The Regard Partnership Limited

The Regard Partnership Limited - Arrowe Park Road

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

Summary of findings

Overall summary

This service provides care and support to people living in a 'supported living' setting, 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. At the time of the inspection 12 people were receiving support from the provider with their personal care all of whom lived in their own home at the location address. The service specialised in supporting people living with mental health conditions, a learning disability and autism.

At the last inspection in January 2017 the service was rated Good.

This inspection took place on the 15 and 17 July 2018. The first day of the inspection was unannounced and the second was announced.

We will update the section at the end of this report to reflect any enforcement action taken once it has concluded.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The management and leadership of the service was not effective. The provider had systems to assess the overall quality of the service which had identified shortfalls in the delivery of care and the management of the service. Action plans had been devised to address the areas of concern but had not led to improvements being made. Therefore, shortfalls had been allowed to continue. These included the completion of care records, completion of medication administration records (MARS), the provision of staff training, staff induction, staff supervision, staff appraisals, the monitoring of health and safety issues, and the recording and monitoring of accidents and incidents. In addition to these shortfalls we identified other areas of concern that the providers own systems had not identified.

People's needs had been assessed before they began using the service and people and their relatives had been consulted about their preferences for how they wanted their care delivered. However, records had not always been updated when people's needs had changed and some contained conflicting information. Therefore, staff did not always have access to the guidance they needed to provide safe and effective care.

The provider had not ensured that people's capacity to make decisions and consent to their care and treatment had always been assessed. Staff told us some people lacked capacity to make some decisions and others had fluctuating capacity however capacity assessments had not always been completed. Staff told us that care was delivered to some people in their 'best interests' however there was little evidence to

show how these decisions had been made or who had been involved in making these decisions. Therefore, the provider was not working within the principles of the Mental Capacity Act (MCA).

The provider had not ensured that procedures in place for people to receive their medicines safely were always followed. There had been many errors in 2017 and 2018 where people had not received their medication as prescribed. Care records contained conflicting information about people's medicines and people's MAR had not always been accurately completed.

The provider has not ensured that there were always sufficient numbers of adequately trained and competent staff on duty. Most people received the support they needed most of the time. However, the lack of effective management of the staff duty rota had resulted in some people experiencing missed calls or having to share their one to one support staff with another person. In addition to this staff had not all received the training supervision and support they needed to provide effective care.

People were not always treated with dignity and respect and their privacy and confidentiality was not always respected. One person told us senior management had entered their home without permission and we saw records containing private information was not always stored securely.

The registered manager shared their office with an administrator and other staff providing little privacy for conversations of a sensitive and private nature. Records containing people's personal information and other records relating to the on-going management of the service were left out on desks in the office and displayed on the walls in full view of visitors.

There was a backlog of many incidents and accidents going back several months that had not been entered onto the providers own quality assurance systems. Therefore, the provider could not be assured appropriate action had been taken to prevent reoccurrence or be sure relevant external bodies such as the local authority and CQC had been informed.

The provider had not ensured that communication was effective or that complaints were always responded to promptly. Relatives told us communication with management was poor with one relative referring to the communication and administration at the service as "Shambolic". The providers systems in place to record and respond to concerns and complaints. However, complaints and concerns received verbally had not been recorded and relatives told us they had to raise concerns multiple times before any corrective action was taken.

Most relatives felt their loved one's regular staff were kind and caring, had a good understanding of their needs and treated them well. Staff told us and records confirmed that people were supported to maintain their independence and spend their time as they wished. Some people were also supported to go on holiday.

Recruitment practices were safe. Appropriate identity and security checks had been completed before staff started work.

We found eight breaches of regulations. 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?

Requires Improvement

The service was not always safe.

People had not always receive their medicines as prescribed.

Some people had not always received the support hours commissioned.

Recruitment of staff was safe and staff used personal protective equipment.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff received the training they needed to meet peoples assessed needs.

Staff had not received the support they needed to develop in their role.

Staff did not always work within the principles of the Mental Capacity Act to gain lawful consent.

People were supported to access health care support but this was not always documented.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff practices did not respect people's privacy and dignity or treat them with respect.

People's confidentiality was not always respected because records were not always stored securely.

Relatives felt most regular staff were kind, caring and had a good understanding of people's needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always reflect their current needs and staffing issues meant that some people had not received the support they needed to spend their time as they wished.

People were supported to participate in activities they enjoyed and to go on holiday.

People knew how to raise concerns or complaints but these had not always been recorded and responded to appropriately.

People's preferences on their end of life care was not recorded.

Is the service well-led?

Inadequate

The service was not well-led.

Action had not been taken to address shortfalls in service provision and ensure people received a safe and effective service that was responsive to their needs.

CQC had not always been informed of significant events at the service.

Communication with stakeholders involved in people's care was not always effective.

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Detailed findings

Background to this inspection

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

The inspection was carried out on 17 and 19 July 2018. Two adult social care inspectors carried out the inspection on the first day which was unannounced. The second day of the inspection was announced and was carried out by one adult social care inspector.

Before the inspection we reviewed information available to us about this service. The registered provider had completed 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 also reviewed notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

As part of our inspection we spoke with two people who used the service, two people's relatives in person, four people's relatives over the phone, one visiting health care professional, the registered manager, the regional director, the locality manager, and seven other staff.

We also received feedback from the local authority quality monitoring team and spoke with four people's social workers.

We looked at a range of records including medication records, care records, staff recruitment, training, supervision and appraisal records. We also looked at records relating to health and safety and quality assurance.

Requires Improvement

Is the service safe?

Our findings

The provider had not always ensured that risks to people's health and safety were always managed safely. Each person's care plan contained completed risk assessments which were specific to their needs. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. For some people this meant aspects of their care needed to be monitored. For example, records showed that one person who had been assessed as being at risk of malnutrition and needed support to be weighed monthly had not been weighed since April 2018. Staff told us the same person had recently been assessed as needing thickened fluids to reduce the risk of choking. However, the person's care plan contained no guidance for staff about this. Further information in this person's care records showed that a healthcare professional had prescribed fortified drinks however there was no records to evidence the person was being given these drinks. Therefore, it was not possible for the provider to assess whether this person received the care they were assessed as needing and risks to their health and safety were being reduced.

The registered manager told us all accidents and incidents were recorded. They explained these were reviewed daily by management to ensure action had been taken to prevent reoccurrence, for example following a fall. However, we saw there was a large back log of accident and incident forms going back to the beginning to the year which had not been reviewed by management. We checked the care plan for one person who had experienced falls but could not see that the relevant risk assessments and sections of their care plan had been updated accordingly. Therefore, the provider could not be assured that appropriate action was always taken to reduce the risk of reoccurrence.

The provider could not be assured that people were receiving their medicines safely. Over the course of the last year, there had been a number of safeguarding investigations in relation to medication errors which had occurred. The provider had met with the local authority to discuss the medication errors and an action plan had been devised in order to address the concerns. As part of which the competencies of all staff who administered medicines was to be assessed and additional checks of the completion of Medication Administration Records (MAR) had been introduced.

Staff training records showed the competencies of some staff had not yet been assessed and MAR showed some people were still not always receiving their medicines as prescribed. For example; the instruction on one person's MAR was for one of their medicines to be administered twice a day but it had only been given once a day. Another person's MAR contained lots of gaps indicating that the medicine had not been administered. Staff told us this was because they administered the medicine 'as required' however the direction on the MAR was the medicine prescribed was to be given once every day. In addition to this when 'as required' medication had been administered to people, the reason for this had not always been recorded.

The allergies section on some people's MAR were blank so it was not clear whether they had allergies or whether this was an omission. The provider wrote to us after the inspection to explain that this meant 'no allergies had been disclosed' however this had not been recorded on the MAR.

There was a business continuity plan (BCP) in place directing staff on what to do to keep people safe in the event of an emergency. However, this was not robust. Key information such as plans for the safe evacuation of people from their homes to a place of safety was not specific to them. For example, the BCP stated to look for bed and breakfast in the area but no specific details of any bed and breakfasts were provided. It also contained details of the previous registered manager. A folder containing Personal Emergency Evacuation Plans (PEEPS) of people from their homes contained information of people who no longer received support from the service and whose homes other people who did receive a service now lived in.

We also saw trailing wires in the registered managers office which were a trip hazard.

The above evidence demonstrates breaches of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us evidence to confirm that the issues relating to the lack of guidance for staff to follow in relation to one person's thickened drinks had been addressed and the care plan had been updated. The provider also wrote to us to explain it was an administration and archiving error that had led to the PEEPS in the file being out of date.

The registered manager and senior management told us although they had some staff vacancies and there were arrangements in place to ensure there was always enough staff on duty to provide people with the number of hours support they were contracted to supply. They explained staff vacancies and leave was covered by regular staff completing additional hours or by agency staff who had worked at the service before. However, we received anonymous information that suggested that on some occasions some people had experienced missed calls or had shared their support with another person. We asked the registered manager and senior management for a summary of times people had experienced missed calls over recent months. This information was not supplied.

Following the inspection, the registered manager told us that they had raised safeguarding concerns with the local authority safeguarding team about people not receiving support as commissioned. They informed us that there had been two occasions between the 8 and 17 of July where it was alleged that people had not received their support. The provider wrote to us to explain one of these people had not received their ten hours one to one support on the 8 July 2018 as planned. They told us that instead they had received shared support with another person. The provider also told us that they had found that another person had not received their support on the 14 July 2018 because they had refused to be supported by the allocated staff member. The provider explained how a third person had not received four hours support on the 8 July due to last minute staff sickness but that they had received two to one support at key times to cover personal care, meals and community activities.

We looked at staff duty rotas which showed gaps on the rota that needed covering. The names of some regular staff and some agency staff had been entered onto the rotas to indicate when gaps had been covered. However, many of the rotas seen still contained gaps so it was not possible to assess whether these gaps had been covered and people had received their support as planned.

Accident and incidents had been recorded on accident and incident forms and most of the time any identified potential abuse was reported to the local authority for them to consider under safeguarding protocols. However, we saw one incident report from February 2018 that had not been reported to the local authority at the time. Following the inspection, the registered manager confirmed the incident had been referred to the local authority and would not be investigated under safeguarding. This is an area of practice that needs to be improved.

Although training updates for 37 staff were overdue, most staff had completed training in relation to 'safeguarding' people from abuse. Staff knew what constituted abuse and who to contact should they need to raise a safeguarding concern. The provider had a whistle blowing policy in place and staff knew how to raise concerns.

The recruitment of staff was safe. Appropriate identity and security checks such as the completion of Disclosure and Barring Service (DBS) checks, obtaining proof of identity and references had been carried out on new staff before they started work. These checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people.

Staff had access to 'Personal protective equipment' (PPE) such as gloves and aprons. They also completed routine health and safety checks of the environment and equipment at people's homes to make sure it was safe to use. Although some training updates were overdue most staff had completed on line training in the Control of Substances Hazardous to Health (COSHH), infection control and food safety.

Requires Improvement

Is the service effective?

Our findings

Staff had not always completed the training they needed to undertake their role effectively. At the time of the inspection the registered manager told us that the staff training tracker was not up to date. Following the inspection an updated copy was sent to us. This showed many gaps were staff had not received practical training or where training updates were overdue. For example, 43 staff had not completed moving and handling training, 29 staff had not completed first aid training, only five staff had completed basic life support training and the training updates for these staff were overdue. The physical intervention / supporting behaviour training provided to 47 staff was out of date and a further 30 staff had not completed this training. Although, medication update training was booked for August and September 2018, this was overdue for 24 members of staff. In addition to this the provider told us the training planner they sent us did not contain details of their newer staff so it was not possible to assess what training they had completed.

The provider had not ensured that staff received the supervision and support they needed to undertake their role effectively. Supervision provides staff with an opportunity to meet with their manager in private to discuss their training and development needs. The registered manager told us that the staff supervision and annual appraisal of performance trackers were not up to date. Following the inspection, updated versions of these documents were sent to us and showed that most staff had not received regular supervision or an annual appraisal of their performance.

Although staff told us they shadowed experienced staff before working unsupervised there was no record of staff having completed a formal induction when they started working for the provider. In addition to this staff told us they had completed a 'probation period' when they first started but did not know what this meant or what it consisted of. One staff member told us "I don't know what it was but I was told I passed it. We didn't have a meeting about it". Records showed some agency staff had completed an induction when they started working at the service however these were not robust. For example, they did not demonstrate that agency staff had been introduced to people or read their care plans before they worked with them. We saw some of these inductions were signed but not dated. We also saw that the provider had obtained profiles for some agency staff detailing the training they had completed but not for others. Therefore, the provider could not be assured that these staff had the skills and competencies needed to fulfil their roles.

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

The providers own quality assurance processes had identified that training was overdue sighting 'significant shortfalls'. The provider had an action plan in place to address this issue and the actions included booking all outstanding training by the 18 July 2018. There were also plans in place to address the issues around the lack of staff inductions, supervision and annual appraisals.

Although many of the training updates were overdue, the majority of staff had completed training in a range of subjects on-line. The subjects this training covered included, communication, dementia awareness, equality and diversity, fluids and nutrition, medication, mental health, moving and handling and

medication. Although the workbooks had not been completed and signed off, most staff had also completed the on-line learning associated with the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff in the health and social care sectors. It's made up of the 15 minimum standards that should be covered for staff 'new to care'.

Other specialist training had been provided to some staff to meet some people's needs such as the administration of emergency medication to people who have epilepsy. Nationally recognised qualifications in care were also held by 38 of the 85 care staff employed.

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.

During the inspection we found evidence that people's liberty was restricted. The related assessments had not always been completed and decisions had not always been properly taken. We were told that some people were under continuous supervision and control and did not have the freedom to leave their home unsupported, indicating a deprivation of their liberty (DoL), however the registered provider had not always established whether an application needed to be made by the local authority for this to be authorised by the Court of Protection (CoP).

We saw the care plan for one person who required a form of restraint. Staff felt this person did not have the capacity to make decisions or consent to their care and treatment but there were unsigned consent forms in their care plan and there was no information about who might legally consent on their behalf. Following the inspection, the provider sent us information confirming that before using the service this person had been assessed as not having capacity to decide for themselves about where they would live and that an application had been made to the CoP to authorise this. However, there was no information in the care plan to indicate an application to the CoP had been made or to detail the outcome of the application.

We looked at the care plan for another person who staff felt lacked capacity to make decisions and who required a form of restraint. This person's care plan contained a positive behavioural support plan which contained a lot of detailed information but the agreement to this plan had not been signed by anyone. Following the inspection, the registered manager sent us an e-mail showing that this person's social worker had been preparing the documents to make an application to the CoP before the person started using the service. However, there was no information in the care plan to indicate whether this application had been made or what the outcome of the application had been.

The provider had not ensured staff followed their own policies and procedures in relation to recording decisions. The providers own quality policy states 'Service users are involved in all decision making concerning their care, unless this is not practicable, for example in an emergency situation. Decisions concerning the service user's care, other than routine day-to-day matters such as choice of food or clothing, are recorded on the individual record, together with the names and job titles of those involved in the decision making. If the service user is not involved in the decision making, the reason/s should be recorded'. We were told that some people received care and support in their best interest but there were no records to

indicate when these decisions had been made or by whom.

The above evidence is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager wrote to us to confirm the action they had taken in relation to the concerns we had raised. They told us they had contacted the local authority in relation to whether applications to the court of protection needed to be made for five people who were under continuous supervision and control and did not have the freedom to leave their homes unsupported. They also confirmed that a multidisciplinary best interest decision meeting, which had been planned before the inspection, had been held in relation to one person's capacity to make decisions about their eating and drinking.

Initial pre-admission documents had been completed for each person which set out their individual physical and mental health issues and looked at them holistically. This information was then used to formulate a care plan. Care plans indicated the person's involvement, their choices, likes, dislikes and where appropriate the involvement of their relatives. Information also included guidance for staff regarding people's mental health conditions and the specific support they required to help manage them.

People were supported to access health care services in relation to their physical and mental health needs. These included appointments with dentists, opticians, podiatrists, Speech and Language Therapist (SALT), dieticians and GPs. Information about the support people required with their health was recorded in their care plans but records of appointments and the advice given had not always been made or care plans updated accordingly. Although regular staff were aware of the appointments and guidance given; any new staff did not have access to information and guidance they needed to provide safe and effective care. This is an area of practice that needs to improve.

Aids and adaptations were in place to enable staff to support people with their mobility and personal care needs. These included specialist beds, sensor mats and hoists.

Requires Improvement

Is the service caring?

Our findings

Staff knew the people they supported on a regular basis well and we observed some warm interactions. Staff offered reassurance to people when they were anxious by laughing and joking with them. However, some staff practices meant that people were not always treated with dignity and respect.

One person told us they came home one day to find two members of the senior management team in their home without permission looking in their cupboards for paperwork. Following the inspection, the provider wrote to us to explain that staff had obtained prior permission to enter this person's home when they were out however, no evidence to support this was provided. We saw staff sat on this person's windowsill when the window was open smoking while they were supporting other people. Relatives also commented that they frequently saw staff gathered outside another person's flat smoking whilst supporting people. One relative told us that staff were sometimes rude and that one staff member often swore when speaking to them. They explained they had complained to the management about this but nothing had changed.

The registered manager shared their office with an administrator and other members of staff. This provided little privacy for conversations of a sensitive and private nature. Records containing people's personal information and other records relating to the on-going management of the service were left out on desks and displayed on the walls in view of visitors. There was a white board in a communal room detailing people's initials and the names of the staff who were supporting them. Therefore, the provider was not meeting the General Data Protection Regulation (GDPR).

On the second day of our inspection we saw the provider had taken delivery of two drawer metal filing cabinets. Later in the day we saw one of these cabinets in a persons' home. The person told us they had not been consulted about whether they wanted or needed the filing cabinet and said they did not want it in their home. They said the person that delivered it said they needed to have it for staff to keep records in. The lack of consultation with this person and others who used the service demonstrated a lack of consideration for people's opinions and showed no respect for them as individuals.

The above evidence demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us and we saw that there was had protected time for the main office during which signage was placed on the office door to let people know office staff were not available. They also told us coffee mornings were held in a communal area to reduce disturbance to the main office.

Despite the shortfalls we identified, relatives did feel their loved ones were treated with dignity, respect and kindness by their regular staff some of whom they felt went over and above what was expected of them. For example, one relative told us that two staff members had worked back to back over a 48-hour period to support their loved one during a stay in hospital. We also observed staff knocking on the door of two people's homes and waiting for a response before entering.

It was clear from the documentation seen that people and or their representatives had been consulted about their care when the service began. For example, records relating to one person contained information about their likes, dislikes and preferred activities. Care plans provided details of things people could do for themselves. For example, which aspects of their personal care they could undertake without support. Staff told us they encouraged people to be as independent as possible and complete their own tasks of daily living such as shopping, cleaning and cooking.

The registered manager explained that staff were allocated to work with specific individuals each of whom had a team of regular support staff. Where possible people's preferences to be supported by a male or female carer were accommodated. People had a named senior support worker who co-ordinated certain aspects of their care and was a point of contact for the person and their family members.

The registered manager explained they did not support anyone with any particular religious or cultural beliefs but that they would provide the relevant support if needed.

Requires Improvement

Is the service responsive?

Our findings

It was evident throughout the course of the inspection that people were not always receiving the level of responsive care that was expected. Feedback from social care professionals and the local authority who were involved in people's care was that people's care plans did not always reflect people's current needs. We saw some care plans contained some conflicting information. For example, the medication listed in care plans were different to that on MAR and although care plans were reviewed regularly they had not always been updated as soon as people's needs had changed. For example, following a fall or to indicate guidance provided by healthcare professionals. Therefore, there was a risk that staff would not have access to the guidance they needed to provide care that was responsive to people's needs.

People's care plans provided details of the type of activities that people enjoyed and daily records contained information of how people had spent their time. However, one persons' relative told us that they felt some activities their loved one participated in were staff led and more about what staff wanted to do rather than what their loved one wanted to do. This was echoed by a social care professional involved in another person's care. In addition to this, staff told us last minute changes to the staff duty rota and staff shortages had meant people had not always been supported with their planned activities.

The above evidence is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In order to address the backlog of paperwork and bring records up to date five senior support workers had been provided with laptops and printers. They had also been allocated time away from providing direct support to complete this work.

Although care plans were not always up to date, most contained clear information on how to meet the person's personal care needs. Staff that worked with people on a regular basis had detailed knowledge of people they supported and how to provide them with person centred care. It was evident from the people's initial assessments that people had progressed since they started using the service and that their support needs had reduced. For example, one person who initially needed three to one staffing now only needed two to one staffing. Staff told us the number of incidents of some people displaying challenging behaviour had reduced since they started using the service and that people were more settled and relaxed. We saw that some people had positive behaviour support plans and staff told us they monitored people's behaviour to help them understand how best to support people. However, we did not see any documentation to support this. This is an area of practice that needs to improve.

Staff told us that people spent their time as they wished. They explained that when social events such as BBQ's and birthday celebrations and fund-raising events were held at the location address they encouraged and supported people to attend. People were also supported to participate in activities such as going swimming, going out for meals, going for walks and going on holiday.

We checked whether the provider was following the Accessible Information Standard (AIS). The Standard

was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support that they need. The registered manager told us people's communication needs were always considered as part of the assessment and care planning process and records confirmed this. For example, we saw that it had been identified that some people would benefit from the use of pictures to aid their understanding and that some people who found choice over whelming should be offered limited choices to minimise the risk of them becoming anxious.

Staff told us they used social stories to support people's understanding. Although staff could tell us how and when they had used social stories and could describe to us the positive impact they had made, they were unable to show us any evidence to support what they had told us. One relative told us that before their loved one started using the service it had been agreed that they would benefit from an activities board and photographs of staff. This was to help them understand which staff were coming to support them and what activities they would be participating in next. However, this had not been implemented. These are areas of practice that need to improve.

There was a complaints procedure available to people. The registered manager and provider told us they monitored any complaints, compliments or concerns and used the information to understand how they could improve the service and what they were doing well. Relatives told us they would feel comfortable complaining to the management if they were unhappy but some said they had to raise issues several times before anyone responded. When we looked at the complaints log it was evident that written complaints had been recorded and responded to however issues that relatives told us that they had raised with management had not been recorded. For example, two relatives told us they had raised concerns about their loved ones being supported by agency staff that they did not know. Other relatives told us they had raised concerns about repairs and maintenance work not being completed but none of these concerns had been recorded within the complaints log. A senior manager told us that concerns raised verbally would be dealt with on a day to day basis and would not be logged as a formal complaint. Therefore, the provider had no way of assessing whether these concerns had been addressed.

The above evidence is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider wrote to us to tell us they had an accessible complaints procedure for people they supported to follow which was on display on the notice board in the hallway. People the provider supported were also invited to attend a meeting every month at which they could raise any concerns and express their views of the service. Minutes of these meetings showed that people had been given the opportunity to share their views and discuss matters relating to the running of the service. The provider gave assurances that any complaints raised within the meeting would be dealt with in line with their complaints procedure. People the provider supported also had the opportunity to provide feedback forms on how their service was delivered on a quarterly basis.

Nobody living at the service was receiving end of life care. The registered manager told us they would make referrals for support to be provided by the relevant health care professionals if someone reached the end of their life and wished to be cared for by the service. Staff explained to us how they had supported one person at the end of their life who had used the service. They told us they had visited the person in hospital until the end of their life and described to us how they had ensured the funeral service reflected the persons likes, dislikes and personality. However, when we looked at this person's care plan there was nothing to suggest the person was poorly or in hospital, it did not contain an end of life care plan and there was no evidence that staff had consulted with them about their wishes for their end of life care or funeral arrangements. This

is an area of practice that needs to improve.

Following the death of this person who had been supported by the service for many years the registered manager and staff held a meeting for the people they support to discuss their feelings about the persons death and to ask them if they would like to do something to remember them by. It was agreed at the meeting that a memorial bench would be bought and placed in the location grounds.

Inadequate

Is the service well-led?

Our findings

The provider had systems in place to monitor and assess the quality of the service. These systems had been effective in identifying areas that needed to improve but had not been effective in bringing about the changes needed to drive improvement.

There was a registered manager in post who had been employed since October 2017 and had become registered in April 2018. The registered manager was supported by a locality manager with whom they had regular contact.

The provider had devised an 'Improvement plan' to address shortfalls identified as part of an internal audit of the service on the 12 September 2017. The issues that needed addressing included; lack of staff training, supervision and appraisals, medication errors, accident and incident reporting, care records not being up to date, health and safety issues, people's emergency evacuation procedures being out of date and issues relating to staffing and the management of the staff duty rota. For each area of concern a planned start and end date had been specified. In addition to this the 'Progress Comments / Evidence' section of the plan detailed what action was needed to be taken by whom.

Subsequent action plans dated 10 November 2017 and 16 April 2018 specified a 'planned start date' for the actions set but did not always state a 'planned end date' and the 'Progress Comments / Evidence' sections of these plans were blank. The 'Progress Comments / Evidence' section of an action plan dated 1 June 2018 had been completed and showed many actions with a 'planned start date' of April and May 2018 but had no 'planned end date' and many of the actions set had not been completed or not started. Therefore, it was not possible for the provider to assess what progress had been made in meeting their own action plan.

An unannounced internal audit of the service completed by the provider on the 19 and 20 June 2018 identified many of the shortfalls identified in September 2017 had still not been addressed. For example, the shortfalls specified on this audit included; lack of staff supervisions, training and appraisals, incomplete care records, insufficient staffing, over reliance on agency staff, medication errors, a package of care commencing for a person without a staff team in place, lack of minutes from meetings, no system for managing and servicing equipment, the need for safer systems for money and low staff morale. This demonstrated that shortfalls identified in September 2017 had still not been addressed.

There was a large backlog of accidents and incidents that had not been reviewed by management or entered onto the providers system. Therefore, these accidents and incidents had not been analysed to identify themes and trends and the provider could not be assured that action to reduce the risk of re-occurrence had been taken.

The registered manager told us that due to the number of medication errors identified additional checks had been introduced to ensure that any errors made could be identified quickly. However, we found these checks were not robust and had not identified the errors on the MAR that we identified.

From the providers action plans, they identified that people's care plans needed to be updated however the action plans lacked details to show what specific areas of the care plans were out of date and what action was needed. Therefore, it was not possible for the provider to check whether the shortfalls had been addressed.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and senior management told us there were aware of the shortfalls and the need to improve their record keeping systems. One senior support worker told us they had been "fire fighting for months". This sentiment was also echoed by the registered manager, senior managers and staff alike.

The registered manager explained the backlog of accidents and incidents had developed over a period of three months when they had not had any internet access. They told us this issue had since been resolved and the information was now being entered into the system to bring them up to date.
The registered manager explained staff turnover at the service had been a problem and they had been working closely with the providers human resources (HR) department to recruit and retain more staff. Following the inspection, the provider wrote to inform us that a HR manager and a HR senior advisor had provided three days support and training at the service in May 2018. A weekly call with the HR department had also been introduced to offer the registered manager an opportunity to discuss in detail the issues within the service.

The registered manager explained they had also identified issues with the performance of a small number of staff which had resulted in some staff being suspended and others being dismissed. In addition to this staff sickness was high which meant there had been lots of last minute changes made to staff duty rotas so people had not always been supported by their regular staff. This impacted on the consistency in the delivery of some peoples care and staff morale.

The registered manager told us due to the number of medication errors at the service earlier in the year, the registered manager, deputy manager and senior support workers had taken over the administration of medicines for two months. This had impacted on the time they had to undertake their managerial responsibilities. Senior support staff told us until recently they had spent most of their time providing direct support to people, meaning they did not have enough time to complete paperwork. An internal quality monitoring tool completed in May 2018 confirmed this and states 'Seniors have provided direct support due to large gaps in rota'. Senior support workers explained that although they had now been given 14 hours a week to complete paper work and undertake supervisions, they had not yet managed to get up to date. The provider also told us that additional agency administrators had been secured to address the administrative backlog.

Due to the concerns identified by the provider through their own quality assurance processes the registered manager had been provided with additional support. An additional deputy manager was in the process of being recruited and the locality manager, another manager and deputy had also been brought into the service to help bring records up to date. The registered manager and staff welcomed this support however some felt that if the support was provided earlier then they would not have fallen so far behind.

Other actions the provider told us they had taken to improve the service was to undertake a full review of the staffing structure at the service o the 4 June 2018 and the attendance of an IT consultant of the service on 8 July 2018. In addition to this on 9 April the provider made enquiries about using an activity monitoring system which they plan to implement to help show people's day to day capabilities and where support is

needed.

The registered manager was aware of their responsibilities to keep the CQC informed of significant events at the service by way of submitting statutory notifications. Although these had been submitted as required most of the time, on other occasions they had not. For example, there had been incidents of potential abuse that had been reported to the local authority that the CQC had not been informed of.

The above evidence demonstrates a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Most relatives knew who the registered manager and deputy manager were but some said they rarely saw them. They commented that the communication with the staff that provided support to their loved one's was generally good but communication with the management was poor. They told us that senior support staff and management rarely passed messages on or got back to them, commenting they often had to ask multiple times before getting a response to queries. They also told us the phone was rarely answered at weekends. Feedback from some social care professionals was that communication with management and staff was not always good and they did not always get a response to e-mails or requests for information.

The registered manager told us they had held one staff meeting this year to which all staff were invited. They told us at this meeting they had discussed staff culture and the improvements needed at the service however minutes of this meeting were not available to view. We saw that meetings with management and senior support staff had been held on a more regular basis. Minutes of this meeting confirmed that the challenges facing the service had been discussed and that senior staff had been tasked with updating records. Support staff told us each person had a team of staff who they were assigned to provide their support and a senior member of staff who oversaw this. They explained these teams met on a regular basis to discuss the persons support and that these meetings helped them keep up to date with any changes. However, minutes of these meetings had not been maintained. This is an area of practice that the provider had identified needed to improve.

The provider had ensured that the rating from the last inspection was displayed at the location address.

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 ensured that they always informed CQC of significant events that had occurred at the service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people always received person centred care that was responsive to people's needs.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were always treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff always worked within the principles of the Mental Capacity Act.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The provider had not ensured that the care people received was always safe.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that complaints had always been recorded and responded to appropriately.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had always received the support and training they needed to meet people's assessed needs.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems they had in place for the monitoring the quality of the service were effective in driving improvement.

The enforcement action we took:

We issued the provider with a Warning Notice.