Turning Point

Turning Point - Derby

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Turning Point – Derby supports adults to live as independently as possible who have a learning disability and/or autistic spectrum disorder and whose behaviour may challenge. At the time of our inspection, eleven people were receiving personal care and lived in their own properties or supported living accommodation.

People's experience of using this service and what we found
People were not always protected from harm, as safeguarding concerns were not always reported or analysed in an effective way. Not all staff had up to date safeguarding training. Medical advice was not consistently sought when injuries occurred.

There were risk assessments in place, however these had not always been updated when changes occurred and not all risks had been identified or mitigated effectively. This included people's personal evacuation plans not being sufficiently detailed.

Gaps in staff training impacted on quality, safety and individual care needs being effectively and safely met.

The systems and processes in place to assess, manage and review quality and safety were not effective in mitigating and managing risks.

People in the main received their medicines safely. Hand written medicine records did not follow best practice guidance, of having two staff signatures. Whilst action was taken internally when medicine errors occurred, this had not always included a safeguarding referral to the local authority.

There were sufficient staff employed and safe recruitment checks were completed, before staff commenced their employment at the service.

Infection prevention and control best practice guidance had been implemented by the provider, including Covid 19 guidance made available for staff.

Rating at last inspection
The last rating for this service was Outstanding (published 20 February 2018).

The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risks associated with choking. This inspection examined those risks.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Outstanding to
Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has begun to take action to mitigate the risks we found and have provided CQC with an action plan.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Turning Point Derby on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safeguarding, risk management, governance and how the provider notified CQC of reportable incidents.

Full information about CQC's regulatory response to the more serious 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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Turning Point - Derby

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector.

Service and service type
This service provides care and support to people living in six 'supported living' settings, so that they can live 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 22 September 2020 and ended on 25 September 2020. We visited the office location on 23 and 24 September 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, locality manager, two team leaders, and two support workers. We spoke with two relatives for their feedback about the service their family member received. We reviewed a range of records. This included reviewing three people's care records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, audits and staff training.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included analysis of incidents and further staff training details and audit reports. We also requested assurances from the provider of action they would take in response to concerns about safety we identified. The provider sent us an action plan within the required time, detailing the action they would take, and this included timescales and who was responsible. We reviewed this and took this into consideration of the action we took against the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not protected by the provider's safeguarding systems and processes. There was a safeguarding policy in place, but this was not consistently used when safeguarding incidents occurred. People using the service were reliant on staff for all their care and support needs and in the main, the only people they saw.
- We identified two incidents that met the safeguarding criteria and required reporting to the local authority safeguarding team and CQC. However, neither of these incidents had been reported and no action had been taken by the provider to investigate or take action to reduce further risks.
- During the inspection, a staff member told us about a further incident that had not been reported as required.
- At the time of our inspection, we were aware of two ongoing safeguarding investigations. Following our inspection, we made a safeguarding alert to the local authority safeguarding team. This was due to the provider not taking any action to reports previously received, indicating suspected safeguarding incidents.
- The provider's training plan showed staff training included; safeguarding awareness and safeguarding workshop level two. However, gaps were identified in this training data. This meant not all staff were up to date with this training requirement.

The systems and processes to record, manage and learn from safeguarding issues was not effective and placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- Risk management was not fully effective in protecting people from the risk of harm.
- A person's care records showed medical advise was not always sought when injuries occurred. This may have impacted on their health and well-being.
- People's individual risk assessments were not always updated to reflect changes to care and support needs. This placed people at potential risk of harm.
- Risk assessments were not always completed to guide staff about how to provide care in relation people's health conditions, this included people who are vulnerable due to a learning disability and autism.
- Gaps identified in staff training put people at risk of harm. Following an incident where a person died of choking, the local authority requested the provider to train staff in basic life support and dysphagia (swallowing). At the time of our inspection, 65 staff were employed, 40 had received basic life support and three had received dysphagia training. The team leader told us most of the eleven people supported, had

some level of risk in relation to eating and drinking. Three people's care records reviewed, confirmed they were at risk of choking.
● We identified further gaps in staff training, regarding specific needs associated with learning disability and autism awareness. People were reliant on staff for all their care and support needs, it was therefore essential staff received training to enable them to provide safe and effective care.
● People's personal emergency evacuation plans lacked detailed guidance of their individual support needs. People were fully reliant on the staff that supported them to safely evacuate them in the event of an emergency. This lack of guidance for staff may have impacted on them providing safe and effective care and support in the event they needed to evacuate people from the building.
● Risk assessments and safety checks of the environment were completed, but they were not fully effective in protecting people from the risk of harm. Staff were not aware of the NHS patient safety alert- 'risk of death from asphyxiation by accidental ingestion of fluid / food thickening powder.' Thickener was not stored in accordance with NHS guidance.

Learning lessons when things go wrong
● The recording, reporting, oversight and learning from incidents was not sufficiently robust.
● Incident analysis was limited in detail and a missed opportunity of learning to reduce further reoccurrence.
● The provider's incident management policy and procedure was not consistently followed by staff. Care records showed not all incidents were reported as required. This impacted on oversight and understanding of incidents.

Risks associated with people's care and support needs were not fully assessed, managed or monitored and put people at risk. The provider did not take sufficient action to mitigate risks. This was a Breach of Regulation 12 (Safe Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● Concerns were identified in the deployment of night staff. A recent situation arose whereby three people sharing a supported living house for one night, had one staff at night instead of the required two staff. Whilst this was described as a one of incident, due to short notice absenteeism, we were concerned the provider's emergency procedures was not sufficiently robust.
● Safe recruitment processes were used to ensure only staff suitable for their role were employed at the service.
● Relatives were confident staff understood their family member's care needs and that there were sufficient staff available to provide safe care and support.

Using medicines safely
● In the main, people received their prescribed medicines safely. Relatives raised no concerns about the management and support their family member received with their medicines.
● Two medicine errors had occurred in the last five months and action had been taken to reduce further risks.
● A review of medicines administration records, found hand written entries of medicines were not signed by two staff. This is best practice guidance to ensure transcribing is correct.
● Some people had their medicines administered covertly (given unknowingly and disguised in food). Whilst this had been authorised by the GP, the team leader advised the pharmacist had not been consulted. This is important to ensure medicines are not affected by how they are administered. The team leader agreed to follow this up.
● Staff had access to a medicines policy and procedure and staff had completed medicines management

and administration training.
● Staff had the required information about people's individual needs in relation to their prescribed medicines. This included the safe administration of medicines prescribed 'as required' such as for pain relief and anxiety.

Preventing and controlling infection
● In the main, people were protected from the risk of cross contamination including the risks associated with the current Covid-19 pandemic.
● The provider's staff training plan showed gaps in infection control awareness. The locality manager told us all gaps in training would be completed by November 2020.
● The locality manager told us of action the provider had taken in response to the Covid-19 pandemic. This included ensuring staff were kept up to date with current guidance and supplied with personal protective equipment and information about testing should they develop signs and symptoms of Covid-19.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection, this key question was rated as Outstanding. At this inspection, this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirement; Continuous learning and improving care

- The provider's systems and processes that assessed, monitored and improved quality and safety were not effective in mitigating and managing risks. This exposed people to potential harm.
- The provider's incident management procedures were not sufficiently robust or followed consistently by staff. From reviewing one person's care records, we identified five incidents that had not been reported following the provider's incident reporting system. Opportunities to learn and reduce further incidents from happening were missed.
- Whilst incidents were reviewed by different senior leaders, there was no detailed analysis completed to review for themes or patterns. Neither was there any consideration if external health care referrals were required for further assessment or guidance. This meant incidents and injuries people sustained may have been avoided or reduced, if this detailed analysis and review had been completed.
- The provider had failed to act on safeguarding concerns reported to them. This included following the local multi-agency safeguarding procedure and completing internal investigations.
- Covid-19 had impacted on the provider's delivery of training. Whilst alternative training was in the process of being delivered, the timescale for some essential training in relation to safety was still on going. This training was a requirement following a death of a person at the service in April 2020. This therefore should have been a priority for completion.
- People receiving care and support had complex care needs, and health conditions. However, the provider had not sufficiently assessed, planed and provided staff with all the required training they needed to provide safe and effective care.
- Individual risk assessments associated with people's individual needs had not always been updated when changes occurred or were missed in places. This placed people at risk of harm.

The systems and processes to assess, monitor and improve quality and safety were not fully effective and placed people at risk of harm. This is a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sent us an action plan of what they would do in response to the higher risk concerns we identified during this inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● It is a legal requirement for the provider and registered manager, to notify CQC of reportable incidents. This enables CQC to effectively monitor services. During this inspection, we identified three incidents that had not been reported as required. The registered manager was unable to provide a reason for this.

The failure to notify CQC of reportable incidents is a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives were positive about the care and support their family member received. A relative said, "I really can't fault the care, [name] has made a lot of progress. The communication with the staff is good. [Name] is kept active, they've lost weight since moving to the service which is good, as they were overweight."

● Staff were positive about their role and responsibilities and through discussion, showed a good understanding of people's needs and commitment in providing good quality care and life experiences.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● At the time of our inspection, people who used the service had complex communication needs and were reliant on staff, relatives and advocates to represent their needs and wishes. Each person had a key staff team that met regularly to discuss their needs and review their care and support.

● Relatives told us they felt involved and consulted about the service their family member received. This included being supported to maintain contact with their family member during Covid-19 pandemic.

● As part of the provider's quality assurance processes, an annual feedback survey was sent to relatives, inviting them to share their feedback about the service.

● Staff told they felt well supported and involved in the development of the service. Regular team meetings and supervision opportunities were provided, to enable staff to raise any concerns and to discuss their training and development needs.

Working in partnership with others

● The staff were positive about the support they received from external health and social care professionals.

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 not notified CQC of all notifiable incidents. Regulation 18 (Registrations) Notification of other incidents.

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 The systems to assess and mitigate the risk of harm were not sufficiently robust or effective. Regulation 12 (1) Safe care and treatment

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not used effectively to safeguard people from harm. Regulation 13 (1) Safeguarding people from abuse and improper treatment

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes were not effective in assessing, monitoring and mitigating risks. Regulation 17 (1) Good Governance

The enforcement action we took:

Warning Notice