following their internal policies. The provider had not notified CQC of reportable incidents and safeguarding allegations by sending us formal notifications. We use this information to monitor the service and to ensure the provider responds appropriately to keep people safe. The provider had not

routinely responded in a timely way to CQC requests for information about safeguarding investigations. For example, we requested information about a safeguarding investigation on 22 April 2016. The provider was on leave and we did not receive a formal response about this until 03 May 2016. The provider had not put in place management contingency measures to ensure we received risk-based information in a timely way, in the event they were not available.

Failure to notify CQC of significant events at the service is a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

The provider had not demonstrated effective leadership and oversight of their organisation. There was a lack of effective governance in place. Robust quality assurance systems were not in place to monitor and improve the effectiveness of care delivery and service quality. Where significant incidents had occurred, there was a lack of effective leadership in place to robustly investigate concerns, work with other agencies and implement required care delivery and service improvements. The deputy manager worked part time and the provider only attended the service once weekly. This did not provide adequate management oversight to meet the operational requirements of the service or to embed the service improvements needed. The provider had not routinely discussed and recorded the operational and strategic requirements of the service with management. They had not put in place an improvement plan to make necessary improvements to the service.

The provider had not demonstrated they valued people and staff's feedback and had not encouraged people to make suggestions to develop the service. The provider had not provided regular opportunities for people to give feedback about the service, to include surveys or other consultation methods. The deputy manager told us that people had not previously engaged with house meetings. However, the provider had not explored other accessible ways of encouraging people to give feedback. The deputy manager told us that they planned to introduce a new feedback and suggestions book. This had not been implemented at the time of the inspection. They planned to consult people regularly about their suggestions to improve the service, record and act on their feedback.

There were limited records in place for previous house meetings that had taken place. Actions had not been taken in a timely way to address issues people had raised. For example, one person had reported that they needed a light fixing in their bathroom. This was recorded in house meeting minutes in July 2015. This had only recently been repaired in April 2016, which was addressed by the deputy manager. One person had a leak in their room which led to a problem with mould. The provider took seven months to address this and they were waiting for the area to be repainted once it had dried out. People had not been supported under the terms of their tenancy agreement to ensure all necessary repairs were completed in their home. An effective system was not in place to report issues such as maintenance to ensure shortfalls were responded to without delay.

Effective systems were not in place to ensure quality standards were met or to promote continuous service improvements. Inadequate quality assurance systems were in place to monitor the service quality or identify any shortfalls in service quality. For example, environmental health and safety assessments had not been routinely completed to ensure people's home environment was free from safety hazards. For example, checks to ensure safe installation of gas and electricity, fire and plumbing were not in place and were not routinely monitored. The deputy manager had identified this gap and had created an audit tool to monitor health and safety issues. However, this had not been implemented at the time of the inspection.

There was no care plan audit system in place to ensure people's care plans were up-to-date and reflected their most current needs. People may therefore not be receiving effective care. The deputy manager was in

the process of adding information to people's care plans to update them, make them person centred and fit for purpose. They planned to complete monthly reviews with people's involvement. The deputy manager had identified this gap; however it was too soon to assess the effectiveness of the new system.

Staff recorded incidents and accidents when they occurred. However the provider had not regularly analysed records of incidents which took place to review any patterns of incidents. This meant that effective control measures may not be in place to reduce risks to people and the likelihood of incidents reoccurring.

A lack of management and provider oversight, lack of records and effective audits, quality assurance systems, and consultation processes are a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Since starting in role the deputy manager had made a positive start to improving quality assurance systems. An improved monthly medicines audit was completed. No medicines errors had been identified as part of a recent audit. This system helped ensure that people received their medicines safely and this was accurately recorded. A first aid box monthly audit was due to be implemented. However it was too soon to assess the effectiveness of these systems.

Staff had recently attended a team meeting to discuss people's support needs, policy and training issues. Team meetings had not previously taken place regularly before the deputy manager started in role. Recent staff meeting minutes showed that staff talked about people's needs and how best to support them. Staff were informed of the need to complete refresher medicines management training, due to concerns identified from a recent safeguarding investigation.

The deputy manager described their role and their vision for the home. They told us they were passionate about providing care to people in a person-centred, inclusive way to uphold people rights. They told us they wanted to support people with their daily needs, help people develop their life skills and independence levels. Staff shared the same vision and values. One staff member said, "I want people to be able to fulfil a normal life, to be independent, to give people support and guidance to help them achieve this. People here want to have the chance to move on." Staff understood what they were trying to achieve with people they supported to provide care in a consistent and person-centred way.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 14 Registration Regulations 2009 Notifications – notices of absence 1.The provider had not provided a formal notification where: a. the service provider, if the provider is the person in day to day charge of the carrying on of the regulated activity; or b. the registered manager, proposes to be absent from carrying on or managing the regulated activity for a continuous period of 28 days or more, the registered person must give notice in writing to the Commission of the proposed absence.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents 1.□The registered person had not notified the Commission without delay of the incidents specified which occur whilst services are being provided. 2.□The incidents referred to in paragraph (1) are— a.□any abuse or allegation of abuse in relation to a service user; b.□any incident which is reported to, or investigated by, the police; c.□any event which prevents or threatens to prevent, the service provider's ability to continue the regulated activity.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured: 1.The care and treatment of service users was appropriate, met their needs and reflected their preferences. 3. a) an assessment was carried out collaboratively with the relevant person, to meet the needs and preferences for care and treatment of the service user; b) care or treatment was designed with a view to achieving service users' preferences and ensuring their needs were met.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 1.Care and treatment of service users had not been provided with the consent of the relevant person. 2.Paragraph (1) is subject to paragraphs (3) and (4). 3.If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. * Mental Capacity Act 2005

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 1.Care and treatment had not been provided in a safe way 2.The registered person had not routinely— a.assessed the risks to the health and safety of service users receiving the care or treatment b.done all that is reasonably practicable to mitigate any such risks

c. ensured that staff had the skills to do so safely
d. ensured that the premises are safe
g ensured the safe management of medicines
I ensured health care planning took place with other professionals

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured: 1.Service users were protected from abuse and improper treatment in accordance with this regulation. 2.Systems and processes were established and operated effectively to prevent abuse of service users. 3.Systems and processes were established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had not ensured: 1.Any complaint received was investigated and necessary and proportionate action was taken in response to any failure identified by the complaint or investigation. 2. An effective and accessible complaints system was established and operated effectively for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 1. Effective systems were not in place. 2. Systems did not enable the registered person to: a. assess, monitor and improve the quality and safety of the services provided b. assess, monitor and mitigate the risks relating to the health, safety and welfare of people c. maintain complete records of the care provided to people and of decisions taken about their care e. seek and act on feedback from people f. evaluate and improve their practice in response to information received

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet people's needs. 2. Persons employed by the service provider in the provision of a regulated activity had not— a. received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Notice of Proposal to cancel registration - non urgent