Voyage 1 Limited

Kilmory

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17 November 2014 and was unannounced. The inspection took place in response to concerns that had been brought to our attention in relation to medicines and staffing.

Kilmory provides residential care for up to six people who have a severe learning disability and who may also experience a physical disability. People who live at Kilmory may present with behaviours that challenge staff. There were four people living at the service when we inspected. The service has locked external doors and people are not free to leave on their own. People have their own bedrooms and access to shared communal facilities.

At our previous inspection on 03 June 2014 the provider was not meeting the requirements of the law in relation to care and welfare, safeguarding people from abuse, supporting workers or assessing and monitoring the quality of service provision. Following the inspection the provider sent us an action plan to tell us they would

Summary of findings

make improvements by 15 August 2014. During this inspection we looked to see if improvements had been made to meet the relevant requirements and found not all of the required improvements had been made.

The service has not had a registered manager since 7 June 2014. 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 and associated Regulations about how the service is run.

The service was not safe as permanent staff had left since our previous inspection and the service had six staff vacancies. There were insufficient numbers of staff who were sufficiently experienced in working with people living at Kilmory to provide people's care safely, resulting in the high use of agency and bank staff. There were insufficient numbers of senior support workers. Staff were working excessive hours to provide people's care. Not all staff were familiar with how people usually appeared and staff had failed to notice the signs that a person had experienced an injury.

The required staff pre-employment checks had not been fully completed for all staff. This placed people at risk of receiving care from staff who had not undergone relevant checks on their suitability to work with vulnerable people. Staffing of the service had impacted negatively on people's experience of the care provided to them.

People had detailed support plans in place that provided staff with guidance about how to meet people's needs and manage risks to them but not all staff had read them. People's care was not always provided by staff who were familiar with how to manage potential risks to them.

Medicines had not always been requested, obtained or stored safely. Controlled medicines had not been stored correctly. People had clear guidelines in relation to their medicines administration but staff had not always read them which placed people at risk of harm.

Staff had not received the training they needed in order to enable them to support people effectively. There were insufficient staff who had been medicine administration trained and who were competent to meet people's needs safely. Staff had not received supervision recently or had an appraisal of their work. People were not supported by staff who were adequately trained or supervised.

The bathrooms did not meet all people's needs who had a physical disability. Action had not been taken in relation to the broken lift. People with a disability may not have been able to access the upstairs bathrooms in an emergency.

Staff were not consistently responsive to people's communications. Insufficient numbers of suitably qualified, skilled and experienced staff and a reliance on staff new to their roles had resulted in inconsistent care and support for people. Not all staff had worked with people at Kilmory long enough to understand their triggers for behaviours that may challenge staff. Some staff were anxious about working with people.

Staff did not always identify signs of people's distress or react promptly. Staff had clear guidelines to enable them to interact with people but did not always follow them. People did not always receive the care they needed as described in their guidelines.

Some actions from the previous inspection had been completed but there continued to be a lack of evidence to demonstrate how people's social care needs were met.

People did not always receive the care needed in relation to personal hygiene, as people did not like receiving care from unfamiliar staff. People's care was not always focused on them as individuals. They were not always able to spend their time as they wished due to staff shortages.

People's representatives did not feel confident that complaints were listened to adequately or resolved to their satisfaction.

People's care was negatively impacted upon by the lack of consistent management of the service. The provider had not ensured continuity for people, by keeping the interim manager in post, until a new permanent manager was appointed. They had notified us in June 2014 they planned to do so.

There had been a consistent failure to ensure people's social care needs were met. Although this issue had been

Summary of findings

identified internally in January 2014 and in our June 2014 inspection. Audits had been completed but the outcomes did not reflect the quality of care we found at this inspection.

People had been placed at risk as the provider had failed to act upon a report they had received on the safety of the lift in October 2013. A person experienced an accident using the lift.

The provider had taken action to assess whether people were being deprived of their liberty. Relevant applications had been submitted and were being processed. Where people lacked the capacity to make decisions best interest decisions had been made.

People had received adequate support to ensure their nutritional needs were met. People had been supported to attend hospital appointments and had seen a variety of health professionals.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were insufficient numbers of suitably qualified, skilled and experienced staff who knew people well. The inconsistency in staffing meant that staff were not able to provide safe care.

Staff had not always read the guidance in support plans to enable them to understand how to manage risks to keep people safe.

Medicines had not been managed safely.

Inadequate

Is the service effective?
The service was not effective.

People were not supported by staff who had received adequate training, supervision and appraisals to carry out their roles effectively.

The location of the bathrooms did not adequately meet the needs of people with a physical disability. Action had not been taken to ensure people could use the lift safely.

Deprivation of Liberty Safeguards (DoLS) applications for all people had been submitted which safeguarded their human rights.

Inadequate

Is the service caring?
The service was not always caring.

Staff were not always responsive to people when they interacted with staff.

Some staff lacked an understanding of the people they cared for and were not confident in caring for them. Staff did not always fully understand the triggers for people which may result in behaviours that challenged staff.

People experienced inconsistency in the way their care was provided.

Inadequate

Is the service responsive?
The service was not responsive.

People's social care needs were not being met. People's freedom to spend their time as they wished was driven by the availability of staff.

People's care needs were not always met as they did not like receiving personal care from staff who they were unfamiliar with and could not trust.

People's relatives had a lack of confidence in the complaints process.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

There was no registered manager in place and this had resulted in inconsistent and ineffective management of the service. Key risks to people such as the safety of the lift had not been addressed.

There was a failure to assess and monitor the quality of the service to ensure the delivery of high quality care. The provider had not reacted promptly or robustly when concerns were raised about staffing.

The service did not have an open culture. Staff did not feel listened to.

Kilmory

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 took place on 17 November 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. This inspection was in response to concerns about the service that had been brought to our attention. These concerns related to medicines and staffing. The inspection team consisted of two inspectors and a pharmacist.

Prior to the visit we spoke with commissioners who commissioned services for two people and two people's social workers. We examined previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the visit we reviewed records which included support guidelines for each person living at Kilmory, three staff recruitment records, staff supervision records and records relating to the management of the service. Following the inspection we asked the provider to send us further evidence of the recruitment checks that had taken place in relation to permanent and agency staff and audits of the service. The provider was not able to provide all of the information we requested because it was not available.

People were not able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing care staff interactions with people and care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with one person's relative, one support worker, the interim manager, the operations manager and the operations director. Following the inspection we spoke with another person's relative, another commissioner of the service and a person's Independent Mental Capacity Advocate (IMCA). The role of the IMCA is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. We also spoke with three support workers and the new interim manager who took over the service two days after our inspection.

Inadequate

Is the service safe?

Our findings

People's care had been affected by the high number of staff vacancies. Since our previous inspection a number of permanent staff had left and the service was reliant on bank and agency staff to ensure on that each shift was covered. The Operations Director wrote and told us the service was staffed for 14 posts. Six of these posts were vacant, and this was having a 'Significant impact.' One person's relative told us "I am really distressed leaving my son in the care of strange staff." On the day of the inspection a staff member failed to arrive for their shift and there were no permanent staff on duty. Of the four staff on duty only two of them had previous experience of working with people at Kilmory.

We observed an incident where a person who required one to one support was left alone. They started to display signs of agitation and the manager had to respond to defuse the situation as the other staff were busy. The staff on duty could not meet people's needs and manage risks to people as effectively. The manager assessed the staffing situation to be unsafe and made arrangements to take people to the day service until another staff member could arrive. We spoke with two social workers who both told us they were concerned about the lack of permanent staff. People were at risk due to the lack of suitably qualified, skilled and experienced staff who knew people well.

Records showed that there in October 2014 there had been only 12 full day shifts when there was a senior support worker on duty. On the weekends of 4 and 5 October 2014 and 18 and 19 October 2014 there was no manager and no senior support worker rostered to work. This meant that inexperienced or agency support workers had no senior staff on site to advise them.

People had been placed at risk as the staff caring for them had worked excessive hours. The interim manager told us shortfalls in permanent staffing had resulted in people being cared for by staff who were working excessive hours. A member of staff told us they had been asked to work 14 hour shifts to cover for staff shortages and to work extra shifts. The interim manager told us they were "Exhausted" as they had been on the roster for 12 days in a row and records confirmed this. A social worker said they were concerned about staff working excessive hours.

Staff had received safeguarding training and had access to guidance. We spoke with a staff member who was able to demonstrate their understanding of safeguarding. However, people were unable to tell staff what had happened to them. One advocate told us that the person they supported was dependent on staff knowing them and recognising when they were in pain or distressed. Staff had failed to notice this person had sustained a serious injury. There was no recorded information in relation to the cause of this injury or when it had occurred.

Not all of the staff had familiarised themselves with how to manage risks to people. This left people at risk of receiving inappropriate or unsafe care. Risks to people had been identified and managed through their support plan guidelines. These provided staff with clear guidance about how to manage individual risks to people. People had plans to manage risks to them when out in the community and to manage people's behaviours that may challenge staff. One person's support guidelines advised 'During my personal care if a second member of staff is needed they should stand back unless required to actively assist.' Staff were required to read people's risk assessments but there was a lack of evidence to demonstrate they had. A member of staff who was new to the service confirmed they had not had time to read them.

The lack of sufficient numbers of suitably qualified, skilled and experienced staff was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were cared for by staff who had not all undergone relevant checks to ensure they were suitable and safe to work with vulnerable people. Staff pre-employment checks were incomplete. Disclosure and Barring Service (DBS) checks had not been completed for two permanent members of staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had not obtained proof of one staff's identity or checked their references for satisfactory proof of conduct in previous health and social care employment.

The provider's failure to ensure all pre-employment checks had been completed was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

Medicines were not appropriately requested and obtained. One person was prescribed their medicine in liquid form. Staff had recorded in the person's Medicines Administration Records (MAR) and the incident log that the liquid medicine was out of stock. Having sought medical advice the person was given the medicine in capsule form until further supplies of the liquid medicine could be obtained. This person's relative told us they only took their medicines in a liquid form and did not like to take capsules. Although the person accepted the capsules on this occasion. There was a risk that they may have refused to take their essential medicine in a capsule form. The provider had failed to ensure adequate supplies of this person's medicine had been ordered in a timely manner.

Medicines were not safely stored. The controlled drugs (CD) storage was not compliant with legislation and the service was not following their procedure for the storage of medicines which were also controlled drugs. During the inspection people were taken to the day service and the required medicines were recorded as being 'Taken out'. However, the service had insufficient storage bags to ensure each person's medicines were kept separately. This meant there was a risk of people's medicines being mixed up and errors in medicine administration.

The inappropriate management of medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Appropriate arrangements were in place to store medicines within their recommended temperature ranges. Medicines were administered as prescribed and safely disposed of when no longer required. Medicines administration was recorded appropriately. We reviewed the MAR and medicines sections within the support plans for all people. These contained detailed and current information on 'How I take my medicines', 'Variable dose' and 'If required' medicines.

Inadequate

Is the service effective?

Our findings

Following the last inspection on 03 June 2014, we asked the provider to improve support to workers as staff had received insufficient training. Some people were diagnosed with epilepsy or autistic spectrum disorders, and displayed behaviours that challenged staff. However, staff had not received relevant training, supervision or an annual appraisal. At this inspection we found the required actions had not been completed.

Not all staff had completed all of their essential training to carry out their roles safely. Staff training records were incomplete so we could not check what training all staff had completed. Two new staff were still completing their mandatory training to enable them to deliver care effectively. Night staff had not completed all of the provider's essential training. A member of staff told us many staff were inexperienced.

The provider had not ensured staff were sufficiently skilled and knowledgeable to support people effectively. One person's guidelines stated they were at high risk if not supported during an epileptic seizure by trained staff. The provider's action plan showed that epilepsy training had been booked; however, there was no evidence to demonstrate that staff had attended. People with epilepsy were at risk as not all staff had received appropriate training in epilepsy to support them safely.

People displayed behaviours which may challenge and required staff to intervene. Staff had not received relevant training to enable them to use physical interventions with people if required. One person had guidelines in place for the use of physical intervention. These stated staff should have completed the required training before using these guidelines. Records showed only one permanent staff member was up to date with this training. This person was at risk as not all staff had undertaken the relevant training in the event staff needed to intervene physically to keep them safe. A commissioner of the service told us they had concerns about staff training and one member of staff confirmed they did not feel adequately trained.

There were insufficient staff who were trained and assessed as competent to administer medicines safely. There had been a recent incident when a person had not received their prescribed medicine and an alternative had to be provided. The person's support guidelines stated they were at an extremely high risk if they did not receive this medicine. We spoke with their relative who said the incident had "Knocked their confidence in the service." Records showed only two of the permanent day staff were trained and assessed as competent to administer people medicines. The interim manager had notified us that the lack of medication training for staff was placing people at risk. The provider had to bring staff from other services to administer medicines to ensure people received their medicines.

The operations manager told us staff should receive at least six supervisions annually. Records showed no staff supervisions took place after July 2014. A member of staff confirmed they had not received regular supervision. One staff member told us there was "Pressure on staff" and they were "Not supported." People received care from staff that had not been appropriately supported to enable them to deliver care and treatment to people safely and to an appropriate standard.

This was a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A person had injured themselves using the lift, so it was out of use. Two people required assistance with personal care but as there was not an adapted downstairs bathroom to meet the needs of people with a physical disability they had to go upstairs. The interim manager told us that although these people were able to use stairs, the lack of a lift was affecting staff confidence to assist them safely. This was particularly difficult if the people were tired or required personal care urgently. One person's advocate told us they were concerned the lack of a lift could compromise the person's dignity as may not be able to access the upstairs bathroom quickly enough.

The lack of a suitable layout and adequate operation of the lift was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection on 03 June 2014, we asked the provider to take action to ensure they met the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care homes. Mental Capacity Act 2005 (MCA) assessments had been completed. As no one had the capacity to consent to living at Kilmory best interest decisions had been made for people and

Inadequate

Is the service effective?

DoL's applications submitted, which were being processed. Although DoLs applications had been made to authorise the use of a key pad on the front door front door and a gate to the service to prevent people from leaving the premises. We observed that the gate remained open throughout the inspection. One person's relative told us their son had tried to leave the service and they had to ask for the keypad code to be changed, which had been done. However, staff had not always followed guidance to ensure people's safety needs in relation to security of the premises were effectively met.

People had decision making profiles which described how the person made decisions and how they should be supported. There was evidence of a best interest decision in relation to one person's dental care. There was however one incident where the requirements of the act had not been followed. The manager described an incident when taking a person to hospital. There was a lack of evidence to demonstrate that a MCA assessment and best interest decision had been made and recorded, this was discussed with the interim manager. The provider had taken measures to identify when people might need to be physically restrained and to reduce the risk of this being required. One person had guidelines detailing how to support the person in the least restrictive way when they presented with behaviours that challenged staff. This ensured the aim of the intervention was not to restrict the person unless it was necessary for their safety and others.

People were supported to have sufficient to eat and drink. People's cultural dietary requirements had been identified in their support plans. People were provided with the adapted crockery and cutlery they needed. People's preferences about their diet had been noted and their cultural dietary requirements met. People's fluid intake had been monitored and recorded where required.

People had been supported to maintain good health. Their weight had been monitored regularly. People's epileptic seizures had been monitored and recorded. Health professionals had been consulted about people's health care support plans. One relative told us their son had been supported to attend health appointments as required. People had seen a variety of health professionals including GPs, consultants, occupational therapists, behavioural specialists, dentists and chiropodists. People had hospital and dental passports in place providing key information about the person that services needed to be aware of.

Inadequate

Is the service caring?

Our findings

People were always supported by staff in a caring manner. Although people could not speak they communicated through sounds, facial expressions and behaviours. On a number of occasions staff failed to acknowledge people when they tried to communicate with them. On several occasions we observed staff chatting together or doing paper work and ignoring people. For a considerable time one staff member who was allocated to work one to one with a person did not engage with them. They watched TV with the sound off and watched the person but made little conversation or eye contact with them. The person made a noise to attract attention; staff looked up but did not go over. At one point he beat his chest for attention staff looked at him smiled and said nothing. When another person woke up, they twisted in their wheelchair to observe activities going on behind them. A staff member watched and did not move the wheelchair to allow the person to see what interested them.

A person's relative told us staff needed to be able to read their son's facial expressions to understand what he wanted and non-permanent staff struggled to understand him. Another relative told us in the past staff knew people. The constant changes in staff had resulted in people receiving inconsistent care from staff who had not been in post long enough to build trusting relationships with them.

The interim manager said staff told them they were afraid of people. They said there were 'Tense' interactions between two people who lived at Kilmory which could result in one person displaying behaviours which challenged staff. This in turn affected staff confidence to support the person safely and well. They said "Staff don't know the residents well enough to pick up on the triggers." A social worker told us that during a recent visit they had observed staff seemed to be trying to keep their distance from people.

Staff did not always show concern for people's well-being or to respond quickly. We saw some examples of good practice, for example, the interim manager provided reassurance to a person through voice and touch. As they spoke, the person became visibly calmer. Another staff member showed concern for people's well-being and involved a person in preparing the evening meal. We spoke with a social worker who commented; when they last visited they observed staff were failing to interact with people. They told us they saw two staff members sit and observe a person rather than interacting with them which made the person uncomfortable. They told us staff seemed to be trying to get through their shift rather than stimulating people. This was confirmed by a person's relative. People's needs had not always been responded to by staff in a caring manner.

Whilst the interim manager made arrangements to take people to the day service one person was placed in a wheelchair at 10.24 and they remained in it until they left at 12.00. During this time he became more vocal, showing distress. Staff provided no explanation and little reassurance. When he tried to amuse himself by fiddling with another wheelchair, he was wheeled out of reach by staff and the wheelchair brakes were secured, with no interaction offered. Staff had not shown concern for this person's well-being or responded to their distress. We observed one incident where a staff member inappropriately tried to encourage a person to say thank you for a biscuit. This interaction did not demonstrate caring behaviour towards the person.

Some staff treated people with dignity and promoted their independence. We observed staff wait outside the bathroom whilst one person used it. The staff member knocked before entering and checking on the person. This helped the person to be independent in the bathroom whilst support was available to them if required. Staff supported a person to prepare their breakfast and later to prepare the house dinner

People's support plans indicated that their families had previously been consulted about their care needs and preferences. People's relatives had mixed experiences of how much they felt listened to. A relative told us they had given staff information about how their son took his medicine and they felt this had been listened to. Another relative told us they no longer felt as involved in decisions about their son's care and support as they had been. They did not feel staff communicated effectively with them since their son's keyworker had left.

Support guidelines stated how people had been involved in preparing their guidelines. One person's guidelines stated they had been involved 'By communicating to staff preferred methods of support in this area during the task itself.' Support guidelines reflected how people wanted their care to be delivered. One person's guidelines stated 'I like to be involved in choosing what I am going to wear

Inadequate

Is the service caring?

each day.' One person's guidelines provided staff with information about how to involve the individual in decisions by showing him items that had meaning to him or providing a choice of two items for example a bottle or orange and blackcurrant squash. We observed staff asking this person if they wanted a drink and showing them their drinking bottle but not giving them a choice of drink as described in their guidelines. Staff were not always implementing the guidance to support the person to be involved in choices.

Inadequate

Is the service responsive?

Our findings

Following the last inspection on 03 June 2014, we asked the provider to improve people's care and welfare; people's pre-admission assessments were not available, a person lacked a care plan to manage their medical condition and a person had not been weighed as required. There was a lack of evidence to demonstrate how people's social care needs were met. At this inspection we found some improvements, but people's social care needs were still not met.

One person's social worker told us the person was not adequately stimulated. We saw this person was scheduled to attend the day service two days per week. There was lack of evidence to show how his social care needs were met when he was not at the day service. One person's relative told us that following the previous inspection the interim manager in post at the time had looked into social activities for their son but nothing has ever been put in place for him. One person's advocate told us the person's time at the day service had been increased to give them something to do rather than their care being focused on their needs. They told us this person required sensory items to help him interpret the world but these were not provided.

The failure to meet people's individual needs in relation to social care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not always receive the support and care they needed. One person's support plans indicated they needed their personal care to be provided four times across a 24 hour period. Records did not demonstrate that this level of care had been consistently provided. Another person's personal care records also indicated a lack of consistency in how often they had been supported by staff with personal care. The manager told us people did not like to receive personal care from unfamiliar staff and that non-permanent staff ether had to stand back and wait for people to be ready to accept assistance or wait for regular staff to assist. A person's advocate told us the person had previously been relaxed in the presence of staff but when they saw him recently he was not relaxed and it was difficult for him to accept care from strange staff. Staff had to make several attempts with this person before they were ready to accept the personal care they needed.

One person had been assessed in June 2014 by the provider's occupational therapist as needing to spend more time out of their wheelchair . The occupational therapist had requested that staff maintain a chart to show how much time the person spent out of their wheelchair. There was no evidence that a chart had been completed. The person's relative told us "My worry is he is not being encouraged to get out of his chair." We spoke with a member of staff who confirmed it was difficult to get the person out of their wheelchair as not all staff felt confident enough to support the person. This person's care need as identified by the occupational therapist had not been met consistently.

People's care was not always centred on them as individuals. The interim manager told us two people needed to be constantly accompanied by staff who were trained to administer emergency medication to them if required. Therefore if one person wanted to stay in and the other wanted to go out two appropriately trained staff had to be available. Records showed there were not always two staff on duty trained to administer this medication. The lack of appropriate staff meant that these people had to spend their time together.

People were unable to access public transport services and were reliant on staff taking them out from the service which is located in a semi-rural location. Although the service had a bus only two of the permanent staff were drivers. People's ability to go out depended upon whether these two staff were rostered to work. Staff rosters showed there were days when neither of them were rostered. The interim manager told us they had to rely on day service staff to transport people when there were an insufficient number of drivers to ensure people could access the day service. They also told us day service staff had been required to take a person to their hospital appointment due to a lack of drivers. One person's relative told us people were taken out but the frequency of this depended upon staffing. People had not always been able to go out due to a shortage of drivers.

We did see some examples of people receiving care to meet a particular need. One person's communication plan described how they disliked excessive noise and used headphones to help them to deal with intolerable noise

Inadequate

Is the service responsive?

levels. We saw this person carried these. The interim manager told us the new fire door was being assembled offsite and installed in pieces when people were out of the service so as not to cause them unnecessary disturbance.

People had pre-admission assessments completed and detailed support plans. These provided clear guidance on support required and preferred care to be provided. People had a one page profile describing the essential information that staff needed to know about the person's care. It also described what support they required to experience a good day. People had support plans in place that identified their needs in relation to different aspects of their lives such as communications, personal care, diet, night time support, travel, medication, mobility, swimming, behaviour, finances, sexuality, behaviours that challenge. People had support guidelines in place that detailed how their care was to be provided.

People were unable to raise complaints themselves and were dependent on staff observing their behaviours for signs they were unhappy with their care. This required staff to understand their behaviours and facial expressions. People's representatives were not confident that action would be taken in response to their complaints. No written complaints had been received by the service in 2014. The interim manager told us they had not received any written complaints but recently they had received two verbal complaints. We saw that an investigation had been completed in relation to one of these complaints. We spoke with a person's relative who confirmed they had raised a verbal complaint following a recent incident and they were not fully satisfied with the response they received. Another person's relative told us they had not made a complaint but they did not have much confidence in it being actioned if they did. There was a complaints process but people's relatives lacked confidence in the process.

Inadequate

Is the service well-led?

Our findings

One person's relative told us "I am not impressed with management" and another commented ""I lack confidence in the management." People's care was negatively impacted upon by the lack of stability in management since December 2013, when the manager left. The service had since been managed by a succession of interim managers. At the time of this inspection the interim manager in post at our previous inspection had left and there was a new interim manager in post. This interim manager told us they had handed in their notice and they were due to leave the day after the inspection. A person's social worker said they were very concerned about the constant changes in management. There had been a succession of temporary managers which had resulted in inconsistency in leadership of the service. There had also been changes in the senior management of the service. A new operations manager and operations director were made accountable for the service in September 2014. Senior managers were still completing a review of the service and understanding the issues.

During the inspection the Operations Director told us the provider "Had concerns about the service." They told us they had been reviewing the staffing and the history of the service since September 2014. They told us they had planned to find more suitable placements for two people and then consolidate the service but now recognised that the situation had evolved and that all four people could have a better quality of life in another service, as it was clear the service was not working. The interim manager told us that the service was not safe and said "I think it should be closed." The lack of effective and consistent leadership had impacted negatively on the quality of care people received.

At our last inspection we found the lack of consistent management had resulted in issues affecting the quality of the service not being addressed. We had noted the lack of individual activity plans for people to meet their social care needs had been highlighted in the provider's January 2014 quality team audit.

We found at this inspection that people's social care needs remained unmet. We asked to see the action plan from the quality team audit but the operations manager told us they could not find this. The provider had still not addressed the issue of meeting people's social care needs originally identified by their own auditing in January 2014 and which we had highlighted in June 2014.

At the last inspection we found the provider had not collated, analysed or responded to the results of the January 2014 survey which had been sent to people's relatives, staff and stakeholders. At this inspection the issue had still not been addressed. There were no action plans evident to address issues identified in the responses received, such as a lack of activities and people not being aware of complaints process. The provider had not given regard to the views of people outside the service. The provider had failed to take action to sufficiently address the issues identified at our previous inspection.

The operations manager had completed their quarterly audit of the service in September 2014. Of the 13 outcomes evaluated the service failed in six areas. The audit did not cover staffing which was a key issue in the service. The interim manager completed an internal audit on 27 October 2014 based on the CQC five key questions. The results showed the service scored 94.1% for caring, 69.2% for effective, 88% for responsive, 84% for safe and 87.5% for well led. These results conflicted with the findings from our inspection which indicated the service was operating considerably below this standard. The audit process had not identified and addressed the level of failings in the quality of the service provided to people.

Records showed that issues were identified in relation to the safety of the lift by the contractor who inspected it on 7 October 2013. Their report contained recommendations to ensure people's safety when using the lift. Action had not been taken to render the lift safe and a person experienced an accident whilst using the lift in October 2014. The provider had not ensured the lift was safe for people to use.

The failure to sufficiently assess the quality of the service, manage risks to people or take account of people's views of the service was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not benefit from an open culture where staff felt listened to and supported when things went wrong. The interim manager told us there was a 'Closed culture' and the service was at a point where people could not be cared for safely. They had alerted senior management to staffing

Inadequate

Is the service well-led?

issues and the resignation of the one senior support worker on 17 October 2014. Senior management met with them on 31 October 2014 to discuss staffing. When we contacted the operations director on 11 November 2014 they told us they had made arrangements to deploy two senior support workers to the service with effect from 17 November 2014. Senior management had maintained staffing levels through staff overtime from the Kilmory team, other local services managed by the provider and long term agency staff. There was a gap of one calendar month between the interim manager alerting senior management and senior support workers being seconded to the service. Senior management had taken action, but it was not swift and had not addressed the issue of too many non-permanent staff working at the service.

People did not experience care from a staff team that were able to promote the provider's values. The service statement of purpose noted the five core values of the service. The staff handbook stated the provider's aim was 'To improve the quality of life for everyone we support, and all the people who work for us . . . Nothing is more important to us than looking after the people entrusted into our care, and with that comes a responsibility to deliver the highest quality of support. Our commitment to this responsibility is achieved through a culture of positive energy, and with every member of staff pulling in the same direction to achieve the same aim.' One member of staff was able to tell us about the values of the service but said it was difficult to deliver the values with the staffing situation. The operations manager told us values were embedded through training, supervision and leadership but values were hard for staff to grasp at present. The evidence we saw during the inspection did not demonstrate the service was upholding the values and principles the provider promoted.

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.