Manchester City Council

DSAS- South Network

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 25 and 26 September 2018, the first day was unannounced.

This service provides care and support to 44 people living in 13 'supported living' settings or flats, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

People lived on their own or in small groups, each person having their own bedroom and sharing lounges and bathroom. Where required staff either slept in the house to be available in the event of an emergency, or stayed awake throughout the night.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

DSAS South had a new registered manager, who had been in post since November 2017. 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.

At the last inspection in September 2017 we found three breaches in regulations because person centred plans and risk assessments had not yet been completed in some properties, support plans had not been reviewed and the governance of the service was not robust as the issues with care plans and risk assessments had not been addressed. Staff job consultations (supervisions) had not been regularly completed.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, responsive and well led to at least good.

At this inspection we found there were continued breaches in the same three areas. Staff and regular contracted agency staff (called R1s) told us they now received regular supervisions with their care co-ordinator although the written record of these meetings was not always stored in the staff files.

There was a variation across the properties we visited, with some risk assessments, care plans, positive behaviour support (PBS) plans, epilepsy care plans and eating and drinking care plans having been reviewed and updated to reflect people's current needs.

However in other properties these had not been reviewed and updated. One person did not have a person centred plan in place. A plan had been partly completed but the care co-ordinator had moved to a sister service within Manchester and the person centred plan had not been finished. Other people's risk assessments and health action plans had not been reviewed. Therefore staff may not have the information they needed about people's needs to support them effectively.

Not all care co-ordinators were confident to review the care plans that had been written by other agencies, for example the PBS plans. At our last inspection in September 2017 the community learning disability team (CLDT) nurse said the service had been informed that they needed to review all the PBS plans and refer people back to the CLDT if there had been any changes in people's needs and behaviours. This was not consistently applied at DSAS South.

The care co-ordinator team had not been fully staffed, due to sickness, vacancies and co-ordinators moving roles, until May 2018. This had impacted on the service's ability to review and update all of people's care and support plans. The provider had not ensured there was sufficient continuity across the care co-ordinator team to complete the review of all care files which had been identified in our previous inspections. We were told the team was now fully staffed and any sickness or vacancies were quickly filled.

The registered manager had started a tracker matrix to monitor what paperwork was in place and reviewed in each property, for example person centred care plans and risk assessments. However, a similar matrix had been put in place by a previous registered manager following an inspection in 2016, but this had not been provided to the current registered manager.

The registered manager also used tracker matrixes to monitor and review incidents, capacity assessments and staff training. The care co-ordinators reviewed the medicines administration records and finance records each month.

An auditing system had been introduced across the three Manchester Council supported living services whereby care co-ordinators from one service audited properties in another service. These audits had been reviewed and streamlined and were being re-introduced. At the time of our inspection three DSAS South properties had been audited in 2018 and action plans written. The findings were in line with what we found during this inspection.

People and their relatives thought they were safe supported by DSAS South. There were sufficient staff to meet their needs and support them to participate in activities. Regular R1 agency staff were used to ensure continuity of the support provided. Relatives told us the staff teams supporting their relatives were stable and the staff knew their relative's needs.

Additional staff were provided when people's needs changed. However, people's needs were not reviewed by the local authority social service department so these hours were not recognised in the service's budget. We were assured that these hours would not be removed for budgeting reasons. This also meant the service could not recruit permanent staff to these hours as they were not recognised in their budget. R1 agency staff were used to cover these hours.

Staff had completed the training they needed to meet people's needs. On line e-learning courses were now available for staff to complete when working in the properties. Medication training had been arranged for all staff who administered medicines.

People received their medicines as prescribed. People were supported to maintain their health, although

not all health action plans had been reviewed and updated. People were supported with their nutritional needs.

The service was meeting the principles of the Mental Capacity Act (2005). People's capacity had been assessed and referrals made to the local authority where appropriate for formal capacity assessments to be completed and applications made to the Court of Protection if required. Any restrictions in place were recorded and staff could explain why they were needed.

Staff said they enjoyed working at the service and felt well supported by their care co-ordinator. Regular staff meetings were held. The care co-ordinators said the new registered manager was approachable and supportive.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments and positive behaviour support plans had not been reviewed and updated in all properties.

There were sufficient staff on duty to meet people's assessed needs. Additional staff were provided when people's needs changed.

Incidents were recorded and reviewed to look for patterns and to assess how the risk of a re-occurrence could be reduced.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain their health; however not all health action plans and hospital passports had been reviewed and updated with people's current health needs.

Staff received the training they needed to support people effectively. We were told staff had regualar supervisions but the records of these were not always in the staff files.

The service was meeting the principles of the Mental Health Act (2005).

Is the service caring?

Good

The service was caring.

Staff knew people's support needs well. Peole appeared relaxed when with the staff.

Relatives were complimentary about the staff teams supporting their relative.

People were supported to complete the tasks they were able to do for themselves.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Person centred support plans had not been reviewed and updated in all properties.

People had weekly activity planners in place and had the staff support to participate in these.

End of life support was co-ordinated with the district nurses and Macmillan nurses where required.

Is the service well-led?

Inadequate

The service was not well-led.

This was the third inspection (June 2016, September 2017 and September 2018) where breaches of Regulations 9, 12 and 17 due to risk assessments and care plans not being reviewed and updated.

The provider had not ensured a stable and fully staffed care co-ordinator and registered manager team was in place to complete all the risk assessment and care plans reviews required.

Not all care co-ordinators were confident to review plans and guidelines written by external agencies for any changes in people's needs or behaviours.

The registered manager had recently implemented a series of tracking matrixes to monitor the service, including the paperwork for each person and incidents.

DSAS- South Network

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 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 25 and 26 September 2018. The first day was unannounced. Two inspectors visited four supported living properties on the first day of the inspection. One inspector returned to visit the service's office on the second day.

We did not ask the provider to complete a provider information return (PIR). The PIR 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.

We reviewed the information we held about the service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law.

During the inspection we observed interactions between staff and people who used the service. We spoke with five people, the registered manager, four care co-ordinators and ten care staff. Following the inspection we spoke with four relatives of people who used the service.

We looked at records relating to the service, including nine people's care records, seven staff files, daily record notes, medicine administration records (MAR), quality assurance systems and records of incidents. Due to the limited verbal communication of some of the people living at the service, and the nature of their learning disability, they responded to most of our questions with a "yes" or "no" answer.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2017 there was a breach of regulation 12 as not all people had current up to date information about the risks they may face and how to mitigate those risks. At this inspection we found that this was still the case.

In some properties we saw a risk screening tool identified risks for each individual. This referenced where the information to manage the identified risk was, for example in the person centred plan, positive behaviour support plan or person centred risk assessment and safety management plan. These plans were in place and reviewed to state they were current. One relative said, "They (the staff) have learnt how to recognise if [name] is not happy and have ways of distracting them." They also said that this was all written up so new staff could learn how to support their relative if they became anxious or agitated.

However in other properties the risk assessments either were not in place or had not been reviewed. For example, one person had a positive behaviour plan in place. This detailed the potential triggers for the person's anxieties and behaviours and strategies for staff to follow to support them. This had been written in July 2016, but had not been reviewed since February 2017 to ensure it was still relevant and the strategies to be used were still appropriate. One risk screening tool had not been reviewed since February 2017. One person's risk assessment for the risk of harm to others referenced a safety plan in another file. This safety plan was not in the referenced file.

It is important that people's risk assessments and positive behaviour support plans are regularly reviewed and updated as people's needs can change and different strategies for supporting people to reduce their anxieties can be developed by staff.

One person we met sometimes hit the back of their head, especially if they were agitated. This behaviour could present a risk to the person if they regularly hit their own head. There was no information about this behaviour in their care file. The staff we spoke with said there were no interventions they could use to prevent this behaviour. However, there was no evidence that any distraction techniques had been tried in order to reduce the person's anxiety and hence behaviour.

The inconsistent availability of reviewed and up to date information about the risks people may face, the behaviours they may have and the strategies staff should use to minimise these risks and behaviours was a continued breach of Regulation 12 of the Health and Social Act HSCA 2008 (Regulated Activities) Regulations 2014.

We were shown an email trail requesting involvement of the Community Learning Disability Team (CLDT) to review the positive behaviour support plan for one person where there had been a change in their presenting needs.

Staff and people we spoke with felt there were sufficient staff on duty to meet their assessed needs. The care co-ordinators wrote the rotas for their properties. Regular agency staff who were on a long term contract

(called R1s) were used as part of the rota, which meant they knew the people they were supporting. One member of care staff said, "[R1 Name] knows the guys really well; she's always here." One relative told us new staff were introduced gradually into the house so they could get to know people's needs.

We spoke with some R1 staff who confirmed they were on the properties rota, were considered part of the staff team and had supported the people living there for a long time. A resource team arranged any further agency cover that was required, wherever possible asking for agency staff who had previously worked at the property where they were required. One staff said, "We are always fully staffed and get agency cover if we need to."

A new electronic rota system was in the process of being introduced at the service. This would mean any shifts that required to be covered would automatically be sent to the resourcing team. The system also included a staff clocking in system which meant the co-ordinators would be able to ensure the support staff were available as planned.

Wherever possible staff worked at the same property so they could form relationships with the people they were supporting. However, staff did move between properties, either due to their personal circumstances or due to operational needs. One relative also told us that their relative was often supported by non-regular staff, especially at a weekend. They said these staff did not know their relative's needs as well as the regular staff.

People we spoke with told us, or indicated to us, that they felt safe living in their homes with the staff support. One person told us, "I definitely feel safe when I'm with the staff" and another said, "The staff help me to feel safe."

We saw that additional staff were deployed if people's needs changed. A care co-ordinator told us, "We have conversations now about are there enough hours on the rotas to meet needs and allow people to go out, not about saving hours here and there."

However, people's needs were not re-assessed by the local authority social services department, which meant the service's budget did not reflect the actual support people needed. This meant the service was not able to recruit permanent staff to meet these additional hours as they were not part of the budget. R1s were used to cover these additional hours wherever possible. The registered manager also told us that overtime was offered to the regular staff to maintain consistency.

We were reassured by Manchester City Council's programme lead for health and social care integration that, where an increase in people's support had been agreed due to an increase in their needs, this would not be removed again due to budget pressures. This is important to ensure people receive a consistent and safe service.

Recruitment information was held centrally by Manchester City Council. The registered manager obtained the Disclosure and Barring Service (DBS) reference number and checked that all references had been received before a new member of staff started work. The DBS checks that staff are suitable to work with vulnerable people. We did not check the central personnel files at this inspection as we had viewed them on seven previous inspections across the Manchester supported living services in the last two years, when we found a safe recruitment process was in place.

Staff continued to be aware of the incident reporting and safeguarding procedures for the service. All incidents were looked into by the care co-ordinators and graded for seriousness. Level one incidents were

logged by the care co-ordinators and discussed with the staff teams. Level two (more serious) incidents were also reviewed by the registered manager to identify any patterns or themes for each property and across the service.

Medicines were administered as prescribed. Medicine administration records were clear and recorded the time the medicine was administered and a daily stock count. Guidelines were in place for when medication that was not routinely administered (PRN) was to be given. However, two of the guidelines had not been fully completed with this information. Care staff told us the person was able to verbally tell them if they needed the PRN medication. This information should still be included on the PRN guidelines in case unfamiliar staff are supporting the person who would not be aware of this.

Staff who administered medicines had completed medicines training and an observation of them administering medicines was completed annually.

People's homes were clean and personalised; however, some were in need of re-decoration. The provider was in contact with the social housing landlords about the need for re-decoration. Weekly safety checks were made of smoke detectors and fire alarm systems where they were installed.

Personal emergency evacuation plans (PEEPS) were in place for people. These detailed the support a person would need in the event of having to evacuate the building. We saw personal protective equipment (PPE), for example gloves and aprons, were available for staff to use where required.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2017 we found people's health action plans (HAPs) had not all been reviewed. HAPs provide information about the person's health needs and the support they needed to maintain their health. Important details about people's medical conditions, including symptoms and traits, were recorded to inform staff about the health needs of the people they supported. At this inspection there were still some HAPs that were not up to date. For example, we saw one HAP was dated 2011 and there was no indication that it had been reviewed to show it remained current.

We had been told at our last inspection in September 2017 that the staff teams would now be reviewing the HAPs instead of the community learning disability team nurse. This had not happened.

People also had completed 'hospital traffic light' books in place which provided key information required by hospital staff if they were admitted to hospital. However, one document we saw did not contain key information about the person's health needs or challenging behaviour that was included in their person centred plan. Therefore, the hospital would not have all the relevant information they needed to support the person if they had to be admitted to hospital. We did not see a hospital passport in one person's care file.

This was a breach of Regulation 9(1) with reference to 3(a) of the Health and Social Act HSCA 2008 (Regulated Activities) Regulations 2014.

We saw people had regular appointments with relevant health professionals, such as GPs, dentists, and psychiatrists. A log of referrals made to the speech and language team (SALT) where it had been identified they had difficulties swallowing, epilepsy team and community learning disability team. This allowed the referrals to be followed up if necessary. Referrals were also made to other agencies through people's GP, for example to the falls team when one person's mobility had declined.

People's nutritional needs were being met by the service. People were involved in planning their menu.

Staff told us they received the training they needed to carry out their roles effectively. All staff had completed or were enrolled on a nationally recognised qualification in health and social care. New staff completed the care certificate if they were new to working in care. The care certificate is a nationally recognised set of principles that all care staff should follow in their working lives.

Staff had now been assigned e-learning courses that they could complete when they were on shift in the properties. The registered manager had a training tracker in place to monitor the training needs across the staff team. Some courses were arranged by the provider's central training department. The service was also able to arrange the specific courses they needed with external training providers. We saw this had been done to refresh the medicines training for all staff who administered medicines which was booked for November 2018.

Staff told us they felt well supported by the care co-ordinators and registered manager.

At our last inspection staff told us there was a variation in the frequency of supervision meetings (called job consultations) they had with their manager. At this inspection all the staff we spoke with said they had regular supervision meetings with their care co-ordinator. In one property staff said, including the regular agency R1s, that they had a supervision meeting every six weeks and this was included in their rotas.

The care co-ordinators we spoke with all confirmed they completed supervision meetings with their staff every six to eight weeks. However; the staff files we looked at did not show that the supervision meetings had been regularly held. All files included supervision notes from August 2018, but notes were not in the files for regular meetings prior to this. We discussed this with the registered manager who told us the care co-ordinators kept their own records of the supervisions they completed and he discussed this with them during the care co-ordinators own supervision.

Regular team meetings were held for each staff team. We were told these were open meetings where people's needs and support were discussed. Staff said they were able to raise any ideas or concerns they had and felt these were listened to.

Care co-ordinators were meant to spend time in each of their properties every week. The co-ordinators we spoke with said they did this and could work from the properties there was now a computer they could use in each property. The co-ordinators were based in one property we visited all the time. In two other properties the staff said they saw their care co-ordinator at least once a week, often more frequently. However; in one property the staff said the care co-ordinator visited when they contacted them.

Therefore, whilst staff said they felt well supported, we were told not all care co-ordinators visited the properties on a weekly basis.

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 people lack the 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. Applications to deprive a person of their liberty in community settings have to be made to the court of protection.

The service continued to meet the principles of the MCA. People's capacity to make decisions had been assessed by DSAS South and the reasons for any restrictions that were required, for example doors being locked, were recorded. The staff we spoke with were able to explain what restrictions were in place and why they were needed. Referrals had been made to the local authority for formal capacity assessments to be completed and applications to be made to the court of protection.

Staff received a handover at the start of each shift. This gave them an update on any changes in people's health or well-being and checked what activities or appointments were arranged for that day. During the handover all monies and medication held in the property were checked.

We saw, where appropriate, properties were adapted to meet the needs of the people living there, including accessible bathrooms and track hoists.

Good

Is the service caring?

Our findings

We observed positive interactions between people and their staff team at each of the properties we visited. Staff knew people and their needs well, including the regular agency staff (R1s). We observed that people appeared relaxed and comfortable when they were with the staff.

People we spoke with were complimentary about the staff teams supporting them. One person said, "[Staff names] are very kind to me" and another told us, "I look forward to being with [staff names] and going out to sing along with them."

Relatives also spoke highly about the staff supporting their relative. One said, "The staff are brilliant, they know how to cajole [name] and he responds to this."

A one page personal profile had been written for each person, giving details of what was important to them, their likes and dislikes. This would enable staff to quickly get to know the person they were supporting. However, one we saw was dated August 2010 and although it did have some hand written alterations on it we could not be sure how relevant the information was.

All staff received training in equality and diversity as part of their induction. People's cultural needs, for example religious or dietary needs, were identified in people's person centred plans. People were supported to attend church if the wanted to.

Staff explained to us the tasks people did for themselves and where they needed support. The person centred plans detailed what people could do for themselves to maintain their independence. One person said, "I make my own breakfast and do the cleaning as well."

Staff clearly explained how they maintained people's privacy and dignity when supporting them with personal care tasks. We were told, "I always talk with [person] so they know what is going to happen." When we arrived at one property the member of care staff checked that people were fully dressed and ready for us to up to the office before allowing us to do so.

Information about people's communication needs was included in their person centred plans. Some people had separate communication passports in place. These included an explanation of any non-verbal communication methods the person may have, for example gestures of facial expressions.

The service made referrals to a local advocacy centre where people may lack the capacity to make a decision and there was no family member available to act in their best interest.

People's confidential information was stored in the staff office rooms in the properties.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017 we found a continued breach of Regulation 9 because not all person centred plans had been reviewed and updated. At this inspection we found this was still the case.

There were variations between the properties we visited. In one property all person centred plans and the support plans developed by external agencies, for example the speech and language team and behavioural support plans, had been reviewed and updated where required.

However, in another property one care file did not contain a person centred plan. We raised this with the registered manager who showed us a partially completed plan for this person written by a care co-ordinator who had been moved to a sister service in central Manchester. The plan had then not been completed.

In a third property one person's plan stated they required the use of a track hoist to transfer from their bed. They told us, confirmed by the staff we spoke with, that they were able to transfer without the use of the hoist.

This was a continued breach of Regulation 9(1) with reference to (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Computers had been installed in each property; however, the staff we spoke with said they did not update people's care plans or risk assessments via the computer system as originally planned. Instead the staff made notes of people's support needs and any changes that needed to be made to the care files and passed these to the care co-ordinator to update the documents themselves. One staff member said, "We have input to the reviews through feedback to [care co-ordinator name] who then updates the care plans."

Where assessed as being required, technology was used to alert staff if people had got up or were trying to leave the property. For example, one person liked to spend time on their own in the garden. A sensor had been fitted to the side gate to alert staff if they tried to leave the garden as they needed support to safely access their local community.

People had weekly activity planners in place. Where people had one to one staff support they could access activities as they chose. Where people shared support, there was a day time flexi shift on the rota to support people to attend their planned activities.

People also had day trips out with staff and some went on holidays, for example to North Wales. Plans were in place where required to assess people's anxiety levels to judge if they were able to safely participate in the planned activity. Not all activities people took part in were recorded on their activity log, making it more difficult to monitor what people had done.

Staff and care co-ordinators told us, confirmed by the relatives we spoke with, that the staff teams kept them up to date with any changes in their relatives' support needs, health or activities. Relatives were also

involved in reviewing the support their relative needed. One relative told us, "The communication (with the staff team) is really good."

There were no formal mechanisms in place, for example surveys or meetings, to gain feedback from people who used the service or their relatives about the service they had. The registered manager told us they had arranged one staff survey in November 2017 to check the staffs understanding of the Mental Capacity Act (2005). Therefore the service did not seek formal feedback from people or their relatives to inform improvements at the service.

Details of people's wishes in the event of their death were recorded in their care files. This included details of any funeral service and the music or floral arrangements they wanted.

Care plans for people's end of life care were agreed with the supporting medical professionals, for example district nurses and Macmillan nurses when they were required. In one property we visited we saw staff had liaised with a person's GP to change their medicines to a liquid form due to their changing support needs at the end of their life. They were also changing the timing of their support, for example for personal care, as the person was becoming increasing tired after any support. This showed the staff team were being responsive to the person's changing needs at the end of their lives.

We saw that a formal complaints policy was in place. The registered manager had not received a formal complaint since they had become manager. They and the care co-ordinators followed up any verbal concerns raised with them, which meant they did not progress to a formal complaint. One relative confirmed that any issues were resolved with the staff team and care co-ordinator.

Inadequate

Is the service well-led?

Our findings

At our last inspection in September 2017 we found a continued breach of Regulation 17 because people's care files were not up to date and contemporaneous. Not all risk assessments and care plans had been reviewed and updated. At this inspection we found this was still the case. This was the third inspection (June 2016, September 2017 and September 2018) where there had been breaches in Regulations 9, 12 and 17 due to risk assessments and care plans not being reviewed and updated.

In one property all care files had been reviewed and updated; however, at another one person did not have a person centred care plan in their care file. At another the information the care plan contained did not reflect the person's current support needs.

The procedure for all providers is that the service reviews the guidelines provided by external agencies, for example positive behaviour support plans or eating and drinking guidelines. If there are any changes in people's needs they re-refer them to the specialist service who wrote the original plan so it can be updated. At our last inspection in September 2017 a community learning disability team (CLDT) nurse told us that the service had been informed that the staff teams should review the positive behaviour support plans and record if there were no changes required and that referrals to the CLDT should be made where there had been changes in people's behaviours. This was not consistently happening across the service.

This was the third inspection where these short falls had been identified and was a continued breach of Regulation 17(1) with reference to 2 (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the care co-ordinator team was not fully staffed due to sickness, which meant the person centred plans and other care file documentation had not been updated as planned. At this inspection we were told the care co-ordinator team had been settled since May 2018 and any vacancies in the team were now filled promptly. One care co-ordinator said, "It means we can now do the job we are meant to be doing" and another told us, "The workload is manageable now."

However, before May 2018 there had been moves of care co-ordinators and gaps in the team. As stated in the responsive domain of this report one person centred care plan had been partially completed by a care co-ordinator who had then been moved to a sister service, but the plan had not been completed by the care co-ordinator who replaced them.

The lack of a stable care co-ordinator and registered manager team had hindered their efforts to review and update all the care files. The lack of confidence in the staff teams to review and guidance provided by a third party, for example positive behaviour support plans, eating and swallowing plans and epilepsy support plans meant these had not all been reviewed as being current.

There had been a different registered manager at each of the last three inspections. The care co-ordinator team had not been at full strength for large parts of this time.

A care co-ordinator also told us there continued to be an issue with staff sickness. We discussed this with the registered manager. The process to look into staff sickness and get them back to work took a long time and caused instability to the staff teams and affected the continuity of the support provided. Where it was identified the sickness would be long term the service covered the shifts with a regular agency staff member where possible.

Providers must have effective systems and processes in place to make sure they assess and monitor their service against the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured there was sufficient continuity across the service to complete the review of all care files which had been identified in our previous inspections. This was a breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had a range of monitoring tools in place. These included a log of all incident, accidents and safeguarding referrals. These were reviewed by the registered manager to look for patterns across the service. Tracker matrixes were used to monitor staff training, deprivation of liberty safeguards applications, risk assessments and person centred care plans. The trackers were only marked as complete when the registered manager had seen the up to date assessments and plans were in place. These trackers could be accessed by the care co-ordinators as well as the registered manager.

The registered manager was in the process of completing a tracker for all the information required in the care files and whether it had been reviewed. However, a similar exercise had been carried out in 2016 by a previous registered manager, but this had not been kept as a live, up to date document.

The registered manager had introduced 'focus topics' for each month four months before our inspection. This was a designated area of the care files that the care co-ordinators and their staff teams should concentrate on during the month to ensure the topic was reviewed and up to date, for example risk assessments, capacity assessments or person centred plans. At the time of our inspection the focus topic was person centred plans.

One care co-ordinator we spoke with had their own tracker information for their properties about what information was needed in each person's file and when it needed to be reviewed. They had done this so they could keep on top of what needed to be done and when.

However, the care file monitoring tool had not been fully completed and the focus topics had only been introduced in June 2018. They were yet to be successfully used to drive improvements across the whole service, as there was continued variation in whether the care plans and risk assessments had been reviewed and updated in a timely manner.

The care co-ordinators reviewed the medicines administration records and finance records each month. Any gaps or anomalies were followed up with the staff team.

The registered manager did not have an overview of the staff supervisions being completed. The previous registered manager had showed us a tracker they used for supervisions but this had not been passed onto the new registered manager. The care co-ordinators kept their own records. Staff and care co-ordinators told us regular supervisions were taking place, but the records of these supervisions were not in the staff files we viewed.

The Manchester City Council audit tool had been reviewed and streamlined since our last inspection. This audit was completed by care co-ordinators from a sister service, which meant it was more objective. A

timetable for the DSAS South co-ordinators to audit properties in the sister services was in place. A follow up visit was made three to six months after the audit to check that the action plans from the initial audit had been completed.

Three audits had been completed in 2018 for DSAS South properties. Action plans had been agreed and were being completed. The audits had identified similar short falls in care plans and risk assessments being reviewed and up to date as we found at this inspection.

The registered manager told us they felt well supported since taking on the role. The previous registered manager was available to offer advice and the Nominated Individual regularly visited the service and was always available to provide support and guidance. A Nominated Individual has responsibility for supervising the management of the regulated activity.

The care co-ordinators said the registered manager was approachable and supportive. Fortnightly meetings were held with the care co-ordinator team. The registered manager also met weekly with their colleagues from the two other sister services in Manchester. This enabled them to share good practice and get advice from each other.

The care co-ordinators also met with their colleagues from the two sister services. They found these meetings beneficial as they were able to discuss shared issues, discuss how they would tackle issues and to learn from each other's experience.

The care staff we spoke with enjoyed working at the service and said they felt supported by the care co-ordinators, although as previously stated in this report not all care co-ordinators visited their properties each week. The registered manager and senior managers from Manchester City Council also held open door meetings where any staff could attend to discuss any changes in the service or council. Staff could raise any topics they wanted to.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.

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 9 HSCA RA Regulations 2014 Person-centred care Not all health action plans and hospital passports had been reviewed. One hospital passport did not contain key information about a person's health needs or challenging behaviours. Not all person centred plans or guidelines written by external agencies (eg. Speech and Language Team) had been reviewed and updated. One person centred plan was not in the person's care files. Regulation 9 with reference to 3 (a)

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risk assessments and positive behavioural support plans and been reviewed and updated.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was sufficient continuity across the care co-ordinator team to complete the review of all care files which had been identified in our previous inspections. Not all care records, risk assessments and positive behavioural support plans had been reviewed and updated. This was the third inspection where these short falls had been identified.

The enforcement action we took:

Issued a warning notice