HF Trust Limited

HF Trust - Wiltshire DCA

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

HF Trust – Wiltshire DCA is a domiciliary care service providing personal care and support to people. Supported living services enable people to live in their own home and live their lives as independently as possible. The service is run by HF Trust Limited which is a national charity providing services for people with a learning disability. Not everyone using HF Trust – Wiltshire DCA receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At this time the service was supporting 11 people under the regulated activity and 13 people in total.

This inspection took place on 6 August 2018 and was unannounced. The inspection was prompted in part by an inspection of the provider's residential service on the same site, which has recently been rated as Inadequate. This service shared the same management team, some of the same staff and the same processes and systems. For this reason, we made the decision to inspect this service earlier than we had originally planned. Although short notice is normally given to services providing a domiciliary care service for people, in light of the concerns it was decided it would be unannounced.

At the last inspection in May 2016 the service was rated as Good. At this inspection we found four breaches of the regulations in relation to Consent, Safe care and treatment, Good governance and Staffing. We have served two Warning Notices on the provider in relation to Regulations 12 Safe care and treatment and 17 Good governance. The service is required to achieve compliance within a set timescale or further action will be taken. We have also made a recommendation around opportunities for staff supervision.

The service has been rated as Requires Improvement with the safe domain rated as Inadequate. We will be asking the service for a report of actions of how they will make the necessary improvements and the service will be re-inspected to check this has been done.

At the time of this inspection there was no registered manager in place. A manager at the service had applied to be the registered manager, however the decision was taken by The Care Quality Commission to refuse the application and management of this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found have the provider and management team at this service failed to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care. Quality monitoring at the service was not robust. There was no effective monitoring or checks made by management and senior management in order to take timely action when shortfalls occurred. The director has implemented some immediate changes to address these concerns but time was needed for the planned actions to be completed before we could judge whether the provider's actions had been effective in making the required improvements.

You can see what action we told the provider to take at the back of the full version of the report. 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.

People using the service their and relatives confirmed that people did not always receive their allocated care hours due to staffing shortages. The manager and staff confirmed this was true. This had a negative impact on people's wellbeing with inconsistent support and times when planned activities had to be cancelled. The manager failed to appropriately report to external agencies when people did not receive their commissioned support hours to ensure that prompt action would be taken to protect people from harm and neglect. This was raised with the manager and senior management at the time of this inspection.

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. We found that not all incidents had been logged or reported to the manager. This meant there was a lack of oversight of what incidents had occurred and the appropriate action and support had not been provided in a timely manner to support people.

Risk assessments did not always contain enough detail to ensure the risks were mitigated or referred to other guidance that staff could read.

Medicines were not always managed safely. We found gaps in medicines administration records (MAR's) where staff had not signed that they had administered the medicines. One staff member told us this was a recording issue and that people had received their medicines as prescribed.
The service was not working within the principles of the Mental Capacity Act (2005). We found mental capacity assessments and best interest decisions were not consistently completed where people lacked capacity to make specific decisions. We found some examples of restrictive practice, where there was no record of the discussion on how this decision was made or what other options had been considered.

People and their relatives told us they were happy with the care they received, as long as it was the regular staff members supporting them. We saw in one person's feedback about the service, that they did not feel comfortable with agency staff. One person said some agency staff shouted and weren't always kind.

There was limited documented evidence available that staff had received regular supervisions and staff gave mixed responses about their opportunity for supervisions. We have made a recommendation that the provider reviews the opportunities available to provide staff with adequate supervision and progression support.

We observed staff respecting people's personal space and ensuring doors were closed when providing care and knocking on doors and waiting for permission before entering. Staff showed concern for people's wellbeing and responded to their needs quickly.

Care plans had information about people's likes and dislikes and how they liked to spend their day. However, the terminology in care plans was at times paternalistic (limits people's freedom to achieve their own level of independence) and inappropriate when referring to adults. Care plans were not dated when there was a change in the care plan. This meant staff may not be aware of the most current actions. A lack of dates on care plans meant it was unknown when things had been put in place or when peoples' needs had changed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their allocated care hours due to staffing shortages placing them at risk of harm and neglect. The service did not always inform external agencies when people did not receive their support to ensure people were kept safe.

The recording of incidents and accidents and actions taken from subsequent investigations, did not show measures to minimise risks safely were well managed.

Risk assessments did not always contain enough detail to ensure the risks were mitigated.

Medicines were not always managed safely. We found that staff had not consistently signed in medicines administration records (MAR's) when they had administered medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not working within the principles of the Mental Capacity Act (2005). We found mental capacity assessments and best interest decisions were not consistently completed where people lacked capacity to make specific decisions.

Staff completed mandatory training as part of their induction which included first aid, moving and handling and safeguarding. We observed gaps in some of the training records.

People were encouraged to make healthier meal choices and supported if required with shopping and meal preparation. We saw that some information was recorded on people's preferences around food and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

The impact of having a staff team made up of fifty percent

agency hours was having a negative impact on people and the support they received. People did not experience staff being familiar with their needs and promoting their independence.

The terminology in care plans was at times paternalistic and inappropriate when referring to adults.

During our inspection we saw staff respond to people in positive ways, taking their lead from them and seeking permission to support them. Staff showed concern for people's wellbeing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had information about people's likes and dislikes and how they liked to spend their day. There were some care plans which had a good amount of detail recorded and others that left statements written without any meaning for the person or further exploration.

There was a lack of dates showing when care plans were reviewed and updated.

People told us they were supported to take part in activities of their choice, however at times activities had been changed or cancelled due to staffing issues.

Is the service well-led?

Requires Improvement

The service was not well-led.

We found the provider and management team at this service failed to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care.

Quality monitoring at the service was not robust. There was no effective monitoring or checks made by management team and senior management in order to take timely action.

Some staff told us they did not feel supported by the management team. They felt the communication in the service from the management team to staff was very poor.

HF Trust - Wiltshire DCA

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 prompted in part by an inspection of the provider's residential service on the same site, which has recently been rated as Inadequate. This service shared the same management team, some of the same staff and the same processes and systems. For this reason, we made the decision to inspect this service earlier than we had originally planned.

This inspection took place on 6 August 2018 and was unannounced. Although short notice is normally given to services providing a domiciliary care service for people, in light of the concerns it was decided it would be unannounced.

The inspection was carried out by two inspectors. During our inspection we went to the service's office and spoke with the manager, new regional manager and director of the south west division. We looked at documents relating to people's care and support and the management of the service. We reviewed a range of records which included five care and support plans, staff training records and quality monitoring documents.

We visited three people using the service in their homes on site. We also spoke with people attending activities on site about their views on the quality of the care and support provided. We spoke with eight staff members, one health and social care professional and three relatives.

Inadequate

Is the service safe?

Our findings

Following this inspection a concern were raised to CQC that the service had failed to provide safe care to two people. Two people supported by this service were left without appropriate staffing for a period of at least 20 minutes when shift changes occurred. One staff had left and the next staff member had failed to arrive for their shift. This meant one person requiring one to one staffing to remain safe was without the supervision they needed. This placed people at risk of harm.

The agency staff member that arrived to cover the shift had not previously worked with the people they were to support. A member of staff from another bungalow was told to deliver a handover to the agency staff as there were no staff on duty at this service to give a verbal handover. However, this staff had not been working in the bungalow that day and would not have current knowledge of recent events and any risks to people that needed to be mitigated. This had a negative impact on one of the two people who was reported to have been left anxious from not knowing if there would be a staff member to support them safely. CQC made an immediate safeguarding alert which is currently being explored by Wiltshire Council Quality Assurance Team and commissioning team. We have informed the provider of this incident.

This was the second safeguarding referral that CQC had to make about this service within a period of three weeks. Another safeguarding alert was raised on 26 July 2018 following a disclosure that people in this service were not receiving their contracted hours of care and support.

The manager told us that when people did not receive their contracted hours a note was made and they would try to allocate the missed hours at another time. The manager told us they had raised their concerns with senior management but they had not gone anywhere commenting, "The hours missed varies from week to week. I have taken this higher and been told we are recruiting each time. We try not to cover with agency but it's impossible not to. If we can't cover then we prioritise people." We looked at the staffing rotas with the manager who explained that these did not highlight the issue as staff would cover across the residential service and the DCA and would nip across the site to complete a visit. During this inspection we followed up these concerns and found further evidence to support this disclosure.

One relative told us "Staff are supporting more than one bungalow at the same time and they pop between the two. They spoke about an occasion when people had planned to go out but then couldn't, as staff had to be around for people in another bungalow due to covering across the site. One person being supported by the service told us that staff did not always turn up at the correct time, and gave examples of an hour difference when they would turn up. We saw that staff did not record the times they visited or for how long they stayed with the person.

The manager showed us there were shortages of staff without any being off sick or on leave. For example, in one house for one week there were insufficient staff available by four and a half hours. The manager said there were some staff on "the books" who had been off sick since they had been in their manager's post.There was no dependency tool for assessing the staffing support needed for the safe delivery of care. The manager had inherited a spreadsheet with names of the people receiving support and the allocated

hours. This meant in this particular week, people were not receiving personal care that met their current needs in accordance with their required support hours.

Staff consistently shared their concerns about the lack of staffing to adequately support people's needs. Comments included "I feel there are not enough staff. I have been aware of times when people have not received their allocated hours and it's not fair on people", "I don't feel there is enough staff to support people's needs", "There are not enough staff, not without using agency" and "We do get the shifts covered but there is a lot of agency which people don't like as they like familiar faces. Some agency recently haven't been up to date on the training so epilepsy trained or epilepsy medicine trained so this can be an issue."

Relative's we spoke with also raised their concerns about the negative impacts the staffing shortages had on people. One relative said "There are usually agency staff in bungalows at weekends. You see the shortfalls and there have been so many issues. People don't get the hours they are entitled to, they share hours." Another relative told us of an occasion where their family member did not get to go out and enjoy their usual activities when agency were covering the shift and instead sat around watching television. One health and social care professional commented "I believe it is generally a good service, but often a high turnover of staff and agency staff, which can often cause difficulties with continuity and consistency." The manager told us "We are currently having a complete overhaul of staffing, we have a team who run the DCA packages but there are crossovers and this will change."

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not always informed commissioners when people had not received their commissioned support hours, despite knowing the concerns previously and being prompted by CQC to make this alert. The manager did not show an awareness that they knew this should be raised with the appropriate agencies to ensure people's safety could be monitored. We were informed that the Local Authorities commissioning team had also not been informed when the service had failed to provide another person's core hours of support. This meant the service were not identifying that people were at risk of harm if they did not receive their contracted support so that action could be taken to keep people safe and prevent neglect occurring.

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. We looked at the incidents that staff had been recording for people and saw these were kept in a communication book within people's homes. We cross referenced incidents from one bungalow against the provider's electronic incident reporting system. This was completed with the regional manager. We found that not all incidents had been logged. Further to this the management team were not aware of all of these events that had been managed in isolation by staff. This meant support to people was not provided in a timely manner when safety incidents occurred because there was a lack of oversight of incidents and whether the action taken had been effective in reducing the risk of a reoccurrence.

We found recordings of incidents dating from February 2018 that were not on the electronic system. This included five medicine incidents, an injury that resulted in a hospital visit, a person who was not supported with personal care and an incident where personalised technology failed during a person's sudden attack of illness. Not all of these incidents had documented actions and not all of these had been reported to the manager. The regional manager told us "There is a concern staff do not always recognise what needs reporting on the electronic system." This meant incidents were not appropriately investigated at a management level to prevent a re-occurrence and keep people safe.

We spoke with staff about recording incidents and most were aware they needed to record on the online system commenting, "If I had an incident or an accident, I would use the online system and report to a manager ASAP", "These need to be recorded on the system, which I have had no training on" and "Any incidents or accidents get reported online and documented in the daily log." We saw one staff members supervision log stated they needed to set some time aside to look at the system as they were not comfortable with this. However, there was no support plan in place for this or assistance by anyone else offered to ensure staff were fully aware of their responsibilities in reporting incidents correctly.

A number of risk assessments were generic regardless if there was an actual risk identified for the person. The manager told us "It is part of senior managements plan to now look at this service and the risk assessments.

We saw that assessments did not promote positive risk taking or consider alternative ways in which risks could be managed. For example, one person required staff support at all times when out, due to their specific medical condition. This person's care plan stated that they were aware they needed support but did not always react well to this as it made them feel like a "child". There was no evidence that this had been explored with the person to see if there were other options to keep safe in a less restrictive way. We then saw that another risk assessment contradicted this by saying the person had expressed wishes to be supported when out. It was hard to know if staff had recorded this or it was the person's preference. This inconsistent recording did not provide clear guidance to staff supporting this person.

Risk assessments did not always contain enough detail to ensure the risks were mitigated or refer to other guidance that staff could read. For example, one person had a risk assessment for choking but it did not reference the choking protocol that was in place. Another person had a risk assessment for being able to stay home on their own for up to an hour. This had been reviewed in June 2018 but there was no information on how the conclusion had been reached they were safe for up to an hour but no longer. We saw other risk assessments for this person also reviewed in June 2018 that stated they were at risk of sharp knives and would not leave the building safely in the event of a fire. This meant they would not be safe to leave for any period of time. We raised this with the manager who was not aware of it and told us that this person was fine to be left and went out on their own safely. The manager said they would look into this. This meant that this person may have been restricted from being left alone unnecessarily.

Medicines were not always managed safely. We found gaps in medicines administration records (MAR's) where staff had not signed that they had administered the medicines. One staff member told us this was a recording issue and that people had received their medicines as prescribed. We saw where people were prescribed time specific medicines, for example for epilepsy, staff ensured they received it as prescribed'

Where people were prescribed medicines to take "as required" (PRN), there was not always enough detailed guidance for staff to follow to ensure people received the medicine when required. In one person's care plan it stated they could deal with a lot of pain, before they complained. There was no protocol in place that included this information for staff. This was also the case for another person where they were prescribed two medicines as PRN. There were no protocols in place to describe when the person might need these medicines. We saw that that this person's relative had requested that one of these medicines be administered after they had a seizure. It stated, "Staff member has administered two [name of medicine] as person's relative said it was needed." This was not the appropriate procedure to follow when administering PRN medicine to people and there was a risk of people receiving medicines that had not been agreed by appropriate health care professionals.

We found some inconsistencies with medicines recorded on people's emergency sheet compared to the

medicines being signed for on the medicine administration record. The director had also picked this up for one person during a recent audit and asked the manager to immediately correct this. We saw that there had been one incident where a person had gone out without their emergency medicine, leaving them at potential risk if they had experienced any health issues at that time. It was recorded in their care plan that the emergency medicine had to be taken each time they went out but this had not been done on that occasion or checked by staff before the person left.

Maintaining the temperatures of cabinets where medicines were stored had been an issue within the service. We saw notes made by staff in the communication books about reminders to check the temperatures. One staff told us freezer blocks had been used to try and bring the temperature down and we saw on some occasions this had been implemented. However out of four days during August 2018 where the temperature was recorded above 25 degrees Celsius, ice packs had only been applied twice. The temperature had not been retaken to check if this had worked and the next day it was found to be as high again. Another person's medicine storage had three occasions recorded when the temperature was above 25 degrees Celsius, but there was no recording of ice packs implemented or any methods tried. There were no protocols for staff to follow in these instances. This meant the integrity of medicines may be compromised

We saw that a monthly audit was completed by the manager. We saw the same issues identified, including a missing signature for medicines administered and stock balances in the audits for May and June. Senior staff had not signed the sheets to show they had completed their weekly medicine checks or identified the actions to follow up. We saw where there had been medicine errors this had not always been followed up or investigated by the manager in order for learning to take place and reduce the risk of a reoccurrence.

This was a breach of Regulation 12 (1) (2) (a) (b) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in their homes and around staff, but did not like it when agency staff were on duty. Staff told us they were aware of the action to take should they suspect someone was at risk of abuse commenting, "I would take notes, this would include the time, date, where, what I have seen and then I would contact my manager if I saw any wrong doings or had my suspicions" and "I would immediately approach my manager and do an incident report." People in the service did not raise any concerns with us and one person commented "I feel safe, staff are available. No worries, if I was worried I would tell staff." None of the staff we spoke with were able to tell us the action they could take if they felt their concerns were not managed appropriately within the service.

At the last inspection no concerns were raised with the recruitment process. At this inspection we were unable to fully view the recruitment files as only administration staff held the keys who were not on site at this time. We requested and received information after the inspection for four staff. This included the checks that had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For people receiving care in their own home, this is as an Order from the Court of Protection.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found mental capacity assessments and best interest decisions were not consistently completed where people lacked capacity to make specific decisions. We saw a form with the word "Consent" which the person had signed. This person had capacity, but the form did not state what they were consenting to. There was also a similar 'Deprivation of liberty' form.

Staff we spoke with did not have always have a good understanding of mental capacity or DoLS stating, "Mental capacity is a decision that is made which won't affect health and wellbeing" and "Everyone has capacity unless they have had a capacity assessment or there is a best interest in place."

The service did not keep a record of people's legal representatives, for example for Deputyship or Lasting Power of Attorney for finances or health and welfare. One person's relative managed their finances, however there was no record if the relative had the necessary powers to do so and to make decisions on the person's behalf. The manager explained that historically relatives had told the service if this was in place, but copies had not been obtained. This meant some decisions may have been made by people who did not have the legal authority to do so on behalf of a person.

We found some examples of practice that were restrictive, for example one person has a listening monitor in place due to a specific health condition so staff could respond in an emergency. However, there was no consent documented for this or evidence of a capacity assessment if the person was unable to consent to this restriction. We further saw detailed in a communication book it said that a staff member had given permission for a person to be weighed weekly. This person had capacity so did not need staff to make these decisions on their behalf and the person should be asked if this was something they wished to happen and have the opportunity to make or be part of that decision.

We saw a note where one person had been asked to only use their phone and skype when in their bedroom. There was no record of the discussion on how this decision was made or what other options had been considered. The staff member told us they had discussed it with both people and the decision was made to protect the one person's dignity due to their medical condition.

This was a breach of Regulation 11 (1) Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed mandatory training as part of their induction which included first aid, moving and handling and safeguarding. New staff would be enrolled to complete the care certificate if they did not already hold a health and social care qualification. It was hard to identify from the training matrix if all staff were up to date with their training because only 15 of the 22 staff appeared on the matrix. We observed gaps in some of the mandatory and non-mandatory training records including, training on the Incident recording system. This showed only two staff had received this. Other gaps included end of life, positive behaviour support and introduction to your role training.

Staff spoke positively about the training they had received commenting "I have done all the necessary training to set me up for my role which prepared me" and "We do online and face to face training regularly. I completed a full three day induction with shadow shifts, getting to know people and reading the care plans."

There was limited documented evidence available that the sample of staff we looked at had received regular supervisions. After the inspection we were sent three staff supervisions that had taken place in July 2018, September 2017 and October 2017. One staff supervision stated it took place in July 2018 but had been signed and dated by the staff member in June 2018. One of the managers told us they had completed a supervision but could not find it in the staff file.

Staff gave mixed responses about their opportunity for supervisions stating, "I last had a supervision a couple of months ago, it was helpful as it lets me know how I can improve my role to give people the best care", "I can't remember when I last had a supervision" and "I haven't had one." We saw the supervision agenda of one staff referred to discussing the visions and values of the 'Fusion model' of support, however there was no reference to this in the supervision (The model is a statement of the provider's intent focused on ensuring each person was at the centre of everything they did. A clear set of values included choice, person centred active support and involvement of families and other partnerships).

We recommend that the provider reviews the opportunities available to provide staff with adequate supervision and progression support.

People were encouraged to make healthier meal choices and supported if required with shopping and meal preparation. We saw that some information was recorded on people's preferences around food and drink.

Each person had information recorded on their specific health needs, details of any treatments received and health professionals involved in their care. We saw that information was not always recorded correctly for people. For example, one person had an emergency protocol in place which did not have the same information about the medicine dose they could be given as recorded in their health management care plan. We spoke with staff who were able to say the correct medicine to give and procedure to follow, however this potential risk had not been identified previously. After discussion with the management team it transpired that this had been incorrectly recorded by staff. The person had not needed their emergency medicine in the last year so no harm had been identified to them, however if they had, there was a risk the wrong document could have been followed. We saw another person's action plan had not been fully completed to give staff the information they needed.

One health and social care professional commented "The carers I have been involved with have a very good knowledge of the people they support and are always very informative. However there have been times

when there has been a new carer supporting who is less confident about the individual and we have had to request someone who knows that person best to support my visit."

Requires Improvement

Is the service caring?

Our findings

The impact of having a staff team made up of fifty percent agency hours was having a negative impact on people and the support they received.

People and their relatives told us they were happy with the care they received, as long as it was the regular staff members supporting them. We saw in one person's feedback about the service, that they did not feel comfortable with agency staff. A staff member told us they felt using agency staff had an impact on people's well-being. The manager said they used the same agency staff to try and ensure some continuity for people. People said the staff were kind and caring, but did not feel the same about agency staff. One person said some agency staff shouted and weren't always kind. The director of the service has been informed so they can investigate this concern further.

One relative told us "[Person's name] doesn't like unfamiliar staff to support them." Another relative said "Some staff are very accommodating and relaxed, however it's the inconsistency of staff, some don't support people to go out at weekends and they are left in. Staff are swapped about during shift and it effects people negatively." One health and social care professional commented "Generally they are person centred but there have been incidents in the past where they have not always considered the effect of changing "timetables" may have on individuals." The service relied on fifty percent agency staff and had been actively recruiting to try to reduce this. However, the service had not fully investigated the impact that this level of agency staffing was having on people.

One person told us that agency staff did not encourage their independence. They said "They do things for me. I don't like it. I can do things for myself." They told us for example that agency staff would come in and make them a drink without asking while they were capable of making their own drinks. The director told us they had seen some really good practice from agency staff during their visits, but it was from individuals not commonplace practice across the site.

Permanent staff told us that they promoted and encouraged people's independence. For example, they would encourage people to try things for themselves and remind them of the things they could do. We observed people moving freely around, helping themselves to food and drink. We saw in one person's care record it stated for their lunch time routine "I [person] am more than capable to make my meal." We observed this person making their own lunch during our inspection. One staff told us "I help to keep people independent by supporting them doing the daily things and support them when they need help. I try and get them to do things as safely as possible and support them and explain things as I go with them." One relative commented "[person's name] independence has come on leaps and bounds."

Although we observed people being involved in decisions about their care, this was not always reflected in the recording. We saw one person had an agreement in their care plan about contributing and understanding the content, however there was no date as to when this had been put in place, if it had been reviewed and remained relevant. Although most people were able to tell staff about their preferences, the use of high levels of agency meant there was little information available to them for guidance. This meant

people may receive support that was not appropriate to their current needs.

While care plans were written in the first person the terminology used did not necessarily reflect the voice of the person but inferred the views of staff. The language used was sometimes inappropriate when referring to adults. For example, we saw statements including "[person's name] can integrate into the community", suggesting they were not already a part of the wider community and "We are collected by minibus and returned afterwards." This referred to people as if they were objects and not in a respectful manner. We saw another person's care plan stated, "Staff to monitor me more and ask how I am, I know I must be polite and either talk to staff or write in my notebook and show staff what I have written about I feel." This was written as if the person was a child and did not allow for the fact that this person may want to keep some thoughts or feelings to themselves or share with people who were not staff. We have raised this with the service to address.

During our inspection we saw staff respond to people in positive ways, taking their lead from them and seeking permission to support them. People appeared comfortable around staff, for example one person was seen gently touching a staff member's face while talking to them. One person told us "The staff help me with a shower and my medicines, I live with friends and we go out sometimes together." One relative said "We have never known [person's name] so happy, they are very person centred. We like the set up at this service, it's brilliant." Staff explained how they tried to deliver person centred care commenting "The service does do well and we all care about the people we support and give them the best care and support to lead independent lives" and "We empower and put people at the centre of every aspect of my job role."

We observed staff respecting people's personal space and ensuring doors were closed when providing care and knocking on doors and waiting for permission before entering. Staff showed concern for people's wellbeing and responded to their needs quickly. We observed a person getting tearful and a staff member immediately went to sit down with the person, offering reassurance. Staff were knowledgeable about things people found difficult and how changes in daily routines affected them.

Information about advocacy services was available to people. The manager told us an advocate had been appointed for a person who needed support with decisions around their financial management.

Requires Improvement

Is the service responsive?

Our findings

Care plans had information about people's likes and dislikes and how they liked to spend their day. For example, we saw it was recorded that a person liked music and disliked staff touching their personal items without their permission. It also included areas such as the person's circle of support, what was important to them and how they liked to communicate. For example, for one person it stated they liked to communicate verbally, but they also used their phone and iPad. There were some care plans which had a good amount of detail recorded and others that left statements written without any meaning for the person or further exploration. For example, one care plan stated if there were changes to the person's routine they became very agitated. However, there was no information on how staff could support this person if this happened, or how changes could be better managed so the person did not become anxious.

The service had not kept a copy of people's care plans in the office prior to our visit. For people that lived off site this meant office staff did not have access to people's records. This meant there was no oversight of what was in place for each person. The manager told us because some people had homes on the site they had not thought to have a copy in the office as well. At the time of this inspection care plans from people's homes off site had been collected and were being audited. The manager told us a copy would be made and kept in the office going forward.

When care plans were changed the date of the update was not included and an audit trail of how quickly peoples' needs may have changed was not provided. An initial date of when it had been reviewed would be recorded but this did not state exactly what parts of the care plan had changed so staff could be directed to look at the specific changes. The manager told us they had identified that dates were not recorded on the paperwork and there was a lack of information about care reviews. We saw that when the Local Authority had completed a review on a person the information from this did not always feed into the person's care plan to update it with their current needs. One example of this was a person's meal preferences which had been highlighted in 2016 but not updated with the care plan in 2017.

Staff signature sheets were in place for staff to sign and document they had read and understood each person's care plan and needs. However, there was a lack of signatures on these documents. One person only had one staff signature for 2018 and then some from 2017 and 2016, however this did not demonstrate if staff were aware of any changes when the care plan had been updated.

Information on people's end of life care, treatment and wishes was not always completed. We saw three care plans that did not have any information around this, not even to record if a conversation had been attempted and the person had declined at that time. This was especially relevant for two people who we saw were at risk of unexpected and sudden death and did not have end of life wishes in place. This meant that staff were not aware of the person's end of life preferences when the time came in order to provide appropriate care in line with their wishes.

This was a breach of Regulation 17 (1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager showed us an example of a new format of care plan they had been working on which would be reviewed three monthly and documented people's needs clearly and was more person centred. The prototype highlighted any medical needs the person had on the front page so staff could see this information quickly.

Staff told us the handover sheet had recently changed. This included the checks staff needed to make during their shifts including communication books, fridge temperatures and ensuring care shifts were covered by staff. Daily logs were completed by staff regarding the care that had been given to people. We saw that part of these were tick boxes and then had space for activities and comments. These varied in the level of detail recorded by staff, some documented what the person had experienced that day and the support given and others were just a brief entry.

People told us they were supported to take part in activities of their choice. People were supported to go out in the community and some people told us they had voluntary jobs. We saw for one person that they had been supported to go to college. People and relatives did make reference to activities sometimes being changed or cancelled due to staffing issues which impacted on them having to stay in. During our inspection some people were away from their homes attending activities and other people were spending time at the day service run on site.

We saw that people had information available on making a complaint titled 'Making things better' Two formal complaints had been received this year and were logged on the system. One had been investigated and the complainant responded to and satisfied with the outcome. The other complaint was in the process of being responded to. One health and social care professional told us they were aware of "A concern raised was addressed in a telephone call and situation rectified appropriately." However, one relative said they would feel uncomfortable to raise concerns and did not have confidence that action was always taken.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection there was no registered manager in place. A manager at the service had applied to be the registered manager, however the decision was taken by The Care Quality Commission to refuse the application.

We found the provider and management team at this service failed to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care. The director has implemented some immediate changes to address these concerns by putting in a temporary structure to oversee this service and support the management team. However, since this inspection we have been informed the manager has left the service and the post will be re-advertised.

Quality monitoring at the service was not robust. Effective monitoring or regular quality checks had not been completed by the management team and senior managers in order to identify shortfalls and take timely action to protect people from receiving unsafe care. Two days prior to our visit the director had begun to complete some audits of this service and had found issues which were in the process of being addressed. Some of the issues identified included incomplete or out of date documents around medicines, capacity assessments and health and safety records which corresponded with what we found. Action was still to be taken at the time of our inspection to address these shortfalls.

The manager completed a self-assessment quality tool each month in the service. This was then checked by a regional manager. We reviewed the monthly audit for July 2018 and saw that the scoring was vastly different compared to the previous month where there had been no indication of serious concern. The manager explained this had been re-evaluated and downgraded in light of a recent CQC inspection on the same site for their residential service. This raised concerns that the compliance tool was subjective and robust provider checks were not made to confirm what was recorded and found by the manager was accurate. There was a risk that these audit systems were not reliable and therefore did not accurately inform the provider of shortfalls and risks in the service.

The audit tool had not been effective in identifying the concerns we identified in relation to incidents and accidents, medicines and risk assessments. Therefore, prompt action had not been taken to address these concerns and risks. An action plan alongside this audit tool stated there was a current CQC action plan in place across the service. However, there were no recorded dates of when actions would be completed. Without specific timeframes in place, there was a risk that issues would not be addressed promptly to keep people safe and progress against the action plan could not be monitored easily.

We found that medicine management required improvement and the checks that the provider had put in place to ensure safe medicine management had not been implemented effectively. The manager told us they had not physically had time to complete all the checks needed but commented "I feel positive that we are at the start now of getting things done. We can build what the service should be." We saw that weekly medicine audits completed by seniors had not always been done. The manager told us this had slipped recently as the seniors were pushed for time. This meant some errors had not been raised or investigated

appropriately increasing the risk of medicine related errors occurring.

Systems put in place to support staff had not been implemented effectively. This was evident in the lack of documented supervisions staff received and the failure to ensure staff were knowledgeable in the recording of incidents.

We raised concerns over the knowledge of the management team in relation to reportable notifications. There was a lack of understanding of when to raise safety concerns with external agencies and the expectation of responding in a timely manner to these concerns to keep people safe.

Prior to our inspection the provider had not identified that they failed to operate an effective incident and accident management system to ensure lessons were learned when safety incidents occurred and plans put in place to keep people safe by preventing recurrence. For example, checks of the communication books had not been made prior to our visit and this had meant that some incidents had not been reported to the manager or received an appropriate investigation. This placed people at risk of harm.

The provider had failed to operate an effective staffing system to ensure people received the care and support they required when they needed it to keep safe.

The recording systems had not been operated effectively for example in areas of care records and supervisions. This had not been picked up by the provider's quality monitoring systems in order for timely action to be taken.

A lack of understanding around applying and following the principles of The Mental Capacity Act 2005 meant people had not been supported appropriately. The correct procedure for making decisions in people's best interests had not been followed and their had been a delay in the providers identifying this shortfall through their own quality assurance systems.

This was a breach of Regulation 17 (1) (2) (a) (b) (f) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they did not feel supported by the management team commenting "At this moment I don't feel support by anyone" and "I really don't know if I do, but I can say if everyone worked together and worked as a team that could go a long way for the company." Other staff felt valued by the organisations. One staff told us "I do feel valued by management, as they do support if I have any problems." Another staff said "There is always help and guidance along the way. Everyone is approachable." One person using the service commented "I know the manager, I do talk to them."

Staff felt the communication in the service from the management team to staff was very poor. Comments included "It can improve in communication", "An improvement would be to have better communication on site from management to staff" and "The thing I find that needs to be improved on is communication between everyone." A health and social care professional told us "Managers can often be difficult to contact due to availability and currently staff shortages, but they are willing to engage as needed." One relative commented "Attitudes in managerial staff prior to the new manager were diabolical and disrespectful."

People had the opportunity to attend a group called "Voices to be heard", a group championing for people's rights, needs and dreams which was held on site. However, we did not see any evidence of feedback surveys for people and relatives spoke about previous meetings that had been held but none in recent times to share their views. This meant there was a lack of opportunity for people to express their views and have a

say in the running of the service if they did not attend this group.

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 11 HSCA RA Regulations 2014 Need for consent We found mental capacity assessments and best interest decisions were not consistently completed where people lacked capacity to make specific decisions. We found some examples of practice that was restrictive. There was no consent documented for this or evidence of a capacity assessment if the person was unable to consent to this restriction. Regulation 11 (1).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive their allocated care hours due to staffing shortages placing them at risk of harm and neglect. The service did not always inform external agencies when people did not receive their support to ensure people were kept safe. Regulation 18 (1)

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 service had not always informed commissioners when people had not received their commissioned support hours. The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. Risk assessments did not always contain enough detail to ensure the risks were mitigated or refer to other guidance that staff could read. Medicines were not always managed safely. We found gaps in medicines administration records (MAR's) where staff had not signed that they had administered the medicines. Regulation 12 (1) (2) (a) (b) (g).

The enforcement action we took:

We have served a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were some care plans that left statements written without any meaning for the person or further exploration. Information on people's end of life care, treatment and wishes was not always completed. When care plans were changed the date of the update was not included and an audit trail of how quickly peoples' needs may have changed was not provided.

We found the provider and management team at this service failed to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care.

Quality monitoring at the service was not robust. The audit tool had not been effective in identifying the concerns we identified. Systems put in place to support staff had not been implemented effectively.

The provider had failed to operate an effective staffing system to ensure people received the care and support they required when they needed it to keep safe.

Regulation 17 (1) (2) (a) (b) (f)

The enforcement action we took:

We have served a Warning Notice.