

# Tameside Link

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## Inspection report

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Date of inspection visit:  
29 September 2016  
10 October 2016

Date of publication:  
19 December 2016

## 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?

Inadequate 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

This inspection took place on 29 September and 10 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a supported living service to people who are often out during the day; we needed to be sure that someone would be in.

Tameside Link provides personal care and support to 13 people who live in their own homes. This includes three people who live in a block of flats and two people who share a home. Other people live in their own homes.

The overall rating for this service was 'Inadequate' and the service was placed in 'Special measures'. This is where services are kept under review by CQC and if immediate action has not been taken to propose to cancel the registered provider's registration of the service, the location will be inspected again within six months. The expectation is that registered providers found to have been providing inadequate care should have made significant improvements within this timeframe

The service had in place 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.

We found the registered provider did not have in place their own care plans or risk assessments. This meant staff were not given guidance on how to provide people's care and reduce any potential risks to people. Professionals connected with the service raised concerns with us about care planning for people.

We saw the registered manager had reviewed the local authority care plan one year after the plan had been dated. People had not been included in their reviews.

We found the administration of people's medicines to be unsafe. Staff had not received up to date training in medicines administration or had been assessed as being competent to give people their medicines. We found gaps in people's medicines administration records and could not be reassured people had been given their medicines as and when they were prescribed or needed them.

Staff had recorded when people had accidents, however we found these had not been reviewed and actions taken to prevent a reoccurrence.

Staff helped to keep people safe in their own tenancies by checking smoke and carbon monoxide detectors.

The registered provider had carried out recruitment checks on staff to ensure they were safe to work in the service.

Staff were able to tell us about how to manage behaviour which challenged the service and told us they had been trained in breakaway techniques. However, we found staff were not supported to carry out their role through the use of regular supervision, appraisal and training which addressed how to care for people with specific needs.

Best interest decisions were not in place to deprive people of their liberty. We found the service did not permit some people for whom they provided personal care to go out on their own and they had not followed the principles of the Mental Capacity Act in making decisions which were in people's best interests.

Staff demonstrated to us they knew people well, their likes and dislikes and how they provided care for people. We observed one staff member on the phone talking loudly about a person and another staff member spoke to us about the person in front of them without including them. We found this showed a lack of respect.

The registered manager told us no one in the service had an advocate and family members acted as advocates for people. Staff told us they had not yet felt directions given to them by family members about people's care needs were not right for people.

We found staff supported people to be independent by encouraging people to cook and taking care of their accommodation.

People were engaged in a range of activities. Some people felt they had enough to do, others wanted more things to do. We saw staff supported people to access their local communities and have contact with their family and friends.

The audits carried out by the registered manager did not address the regulatory requirements and did not find the deficits we saw during the inspection.

The documentation in the service was not dated and we found there were no updates in place for people's care plans. We found the staff had not been provided with systems for them to provide people's care safely and which the registered manager could use to monitor the quality of the service.

The registered provider had notified local care managers of safeguarding incidents but had failed to notify CQC of the same incidents. This meant they were not complying with their registration.

During our inspection we found a number of 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 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 safe

People did not have in place risk assessments which guided staff on how to mitigate risks and prevent people from having accidents.

We found a number of medicine errors in the service. Staff had not been assessed as being competent to give people their medicines or had received recent training.

Staff told us they felt able to speak to the registered manager about any concerns or worries they may have had about the service.

### Is the service effective?

**Inadequate** ●

The service was not effective.

Staff were not given sufficient support through supervision, training and appraisal to carry out their role.

Staff were not trained in the Mental Capacity Act. We found there were no best interests decisions in place. Staff were unable to ensure the care they were providing was the least restrictive.

We saw staff provided handover information to each other to ensure people received a continuity of care.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

We found respect for people's privacy was not always upheld.

Staff supported people to be independent in their own homes.

We found staff promoted people's well-being by supporting them to be active in their communities and by accessing local services

### Is the service responsive?

**Inadequate** ●

The service was not responsive.

We found the registered provider did not have in place care plans which described their needs and gave staff guidance on how to care for them.

Reviews of people's care needs were not carried out by the registered provider.

People had in place hospital passports which described their needs should they require hospital treatment.

### **Is the service well-led?**

The service was not well led.

The registered provider did not have in place audits to monitor the quality and improve the service.

Records held by the service were out of date and did not accurately describe people's care needs.

The registered provider had not notified CQC of safeguarding incidents.

**Inadequate** ●

# Tameside Link

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 September and 10 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a supported living service to people who are often out during the day; we needed to be sure that someone would be in.

Before we visited the service we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Care Quality Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners.

The inspection was carried out by one adult social care inspector.

During the inspection we spoke to six people who used the service. We looked at seven people's records and spoke to four professionals. We also spoke with the registered manager, a new manager to the service, four staff and the administrator.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

## Is the service safe?

### Our findings

People who used the service confirmed to us they felt safe when they were with the staff who worked in the service. One person said, "I feel safe, yes." Another person said, "I am happy here. I feel safe." People told us they liked the staff who cared for them. We observed people were comfortable in the presence of the staff.

We looked at people's medicines. We saw some people had previously had in place homely remedies and found some over the counter flu remedies had been returned to the pharmacy. One member of staff told us the registered manager had told staff people were not to have these. This meant people who for example had a headache were unable to access over the counter medicines. One professional told us that some family members had bought such medicines for one person and they needed to remind staff to check if they were safe to give a person with their other prescribed medicines.

We saw some people had in place PRN medicines. These are medicines which are given to people as and when they require them. We found the service did not have in place PRN plans to tell staff under what circumstances and when to give people such medicines. We found one person had been prescribed a PRN medicine for a specific condition, however, they had been given this medicine every morning for two consecutive months. Staff confirmed permission had been given by the person's G.P. but this was not written in their care plan or in their medicines administration record (MAR).

We found staff training in medicines was not up to date, and staff did not have in place competency checks to see if they were competent to give people their medicines. One staff member said they, "Had never had one." We looked at the administration of people's medicines and found there were errors. Staff told us if people refuse their medicines they will contact the registered manager to let them know. One person was meant to have some prescribed medicine for five days. We found they had not been given their medicine in the prescribed way and had been given it over a nine day period. Another person administered their own medicine; we found there were no assessments in place to check if the person could do this and there were no checks in place to ensure they were taking it correctly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the local authority had carried out risk assessments on some of the people who used the service. However we found the registered provider had failed to develop their own risk assessments which gave guidance to staff on how to mitigate risks to people. This included risk assessments for people with specific diagnosed conditions for example epilepsy. This meant the provider had not done everything possible to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw staff recorded when people had an accident. We asked the registered manager for a copy of the

accident records since September 2015. The registered manager sent us 11 accident forms. We found three people had three accidents and one person had one accident. The accidents had not been reviewed and actions incorporated into risk assessments to prevent any reoccurrence.

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

Staff told us when they met their manager for supervision they always asked if they have any worried or concerns. We found staff understood how to safeguard people and confirmed to us they would raise any concerns with the registered manager. Staff were able to describe to us the different types of abuse. This meant staff had some understanding of safeguarding issues.

The registered manager told us staffing levels to support people were prescribed by local authority assessments. We found people were cared for by small groups of staff who were familiar with people's care requirements. The rotas demonstrated consistency in people's care provision and the required hours were being covered. This meant there was enough staff to meet people's needs.

The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We saw the registered provider had in place a recruitment procedure for staff and had used DBS checks to help them make safer recruitment decisions. Prospective staff were also required to complete an application form detailing their previous knowledge and training as well as provide the names of two referrers. The registered provider had sought two references for each staff member before they started working in the service. However we found one staff member had returned to the service after a period of four months with no additional checks in place.

We saw the service had a whistle-blowing policy which supported staff to tell someone about their worries. There was also a staff disciplinary policy. The registered manager told us there were no whistle blowing concerns at present and no member of staff was currently subject to disciplinary procedures. Staff told us if they had any worries or concerns they felt able to approach the registered manager and speak to her about them.

Although people lived in their own tenancies staff helped to keep people safe by ensuring their properties were kept in a good state of repair. They carried out checks to see if their smoke and carbon monoxide detectors were working.

The registered provider had in place a staff disciplinary policy. This meant people were protected from unsafe staff practices. At the time of our inspection the registered manager told us there were no on-going disciplinary investigations.



## Is the service effective?

### Our findings

People told us staff looked after their healthcare appointments. One person said, "They keep track of my appointments for me." We saw in the diaries appointments for people had been made resulting in them receiving prescribed medicines and we found arrangements had been put in place. Staff knew which relatives liked to be involved and had invited them along to health care appointments to support people. The diaries provided a source of communication for staff to update them on people's needs. We observed a handover taken place. The member of staff communicated to the next member of staff coming on duty the person's level of activity during the night. We found the information recorded in the diary. This meant the handover information was clear and documented.

Although staff told us they were supported to work in the service we saw there was little or no information about staff induction in their files. We found one staff member's induction record incomplete. The registered manager told us staff had received an induction which included shadowing other staff to learn about people's needs. This meant the service did not have staff records in place appertaining to induction.

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

We spoke to the registered manager about staff training. They told us they did not have a training plan in place. One member of staff said, "I've just done the level two in Mental Health. I go on as many courses as possible." Staff told us they had been trained to manage behaviours which challenged the service. We looked at seven staff files and found staff had not received updated training in food hygiene, safeguarding and some staff first aid training was out of date. One member of staff who was caring for a person with a mental health condition confirmed to us they had not received training in mental health.

We looked at staff supervision records. The registered manager told us staff were expected to receive supervision every six to eight weeks. We found there were a number of gaps in people's supervision records and not all staff had received regular supervision. We also saw staff did not have appraisals in place.

This meant staff were not given suitable support through training, supervisions and appraisal to enable them to carry out their roles.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us there was no-one subject to any restrictions under the MCA. We spoke with staff about people going out alone. Some staff told us they were working with people who were unable to go out on their own and always needed supervision. One staff member told us about one person, "I will stop [person] going out." Another person told us one person required constant supervision.

We spoke with staff about people's mental capacity and asked them how this was assessed. Staff were unclear about these assessments and had not received training in mental capacity. We found the service did not have mental capacity assessments in place nor had in place a best interest decisions to use the least restrictive practices. Staff told us they would prevent some people from leaving their own homes if they tried to leave. We found no one in the service was subject to restrictions placed on them by the Court of Protection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not practice restraint but had been taught how to break away from people and keep them safe. Staff also described to us de-escalation techniques and how to help people calm down. This meant staff understood how to manage people's distress reactions and behaviours which challenged them without resorting to the use of restraint.

We saw staff either helped people prepare their own meals or they prepared them for people. One staff member said, "We try to have healthy meals. We try to get [person] to have fruit and veg every day." Another staff member said, "I chop up [person's] food to make sure they don't choke." People told us staff helped with their meals, one person said, "[Staff member] helps me." We observed a member of staff give clear instructions to a person to make their breakfast. We saw one person was deemed to be at risk of choking with their medicines and was required to have a soft diet. Neither issues were addressed in care plans or risk assessments. This meant people were at risk as staff had not received guidance to support people's nutrition.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Is the service caring?

### Our findings

One person said, "They [the staff] are nice to me. They care for me all of the time." Another person told us they "Liked the staff." One person told us if they had any worries they would be able to tell their staff. Another person said, "Staff are kind to me." One person said, "The staff are nice."

We talked to staff about people's dignity and privacy. One person said, "If [person] is in the bathroom we wouldn't walk in without knocking." They went on to say that the person needs support to wash themselves in the bath and would help them if the person asked. We observed staff knocking on people's doors and asking their permission to enter their homes. Another staff member told us when a person goes to the toilet they leave them and ask them to shout out when they need support. During our inspection one member of staff spoke with us about the person in front of them without including them in the conversation. We also heard a member of staff having a loud conversation about a person within earshot. This meant people were not always treated with respect and their confidentiality maintained.

The registered manager told us Tameside Link was set up by a group of parents who wanted their children to experience living independently and have exactly the same rights and choices of a person who did not have learning disabilities. We found the service had continued to support people as the parents had wished. For example one person was supported to volunteer in the community and were able to access their volunteering role on their own using public transport. They told us they enjoyed their volunteering opportunity and the place where they volunteered had made sure they were safe. This meant the service supported people to take an active role irrespective of people having any additional learning needs.

Over the years the registered manager told us parents had become trustees of the service and some had retired. They had acted as advocates for people using the service. The registered manager told us no one in the service had an independent advocate. We saw some parents had continued in the role of advocates and were proactive in describing how the care of their adult children should be delivered. We spoke to staff about people being involved in their care and being enabled to make decisions. Staff told us they had not been asked to do something for people by their relatives with which people or themselves disagreed.

Staff were able to tell us about people's needs in detail and their likes and dislikes. We found staff knew people well; they demonstrated to us how they promoted people's well-being. One member of staff spoke with us about a person's mental well-being and showed us how they supported them. Staff demonstrated they care about people and were able to promote their well-being. For example one person was supported to access a number of places in the community which they enjoyed. Another person was frequently taken out by staff in their car and another person was supported to remain calm by using their personal possessions.

The registered manager told us there was no one end of life care. However one person shared with us information on a family bereavement and became tearful when speaking to us. Staff told us they had been offered bereavement counselling. We found there was not a plan in place to support the person when they felt upset.

We saw staff supported people to be independent and supported them to care for themselves . For example staff supported people to do their own cooking. We also saw staff supported people to maintain their independence in their own tenancies by ensuring they paid their domestic bills, their home insurance was up to date and their TV licence was being paid.

Staff had supported people to personalise their own homes. One person told us they their flat the way they wanted it. Another person showed us the new cushions staff had helped them buy. They told us about how staff had helped them sort out their flat when it had recently been redecorated

## Is the service responsive?

### Our findings

One person said, "They don't rush me, I can get up whenever I want." Another person told us how staff had come in on a weekend and taken them out. Another person told us about how they enjoyed staff supporting them to do baking and "Arts and crafts." One staff member said, "I always make sure [person] is not in any danger and won't fall." Another staff member described to us how they supported a person and told us they asked the person what they wanted to do, "So they can have a fulfilled life."

We discussed with staff how they found out if there were any changes to people's care. One staff member said they go through the files every week. Another member of staff told us they are informed by their manager in supervision or, "Over the phone."

The professionals we spoke to during our inspection expressed concern about the lack of care planning carried out in the service. They told us they had made suggestions to the service about how this should be carried out and we found one specialist nurse had written a plan for the service. During our inspection visit we were shown a new format for a care plan, and a new care plan had been drawn up for one person.

At our last inspection in 2013 we advised the registered provider that although the local authority plans provided information to support people's care the provider, "May wish to consider how to maintain and update more detailed and person-centred care plans. These should include appropriate information and documents relating to the care provided to each person supported by Tameside Link." Following the implementation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we found the registered provider had not carried out collaboratively with the relevant person an assessment of their needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In some people's files we found there was a list of tasks to be carried out with each person. We found some people who used the service had complex needs and there were no care plans to describe their needs and how staff should care for them. For example we found staff were caring for people with autism and epilepsy without appropriate guidance in place. This meant the registered provider had failed to ensure they had done everything possible to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found people had in place "Mood Diaries". The registered manager told us these were for people to record their thoughts and feelings. We saw staff had recorded in people's mood diaries comments for example, "I am in a lovely mood." In one person's mood diary staff had recorded they had put some foodstuffs in the bin. We found these diaries were not reviewed to support people's care needs.

We checked to see if the registered provider carried out reviews of people's care with them. Staff told us they meet approximately every five weeks with one person's family members to check on progress on and what will happen next. The staff told us the person is not involved but happy with the decisions made. In other people's files we saw the registered manager had written on the front of the local authority care plan, "Reviewed, no change." We saw these paper reviews had been carried out a year after the date of the original local authority plan and people had not been involved in their reviews and given choices about how they would like their care to be delivered. We were concerned that where people live with others either together in their home or in flats in one block staff wrote daily information about people in the diary. This meant it was difficult to extract information about each individual person to review their care.

We saw some people were protected from social isolation and found people had activities planned during the week and at weekends. One person said, "Yeah, I have enough to do." We saw one person had a weekly plan in place including contact with their family members and a visit to a social club. Other people had been taken shopping by staff on weekends. Another person was supported to volunteer. One staff member spoke with us about people's activities and said, "At the end of the day it is up to [person]." Another person told us they were, "Bored" and wanted more to do. The registered manager explained they had been unsuccessful at supporting the person to engage in other activities, however, staffing was put in place to meet people's needs. However we found people's activity plans had not been updated, for example one centre where a person used to go to had been closed down in April 2016. This meant the person did not have in place accurate records to meet their needs.

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

We saw the registered provider had in place a complaints policy. The registered manager told us they had not received any complaints. In the service user guide we saw people were given information on how to complain. People told us they would tell the staff if there was anything they did not like.

People had in place hospital passports, these were documents which described people's needs should they require the services of a hospital. We saw these had been completed and provided detailed information to medical professionals if a person needed to go to hospital.

## Is the service well-led?

### Our findings

Staff told us they were supported by the registered manager. One staff member confirmed they thought the service was well managed and said, "It's well managed, I think well run." They told us about the line management structure and who they would go to in sequence of seniority to get an answer to concerns they might have. Another staff member told us they thought the service was well managed and described how they had responsibility to resolve difficulties, they said, "It is up to me to get things sorted."

The service had in place a registered manager. Following the inspection of the service in 2012 and in the registered provider's submission of the PIR we were advised that the service was developing new management roles whose function was to improve the quality of the service. During the first day of our inspection we were advised that Tameside Link was bringing in a consultant to help improve the service and on our second inspection day we met the person and were told they were to become the new registered manager.

During our last inspection we suggested to the registered manager that they carry out their audits on a more frequent basis in order to ensure any deficits in the service were quickly addressed. During this inspection we found the registered manager had continued to carry out audits on a quarterly basis. We saw the one page audits which were carried out did not address the regulatory requirements. The registered provider was unable to demonstrate they assessed and monitored the service to improve its quality and safety. This meant the deficits we found in the service had not been found or addressed.

We asked the registered manager if they carried out surveys with people who used the service, staff and other professionals to monitor the quality of the service. The registered manager told us they did not have any surveys in place. This meant the quality of the service was not being monitored using people who were connected to the service.

We found the service records were not up to date or accurate. For example we found in some people's files the information began by stating their age. We saw this meant some records were up to 12 years out of date. We found documents which were undated; this meant we were unable to ascertain if the records were contemporaneous. Due to the lack of person centred reviews we were unable to ascertain if the documentation held for each person was accurate. Staff provided us verbally with their most up to date knowledge. We found in one local authority plan the service was expected to have in place records to monitor one person's diagnosed condition and found there was no monitoring in place.

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

During our inspection we found there had been a safeguarding incident. We spoke to the care manager for one of the people who used the service and found there had been a second earlier incident. Whilst we found the registered provider had advised the local teams of the safeguarding incidents they had not made the statutory notifications to the Care Quality Commission. This meant the registered service was not meeting their registration requirements. We advised the registered manager of what actions they needed to

take in the future.

This was a breach of Regulation 18 – Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

In the absence of the regulatory framework being in place in the service we found people were cared for by staff who did not have the structures or systems in place to demonstrate they were meeting the regulations. For example staff were not given guidance in how to complete a Medicine Administration Record (MAR) and could not demonstrate they had offered people their medicines and they had refused. Where staff were required to monitor people's conditions systems were not in place to do this. We found the culture of the organisation to be based upon small groups of staff knowing people well rather than the service having in place leadership to guide staff on what to do.

The service had in place a network of professionals who had supported the service by providing plans for people and explaining to the registered manager the requirements of care planning. We saw the staff had attended multi-disciplinary team meetings to support partnership working. However we found partners were concerned at the lack of detailed planning for people and had questioned the practice of the service. One professional told us they had been shown a new care plan format and described it as a, "Good start."

People were supported to access local community facilities. We saw people enjoyed shopping locally with staff, going to the local pub and accessing clubs. We also found people had access to local GP's, dentists and chiropodists. This meant people were supported to be a part of their own community and there were community links in place to support their health needs.

The service had in place a statement of purpose, this is a document which tells people and their relatives what they can expect from the service.



This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents  The provider had failed to submit statutory notifications to CQC.
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  The registered provider had not acted in accordance with the Mental Capacity Act 2005