Lifeways Community Care Limited

Lifeways Community Care (Swindon)

Inspection report

7-8 Pembroke Centre,
Cheney Manor Industrial Estate,
Swindon,
Wiltshire,
SN2 2PQ
Tel: 01793 539875
Website: www.lifeways.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Requires Improvement

Overall summary

We inspected Lifeways Community Care (Swindon) on the 8, 13 and 15 December 2014. Lifeways Community Care (Swindon) provides care for people with specialist needs living in the community. People supported by Lifeways Community Care (Swindon) may have physical and learning disabilities, profound difficulties in communicating and present with behaviours that may challenge. The Swindon office manages supported living and community services for people living in a range of housing, in both Swindon and West Berkshire. This was an unannounced inspection.

The previous inspection of this service was carried out in June 2014. In June the service was found in breach of regulations in relation to Records and Supporting

Summary of findings

workers. This was because records did not always contain adequate detail or were not always in place to ensure people's safety. We also found that staff were not receiving supervision, appraisal and adequate training. Staff were not always supported to understand changes to their role in a way that allowed excellence to flourish.

There was not a registered manager in post at the service at the time of our inspection, but the manager was in the process of becoming registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At this inspection in December 2014, we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; you can see what action we've taken at the back of this report.

People using the West Berkshire services did not receive the same level of care as people being supported in Swindon. The majority of concerns identified were in relation to West Berkshire services and those being supported in the community.

People were not always safe as not all staff understood their responsibilities with regard to safeguarding and identifying abuse. There were not always enough staff to ensure people had their needs met. The service was aware of this issue and working proactively to improve the situation. The changing staff team and staff vacancies were impacting on people developing caring relationships as care staff were often not with people long enough to develop relationships, or people were being supported by people they preferred not to be. We found that whilst some staff were caring there had been occasions where people were not being cared for appropriately.

Whilst some services were effective in understanding and meeting people's needs, we found some people were at risk of unsafe care and treatment because their care plans did not detail specific guidelines to ensure consistency. Staff did not fully understand the Mental Capacity Act 2005, so the correct process was not being followed to ensure people were being supported to make decisions and provide consent. Not all staff were receiving regular supervision and appraisal and none of the staff we spoke with had a development plan in place. Not all staff benefited from appropriate training to meet the needs of the people they were supporting. Some staff in line management positions, did not all have the necessary skills and knowledge to perform their roles effectively.

People and their relatives were not always involved in care planning and the service was not adhering to the key principles of person centred care. People were not always being supported in a way that respected it was their own home.

The Manager, who was in the process of being registered, demonstrated a personalised approach and a commitment to good quality care. However, the systems in place to monitor the quality of the service were not effective. We also found that the experience and qualifications of key staff was not at the standard the service stated as 'essential'.

Summary of findings

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

This service was not always safe. Not all staff understood their responsibilities with regard to safeguarding and identifying abuse.

There were not always enough staff to ensure people had their needs met. The service was aware of this issue and working proactively to improve the situation.

Assessments in place to manage risk did not always contain information to support people safely.

Is the service effective?

Inadequate

The service was not effective. Peoples support plans did not always contain information that enabled staff to consistently meet their needs.

Not all staff received regular supervision and appraisal. Staff were not supported to develop their skills through regular and appropriate training.

People did not benefit from a service where the principles of the Mental Capacity Act 2005 were followed.

Is the service caring?

Inadequate

The service was not always caring. Whilst some staff were caring and we observed some caring interactions, not every person benefited from caring staff at all times.

People were not always supported to maintain friendships or develop positive relationships with staff supporting them.

People's environments were not always respected as their own homes.

Is the service responsive?

Inadequate

The service was not always responsive. People did not benefit from a culture that understood the key principles of person centred planning. People and their relatives were not always involved in care planning.

Summary of findings

People did not always benefit from activities that supported social inclusion or that respected their preference.

Is the service well-led?

Requires Improvement

The service was not always well led. The systems in place to monitor the quality of the service were not effective.

There was not a system in place to ensure records and governance were completed and stored appropriately in relation to people's care and staff supervision.

The manager showed an awareness of the culture needing to be improved and showed a commitment to improvement and person centred values. Issues that the manager was being made aware of were responded to in good time.

Lifeways Community Care (Swindon)

Detailed findings

Background to this inspection

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

This inspection took place on the 8, 13 and 15 December 2014. It was unannounced. The inspection team consisted of two inspectors and two experts by experiences. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of the inspection there were 85 people being supported by the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our visit we also reviewed the information we held about the home. This included notifications, which provide information about important events the service is required to send us by law. We also contacted and received feedback from four health and social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We used a number of different methods to help us understand the experiences of people who were supported by the service. We spoke with the three people who were using the service. As some of the people who were being supported were not able to speak with us, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 26 relatives and 19 care staff, which included three team leaders, two service managers, the manager, who was in the process of becoming registered, and two administrations staff within the office. We also spoke with a regional director who was supporting the service at the time of our inspection. We spent time with people in their homes, observing daily life including the care and support being delivered. We reviewed peoples care files, records relating to staff and the general management of the home.

Requires Improvement

Is the service safe?

Our findings

Some people we spoke with felt safe, one person told us, “I feel safe here”. However another person told us, “I sometimes feel unsafe when I don’t know who is working”. A number of relatives we spoke with felt their relatives were not always safe. One person’s relatives told us, “how can [my relative] be safe if staff don’t turn up, [my relative] is not supposed to cook but what can they do if staff are not there”. Another relative told us, “I don’t think my relative always feels safe, they have lost their confidence and sometimes asks to move here with me”.

Some staff told us they had received training in safeguarding and we saw training records which confirmed this. However other care staff we spoke with could not tell us what they would do if they suspected a person was being abused. Some staff told us they would report any safeguarding concerns they had to the manager, however four staff we spoke with could not tell us about the types of abuse and how abuse could be identified. One staff member told us, “I remember it’s something about keeping their belongings safe”. Another staff member told us, “I know it’s about protecting people, but I can’t remember”. We reviewed safeguarding records and saw that events which had been raised to managers had resulted in appropriate action being taken to ensure people’s safety but we were not confident that all concerns would be identified by staff. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not always get the support they needed. One staff member told us, “I just have to make sure the most complex care needs are covered, but some people miss out and I try and make it up to them at different points in time”. Another staff member told us, “I am seriously concerned that we are dependent on such a small group, one person we support requires support that only trained staff can give, there just isn’t enough of us”. We were also told by a relative that their daughter was assessed to require one to one support, but they had arrived to see one member of staff supporting their daughter and another person on their own.

The service had identified an on-going issue with staffing levels. At the time of our inspection there were 26 full time vacancies that were being covered by agency staff. We were told the service tried to ensure the same staff were consistently used. The service was in the process of recruiting a recruitment specialist to assist with recruitment at the service. However at the time of our inspection, despite the service taking some action, there were not sufficient numbers of permanent staff to be flexible and meet the needs of people they supported. For example we heard from three people and other peoples relatives that they 'at times had their planned support changed to accommodate people who need more support".

This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw risk assessments were in place in some services and were reviewed monthly or when changes in people’s needs had been identified. For example, one person had fallen, they had specialist equipment in place to support with their mobility and a new risk assessment was in place. Staff we spoke with in these services were able to tell us about people’s needs in relation to risk management. However, this was not happening in all services. We saw risk assessments in other services did not contain adequate measures to manage risk or had not been updated following incidents. One person with complex needs had needed additional support whilst out in public due to an unforeseen incident. This incident had not been updated in their risk assessment. Staff we spoke with were not aware of the risk to this person. Another person who could present self-harming behaviours or behaviours that challenged was at risk of not being supported appropriately. This person had a risk assessment in place. However, this did not identify the steps staff needed to take to prevent or manage the issue safely. One staff member told the person “needs a consistent response and we are not consistent; it’s not helping [the person].”

Recruitment records showed that all relevant checks were carried out before staff began work at the home. Checks included a disclosure and barring certificate and references. There were arrangements in place to deal with foreseeable emergencies.

Inadequate

Is the service effective?

Our findings

One person we spoke with felt that care staff understood their needs. We were told, "some of the staff really understand me". Our observations also identified that most staff understood the people they were supporting. For example in one household we visited in Swindon the care staff had a good understanding of each person in their care and we observed staff following the guidelines set out in people's support plans. However in another household, we observed one person trying to communicate and becoming unsettled. The staff member could not understand the person and was not aware of the person's communication support plan.

Some relatives we spoke with were concerned that their relatives were not always supported by people who understood their needs and preferences. One relative told us of a recent experience where her relative had a support worker who wasn't aware they took medication. Another relative told us, "some staff are very good but the new people don't seem to know my relative". One person's relative told us, "[my relative] wears clothes that are too small, they have not been supported to keep their job, [my relative] is less independent now than when he went there". One person had a behaviour support plan in place due to presenting behaviour that may challenge. We spoke with this person's relative who told us on a recent family outing the staff supporting their relative were not aware of this plan. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our inspection in June 2014 we found that staff were not receiving regular supervision and appraisal or opportunities to develop professionally. Despite some action being taken, this hadn't resulted in improvements across the whole service. We found induction; supervision and training had improved in Swindon. However very few staff had received supervision in Newbury services and the service's training records showed staff had completed limited training. One member of staff said, "I haven't had any training in about two years". Another member of staff told us, "managers always seem too busy, I couldn't tell you who my manager was, I have never had an appraisal". Another staff member told us they had only just completed their induction having been at the service a year. This is a repeat breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some staff who worked in parts of Swindon told us, I feel very supported, the manager is always available". Another member of staff told us, "training has improved, but it isn't as good as we would like, the manager would agree". No staff we spoke with had a development plan in place. No staff we spoke with had heard of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals.

We saw there were guidelines in place for staff to support people with making choices which the service referred to as 'guided choice', but these did not include capacity as a factor and did not ensure people were consenting to the decisions being made. We saw one Mental Capacity Assessment in place that had been implemented by external professionals. We saw occasions where family were involved in making decisions with their relatives, but these were not documented as best interest meetings and staff could not explain what best interest meetings were. We saw that only three staff out of 265 had received training in Mental Capacity. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had healthy eating support plans in place. We did not observe during the inspection whether these were being followed but a number of relatives we spoke with were unhappy about their relative's health. One relative told us, "my relative has put on three stone since being there, all they eat is junk". Another relative told us, "the staff change so often that each new person coming in goes out for takeaway". We were informed of some initiatives that were in place to support people such as the 'change4life'. Change4Life is a public health programme in England run by the Department of Health. It is a campaign to tackle the causes of obesity by helping families and middle-aged adults make small, sustainable yet significant improvements to their diet and activity levels. We spoke with staff about these concerns. One staff member told us, "we can only suggest healthier option, we respect people's choice". A relative told us, "they just don't understand the consequences of eating the wrong things, staff don't seem to understand their responsibility in that". No staff or relatives we spoke with were aware of the 'change4life' initiative within the service.

Inadequate

Is the service effective?

In some services support was not always delivered in a way that safely met people's needs. We reviewed one person's file who could present behaviour that could result in self-injury or present as challenging to others. Guidelines did not clearly state how this person should be supported in order to prevent incidents from occurring. We saw there was no monitoring of this behaviour to identify triggers or trends that could be used to support this person. Another person who could present behaviours that challenged had guidelines in place that stated they may require support when anxious. The guidelines did not identify what this support may need to be. This person's risk assessment also identified they could become challenging when confronted. No staff we spoke with about this person identified confronting them as a trigger and we saw from a recent incident form that this person had become aggressive when staff had confronted them.

We saw one person in a household we visited had been supported to attend GP appointments due to their deteriorating health. Care staff had a good understanding of this person's changing needs. We saw this person had shown a preference for certain foods and the service had worked with the speech and language therapist to ensure this person could make this choice safely.

Medicines were not always managed appropriately. In supported living services arrangements for administration of medicines are not regulated in the same way as a care home. These services have a responsibility to meet peoples assessed needs and agreed care plan in line with regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, rather than regulation 13 medicines. We looked at the management of medicines for people who had been assessed to require support in this area. We saw evidence of medication errors in a number of households we visited. On the day of our inspection, a nurse from the Community Team for People with a Learning Disability (CTPLD) was present due to ongoing issues with regard to medication errors. We saw examples of other medicine error incidents, there was a lack of clarity in directions for staff and dates had been changed on MAR sheets.

Inadequate

Is the service caring?

Our findings

One person we spoke with felt they were supported by caring staff. They told us, "they care a lot, I like them". Some relatives told us staff were caring. One relative told us, "the staff that have been there for a while are very caring, it's more than just a job to them". Our observations in some services supported this. We observed people benefiting from warm and caring interactions. In one service we saw people enjoying a music session with staff, In another household we saw one person visibly enjoying the company of staff whist choosing a dress for an evening meal. We also spoke with a number of staff who supported these statements. One staff member told us, "I care for people as best as I can, like they are my own family".

However, a number of other relatives regarding other areas of the service did not share this view. One relative told us, "the staff do not seem to remain in post long enough to become caring". Other relatives' comments included, "I can't say that all staff have been caring, my relative complains they just sit around on the sofa and don't want to do anything" and "My daughter is meant to have 40 hours support and it rarely reaches this, I am angry that my daughter loves to go out, but carers don't seem too bothered". Some staff we spoke with told us, "I get fed up with some staff, they don't seem to be here for the right reasons, they sit around on their phones and openly say they can't be bothered to go out anywhere, it's the people we support that miss out, it's because we don't get the right training or the right staff, the good ones leave".

Some staff shared concerns that relationships were difficult due to the changing staff teams and organisational changes. We were also told that recent changes to the team leader role meant that administrative tasks needed to be completed whilst with people. We were told there were occasions where people had to arrange their time around staff. One person had to go with a member of staff to another home as he was the only member of staff trained to administer medicines. Another person had to travel to the office with a member of staff to sort out paperwork. A relative also said "when I arrived my relative was sat in urine shivering, the staff were trying to care, but showed no understanding of the need to keep my relative warm and comfortable before trying to move them" this relative was not concerned with regard to their relatives safety.

People did not always benefit from positive relationships with staff, some people and their relatives told us things had "got worse". There were a number of care staff who showed care and understanding of people's needs during our visit. However, we heard of examples where people were taken out but staff sat in the car whilst people shopped. We were told by one relative, "staff can often appear fed up, on one occasion a staff member was cooking with [the person] and staff didn't say a word to [the person], until dropping the plate down in front of them and leaving".

People's confidentiality was not always respected. In two households we saw people's personal information on shelves in communal dining rooms or on window sills in a communal living area. Staff we spoke with said that's how it's always been and they hadn't considered keeping them in people's rooms. We also saw staff openly discussing people's personal detail in the presence of other people being supported. Supported living environments are for people to be supported in their own homes. We found that households were not always being treated as peoples own homes. For example, when entering one property we were asked to sign in. People's information was not being stored in their own living space but in communal rooms. Staff referred to certain rooms as the office. This is a repeat breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We raised these issues with a service coordinator who explained it required improvements as some sites had not "moved on from what the institutions they were previously".

The shortage of permanent staff made it difficult to plan staff around people and their preferences. One person was being supported by a staff member they had asked not to support them due to the anxiety of an earlier issue. We spoke to a staff member responsible for allocating staff who told us. "We just have to use what we can get when it comes to staff".

Inadequate

Is the service responsive?

Our findings

Relatives we spoke with had mixed views regarding the services responsiveness. One person told us, "they seem quite responsive; we've not had a problem". However a number of other relatives we spoke with did not agree. Relatives we spoke with consistently told us "things have got worse in recent months." One relative told us, "key staff seem to have gone, we don't get the responsiveness we used to, we are actually worried about it". Another relative told us, "person centred care is so important, they just don't get it".

Many staff we spoke with had not heard of person centred plans or positive behaviour support plans which are recommended approaches for supporting people with learning disabilities from the British Institute of Learning Disabilities (BILD). Person centred planning is a process for continual listening and learning, focusing on what is important to someone now and in the future, and acting upon this in alliance with their family and friends. A Positive Behaviour Support Plan is a plan to support a person and includes assessment and planning and implementation of strategies to meet the person's needs, improve their capability and quality of life, and reduce the occurrence of the behaviour that causes harm.)

We found that care plans and assessments were completed by a Referral and Assessment Manager (RAM) before being passed onto the appropriate teams. One staff member told us, "a huge amount of information and relationship disappears, it feels disconnected". Another staff member told us, "care plans are done at the office, based on previous information with no involvement from the person or an advocate".

Some staff raised concerns regarding people's social isolation. One staff member told us, "the culture has changed, one person I support is left alone, they aren't a nuisance and keep quiet so nobody bothers, I go and see them and they have often scratched their head until it bleeds" and went onto say "people have gone backward immensely, they have lost independence. People don't get the attention they need." Another member of staff told us, "people are becoming more isolated, when staff leave, friendships people have aren't known by new staff so people don't get to maintain those friendships, it's very sad". Another staff member told us the absence of staff, especially staff that could drive, was "preventing people from accessing clubs". We were told one person "has been going to the same club for years they have had to reduce how much they go due to staffing and sometimes can't go at all if staff don't drive". Another staff member told us, "people have their own cars but end up having to spend their money on cabs because staff can't drive".

Relatives raised concerns that people were not supported to access a range of activities. We found routines were not reviewed to see if they were the choice of the people using the service. We saw some people benefited from a range of activities both in their home and through day services. However, we found many people accessed the same services as a matter of routine and not necessarily services that supported their social inclusion. People were supported to maintain voluntary jobs or attend courses. However one person's relative told us their relative had not been supported to maintain their employment which had affected them negatively. Another relative told us, "My relative has been involved with Lifeways for a number of years, I did attend review meetings in the beginning. I have felt that my knowledge about my relative has never been listened to. Staff turnover is too high and too fast. This Sunday a new member of staff was there with an agency worker, they were clearly not aware of my relative's needs and medication. This should not have happened." Another relative told us, "they just aren't all aware of my relative's needs, it would be ok if they were and they don't seem interested in my experience to help them".

We saw that people were unable to access activities after 9pm due to needing to fit in with staff. This was not policy, but a necessity due to peoples plans fitting in with staff rotas. One relative said, "how many adults do you know that want to be in by 9pm, or want to go to afternoon shows at the theatre, surely it should be planned around the people who pay for the care". One staff member told us, "they [people] stick to what we know, we really don't support people to know what's going on locally we just do what's on their board". However, we did hear one example of a person who wanted to do a sky dive; we heard this person had been supported to access this activity in a simulator to see if they enjoyed it.

One person we spoke with told us they were involved in their care planning. However it was not always clear through other care plans we saw how involved people were and/or their relative on their behalf. Most relatives we spoke with did not feel involved, one relative told us, "We

Inadequate

Is the service responsive?

used to be involved in review meetings but we are concerned now though, our family no longer feel as involved, some staff have gone and it definitely feels different to us now". Another relative told us, "families do not seem included or welcomed as they used to be". Other comments we received included, "I have on-going concerns at reviews regarding Lifeways involvement these are serious and again I have raised them, it improves for a few days and then goes back to how it was".

The service had a complaints policy and information regarding complaints was given to people when they started receiving the service. The service had a central record for all complaints, however we did not see a number of complaints we were told about documented in this record. For example, eight out of 23 relatives we spoke with told us they had shared concerns with 'managers' who they told us "did not listen". We did not see a record of these concerns kept centrally, despite some of the concerns directly relating to the well-being of people using the service. One team leader told us, "I didn't know I had to [keep a record] I thought the office kept the complaints, I don't know what happens after them". We saw that a record of some complaints was shared through service manager workbooks to head office. However, it was not always clear what action had been taken. We saw one example of a compliant that had been responded to and appropriate action identified in relation to a number of areas of improvement for one service. The service was in the process of implementing these actions.

Requires Improvement

Is the service well-led?

Our findings

People were complimentary about the manager who was in the process of being registered. One professional told us, "she has had a big job on her hands but has a clear focus on what's best for people; she is just spread too thin". Staff we spoke with told us, "The manager is very supportive when she is around, clearly cares about people". Our findings supported these views. The manager had a good understanding of their responsibilities. The manager maintained an open and honest attitude towards improvement and showed a willingness to understand the areas that needed improvement.

We spoke with the manager about concerns we had received before and during the inspection and the manager acknowledged that there had been a significant culture shift within the service that was taking time to improve. The manager responded swiftly to concerns raised before the inspection by investigating and reporting on their findings. However, the manager also acknowledged additional responsibilities for other services may have contributed to not being on top of issues identified at the time of our inspection. The manager had also been notifying us of incidents in line with her regulatory responsibility. However there was a concern that the manager was not being informed of incidents that would require investigating and notifying. For example a number of incidents we were told about during the course of the inspection by staff or team leaders had not been notified to the care quality commission. Also the lack of permanent staff that prevented people receiving a service had not been notified.

A system was in place to monitor quality and safety within the service, but it was not always effective. We reviewed all internal quality assurance documents made available to us. These documents were identifying issues in relation to medication errors and accidents and incidents. Despite some of these records showing robust and responsive action taken, it was not clear in all records what action was taken. None of these systems had identified the issues we found during our inspection or issues that had been identified by the local authority quality and contracts team. When the manager received information they responded to it appropriately and in good time. For example, when concerns were raised in relation to people's practice, this was investigated and the disciplinary procedure was followed.

Nine staff we spoke with did not feel their line mangers had the necessary knowledge and skills to fulfil their role. During the inspection we also received anonymous information expressing this concern. Some staff also shared concern regarding communication from management. One staff member told us, "Communication to staff is a problem, I've not been to a team meeting for some time. I am positive, with no reason to be bitter, but they just don't have time to value their staff". 10 relatives we spoke with told us their relatives were not supported by a well led service. Relatives we spoke with raised concerns about a lack of consistent leadership and how this did not support a culture of putting people first. Seven out of 19 staff we spoke with felt they could not speak with their line manager regarding concerns. One staff member told us, "I don't feel safe saying anything. Staff aren't supported to learn from mistakes here they are shouted at, I would rather speak with the top manager [the manager applying to be registered]". This concern was raised directly with the manager during the inspection.

We identified concerns with regard to records at our last inspection in June 2014 that were a breach or regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These issues were in relation to people not being protected against the risks of unsafe or inappropriate care and treatment due to inaccurate or unclear records. We found that despite some improvements, there were still concerns. We found some documents hard to read due to either illegible hand writing or fading print. We also found the key care records lacked detail or remained blank. Several key documents relating to peoples care were not dated and lacked signatures. We also found one staff member's supervision notes contained personal details in another person's staff file. This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager felt supported by her senior management team receiving additional resources and support when needed. At the time of our inspection issues had been identified within services in West Berkshire by the local authority monitoring visits and the manager had requested additional support which they had received.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Consent to care and treatment The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. There was not a culture that understood the Mental Capacity Act 2005 therefore service users could not be confident that their human rights are respected and taken into account. (18)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 - Safeguarding Not all staff we spoke with could take reasonable steps to identify the possibility of abuse and prevent it before it occurs. (11) (1) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Staffing There were not sufficient numbers of suitably qualified, skilled and experienced staff employed to meet peoples needs. (22)

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Service user's dignity, privacy and independence was not always respected. Service users were not always enabled to make, or participate in making, decisions relating to their care or treatment. Service users were not always treated with consideration and respect. Service users, or those acting on their behalf, did not always understand the care or treatment choices available and were not always able to express their views as to what is important to them in relation to the care. Where appropriate service users were not always provided with opportunities for service users to manage their own care or treatment or involved in decisions relating to them. Not all service users were provided appropriate opportunities, encouragement and support in relation to promoting their autonomy, independence and community involvement. (17)(a)(b)(2)(a)(c)(i)(ii)(d)(c)(ii)(e)(f)(g)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare.

This section is primarily information for the provider

Enforcement actions

People were not always receiving care that was planned in a way to meet their individual needs and ensure their safety and welfare.

Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records.

Accurate records in respect of each service user dis not always include appropriate information and documents in relation to the care and treatment.

Records relating to service users and people employed lacked details and were not always stored securely.

(20) (a)(b)(i)(ii) (2) (a)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

The provider did not have an effective system to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of service users.

The analysis of incidents that resulted in, or had the potential to result in, harm to a service user did not lead to changes to the treatment or care provided in order to reflect information.

This section is primarily information for the provider

Enforcement actions

Did not have an effective system for ensuring that decisions in relation to the provision of care and treatment for service users are taken at the appropriate level in relations to planning workers on shift.

Regulation (10) (1) (a) (b) (c) (i) (d) (i) (2) (b) (i)

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting Workers. Persons employed for the purposes of carrying on the regulated activity did not receive appropriate training, professional development and supervision. Regulation (23) (a)