Milford Del Support Agency Limited

Milford Del Support Agency

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Milford Del Support agency provides care and support to people who live in their own homes. The majority of these people are people with learning disabilities and autistic people. It is registered to provide personal care. At the time of the inspection the service was delivering personal care to 17 people. Most people lived in their own home; some people shared their house with up to three other people who received support. Where staff slept in to ensure people were safe overnight, they had a private space to do so in people's spare rooms. Staff did not have allocated space that people could not access in their homes unless this was agreed as part of their support plan. Staff worked in teams focused on the support of individual people.

In 'supported living' settings people's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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.

People's experience of using this service and what we found

Right Support:
Not all people were supported to have maximum choice and control of their lives and staff did not always support some people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Restrictions were not always identified or reviewed effectively.

All restraints were recorded but these records were not reviewed adequately to enable safe oversight and to support learning with the aim of reducing restrictive intervention.

Staff enabled people to access appropriate health care and advocated for them. Staff encouraged people to play an active role in maintaining their own health and wellbeing.

Staff supported people to take their medicines safely.

Right care
The service usually had enough staff to meet people's needs and keep them safe. However, there had been times when this was not the case. Staff had not all received training that reflected the needs of the people they supported.

People could communicate with staff because staff knew them well. Not all staff had undertaken specialist communication training that would support the development of communication and choice.

Staff were respectful when they spoke about people's needs. Staff knew people well and were committed to working with them as individuals.

Staff had training on how to recognise and report abuse and they knew who they should contact to raise any concerns they had.

People's support plans usually reflected the risks they faced. Work was ongoing to ensure support plans were up to date before they were being moved onto a new electronic recording system.

Right culture
People's support plans did not respect their rights as tenants. We have made a recommendation about this.

People were supported by staff who were committed to delivering a quality service to the people they supported.

The management structure had been created to support the organisation's values and ethos. The service had grown quickly and the leadership team had been impacted by personnel change and absence. This had led to oversight omissions.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published September 2018)

Why we inspected
We received concerns over a period of time in relation to staffing and staff training. As a result, we undertook a focused inspection to review the key questions of safe, effective, and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Milford Del Support Agency on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to staffing levels and training, restrictive interventions and practices, risk management and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Milford Del Support Agency

Detailed findings

Background to this inspection

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

The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave a short period notice of the inspection because some of the people using the service could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 14 March 2023 and ended on 27 March 2023. We visited the location's office on

14, 15 and 16 March 2023.

What we did before the inspection
Before the inspection we reviewed information, we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We visited 5 people in their homes and had telephone calls or received written feedback from 3 further people who received a service and the relatives of 6 people. We spoke with 16 members of staff, the registered manager, the provider's nominated individual and a director. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with, or received written feedback, from 2 health and social care professionals.

We looked at records related to the care and support of 7 people. We also reviewed records relating to the management of the service including service improvement plans, staff meeting minutes, rotas, training records, satisfaction surveys and 2 staff files.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things went wrong

- Evidence related to the management of risk was mixed. Risk management strategies in place to support people when they were distressed were not always applied consistently. A member of staff described how they calmed a person in a way that was not described in the person's support plan. Staff had not implemented a clear plan to monitor blood sugar levels for a person living with diabetes and there was mixed information about this condition in their care records. People and staff were at risk of harm because plans were not consistently implemented.
- Training necessary to reduce identified risks to staff and people was not provided in a timely manner. A physical risk to staff was identified in April 2021 when a person bit a member of staff when they were distressed. Appropriate training had not been provided for staff working with this person. Staff working with people who were sometimes restrained due to risks they posed to themselves and others when distressed had not refreshed their training appropriately. This put staff and people at risk of harm.
- Investigations into incidents and accidents did not always involve robust analysis of the root cause. This meant actions taken were not always sufficient. During a safeguarding investigation a member of staff had been clear that they did not have confidence in a person's support plan. This had not been explored further which meant neither the staff member's training nor the person's support plan had been reviewed. This put both staff and the person at risk of harm.
- Risks associated with the support people needed to move safely had been assessed, however the competency of staff undertaking this support had not been reviewed after their initial training. This put staff and people at risk of unsafe techniques being carried out.

Risks were not being managed consistently. Staff did not have the training necessary to provide safe care. There was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection the provider told us about actions they were taking to improve risk management and mitigate known risks. We have not been able to review the effectiveness of these actions at this inspection.

- The recording and monitoring of restraint had not been sufficient. Records were not always signed by staff involved, did not always describe the restraint used, and post incident discussion was often not reflected. Records of restraint did not evidence manager review of the events surrounding the restraint. Discussions with the senior team identified that due to an absence in the senior team one person's restraint records were not being overseen. This person was being restrained regularly. Whilst staff told us people's freedom

was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible, it was not possible to evidence that restraint reduction strategies were being implemented.

People were not protected from unnecessary control and restraint. There was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was responsive and put plans in place to address shortfalls identified and following the inspection we were sent an example of restrictive intervention analysis for the person whose records had not been overseen. We have not been able to review if this oversight has been embedded at this inspection.
● The need to improve the sharing of learning from incidents and accidents had been identified by the senior team just prior to our inspection.
● There were examples of people being less distressed and therefore needing substantially less physical intervention since they had been supported by the service and moved into appropriate accommodation.
● People who received support to manage risks associated with the impact of physical impairments told us these risks were well managed by staff who understood what they needed to do and involved them in the process. One person told us, "They are brilliant…They notice marks. They notice when I'm quiet."

Staffing and recruitment
● Staffing challenges had varying impacts on people. We heard from some people that they were always told about staffing issues and, despite staffing challenges their care was always provided. However, we also heard from two people and their relatives about the impact staffing shortages were having on their life. This included not being able to get out to arranged social events, without the support of their family, and not receiving support with their continence in a timely manner. The two relatives reflected on how unpleasant it was for their loved one's not to be helped with their continence when they needed it.
● Staffing was not always provided in line with agreed safety protocols. A health professionals flagged concerns that emergency plans to ensure safe staffing for a person had not been implemented. The provider reviewed when this had occurred and identified 3 occasions in an 18 day period in March 2023. Another person was admitted to hospital twice during our inspection. Additional staff were not available to support these admissions in line with guidance. Another person had moved house and agreement had not been secured prior to this move about how to ensure the staffing level detailed in their support plan. These omissions put people and staff at risk.

There were not always sufficient staff deployed to ensure people's assessed needs were met. There was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited to work with individual people. Recruitment processes were robust and included appropriate checks and references. There were plans in place to involve people in recruitment processes.
● Managers had acted to secure additional funding for one of the people impacted by staffing levels in response to their concerns about the availability of continence support.
● Following our inspection we were provided with assurances that the staffing level assessed as necessary by the service was being maintained for the person who had moved. We have not been able to review the sustainability of this action at this inspection.
● The service had been impacted by the sector wide challenges in ensuring they had enough staff. There was ongoing recruitment with the aim to create greater resilience and flexibility within the teams. We heard from some staff that they currently worked long hours to ensure people were supported by familiar staff. The risks of staff working long hours was not reflected on the risk register or service improvement plan.

● Managers had taken action to secure appropriate staff and this meant staffing levels were improving.

Systems and processes to safeguard people from the risk of abuse

● Staff were confident in their description of the actions they should take if they thought a person was at risk of abuse. However, whilst some staff expressed concerns about staffing levels and training to us during the inspection these concerns had not been addressed through internal structures as safeguarding concerns.

● Anonymous whistle blowers had raised concerns indicating these issues. Work was ongoing to improve communication between staff and the senior team.

● People told us they felt safe with the service they received and the staff who supported them. Relatives and people knew who they could raise concerns with. Four people told us they liked the staff who supported them. The reduction in distress for people was a strong indicator that they trusted the staff who supported them. We received feedback from one person who shared, "(They) would also like to make it known how happy (they are) here with the care and support."

Preventing and controlling infection

● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. Where people could not follow the guidance risks had been assessed and mitigated. Staff helped people keep their homes clean.

● The provider organisation had ensured that the infection control policy had been kept up to date and that staff and people had appropriate guidance and information.

Using medicines safely

● People received their medicines as they were prescribed. Staff told us they had been trained to give medicines safely and we were assured that their competence had been assessed although evidence of this was not made available.

● Medicines were stored safely and securely. We noted the temperature of a room that medicines were stored in was close to the safe threshold for storage, we were assured this would be monitored and actions taken should it become unsafe.

● Audits were undertaken regularly. This reduced the risk of mistakes being made.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were supported by staff who had not always undertaken the appropriate training for their specialist roles. The senior team had been aware that there were risks associated with training since May 2022 when training was added to the organisation's risks register. Actions had been taken but these had not been sufficient to support staff to undertake training and embed learning in their work. The majority of staff worked with people who had assessed needs associated with their communication and most staff had not undertaken specialised communication training after a short session on their induction. This mattered because we did not see, or hear about, the regular use of enhanced communication support designed to enable people to influence plans, understand expectations and control their environment. This type of support is recognised as being closely related to a reduction in distress.
- Some staff supported autistic people. Those staff who supported autistic people had not all completed training about autism following an introductory session on their induction. Whilst we saw evidence that staff considered how people's autism affected them, we also heard examples that did not reflect good practice such as inconsistent approaches and the use of language that indicated uncertainty. We also heard from an experienced member of a staff who supported an autistic person. Their interpretation of why this person may become distressed was not reflective of a positive behaviour support approach.
- Other training identified as essential by the provider had also not been completed by most staff. This included training related to oral care, dignity and respect, and recording and reporting.

People's support was not provided by staff who had received appropriate training and support. There was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they had experienced mixed support. We heard reflections on changes at manager level leaving staff uncertain about their support. The senior team were aware of the risks associated with staff morale and were working to improve this. Staff awards had been made and ways to involve staff effectively in a forum were being explored.
- People had confidence in the skills and knowledge of the staff who supported them. One person reflected positively on the training both long serving staff, and new staff, had received. A relative commented that they could see the competence of staff in their interactions with their loved one.
- Most people were supported by a number of long-standing staff who they knew well. Staff were individually consistent with people and committed to ensuring constancy in their lives.
- A short term training plan was being implemented to ensure staff had the skills to keep themselves and

people safe as we started our inspection site visits. A longer term plan was in progress to monitor staff training across all the teams.
● Staff attended meetings with their colleagues who supported the same person. This provided a structure for peer support and afforded the opportunity to discuss care and support.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and whether any conditions on the authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff had received training about the MCA, however, evidence indicated they had mixed understanding about its application in their work. Where restrictions had been identified the process for review was not robust and plans to reduce restrictions were not inherent in these processes. Some restrictive practices one person experienced, such as lack of access to a communication tool and internet access and how they were persuaded about their diet had not been identified because the MCA code of practice was not embedded in working practices.

People were not protected from unnecessary control and restraint. There was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people lacked capacity, mental capacity assessments were undertaken related to some decisions such as those related to the provision of a restricted diet, the use of medicines administration and locked doors. Some of the examples provided to us did not follow the processes detailed in the MCA Code of conduct appropriately. Work was ongoing to address these shortfalls.
● Some people could not consent to the care they received and as a result legal protections had been granted, or applied for, to deprive them of their liberty. This process is known as a community deprivation of liberty safeguard (DoLS) and it is the responsibility of the funding authority to make these applications. Oversight of DoLS within the service had not been robust and the status of applications was not known within the senior team. The senior team were not aware if any relatives or friends of people had legal authority to make decisions for them as powers of attorney. This meant there was a risk that people with the legal status to make decisions were not being asked to do so. This was addressed immediately.
● Where people had capacity to consent to their care this had been sought. Two people told us the staff always asked for their consent, one followed this observation up by telling us "They are a cracking team". We also heard from a relative who told us they had observed staff asking their loved one for consent before carrying out care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● People's care and support plans did not always reflect that people were tenants in their own home and

the day-to-day tasks of life such as cooking, cleaning and shopping were not always described. This was reflected in staff discussions for example, one member of staff described how a person liked to observe them when cooking but they did not know what other staff did. This matters because it encourages a shift in thinking about the rights and responsibilities of people living in their own home.

We recommend the provider considers current good practice guidance related to supported living.

● People had their needs assessed prior to receiving support. A new assessment process had been drawn up by the registered manager in order to ensure this process was enhanced.
● Each person had a support plan. People told us they had seen their support plans. One person told us "I have a care plan. We go through it and make changes. If I get a new carer they are given the care plan to read." Another person told us their care plan was reviewed with them on a regular basis.
● Support plans were being transferred onto an electronic system that would allow staff to record onto handsets.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff advocated for people, and when appropriate worked with families and professionals to ensure people had access to healthcare. One relative described their involvement in health checks and the communication from the team about health-related issues.
● Plans had been made to enable successful health interventions. This had included planning staff rotas to ensure people were supported by familiar and trusted staff at times when they were vulnerable.
● Most people and relatives told us the staff worked with local healthcare teams to ensure their health needs were met. One relative described how local professionals were working alongside their loved one's team to help them accept medical checks and interventions.
● Feedback from professionals was positive about the caring nature of staff and the support they had provided.

Supporting people to eat and drink enough to maintain a balanced diet
● People had risk assessments and support plans in place related to eating and drinking safely. One person's support plan did not reflect their preference to disregard advice regarding drinking safely. Staff were aware of this decision and action was taken to ensure their support plan was consistent with their preferences.
● Staff monitored people's dietary intake and weight. This meant they were able support people to eat and drink enough and seek additional input form appropriate professionals if their intake deteriorated.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- Milford Del Support Agency had grown fast, and this expansion had occurred against the backdrop of the pandemic. A risk register had been established in May 2022 and risks associated with staff training and accountabilities had been placed on it at this time. The resultant actions had not been sufficient to secure the change needed and key risks faced by people and staff were not mitigated.
- People received care and support from a staff team who had mixed views about changes in the structure and management of the organisation. They told us changes in staff at the main office meant they were not always sure who they needed to talk with. They told us they were not always told about new appointments. Staff in different settings within the service had differing experience of guidance and support.
- Monitoring had not led to the identification of restrictions that had been long standing. This meant people's rights had remained unprotected.
- Policies and procedures were not implemented that supported the legal status of people as tenants.
- Complete and accurate records in respect of people's care and support had not been maintained.
- The failings in oversight meant that people received support that was provided in breach of regulation.

Systems to monitor the quality and safety of people's support were not effective. There was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Statutory notifications had usually been made to the CQC. Notifications are required regarding situations described in the regulation that have an impact on the support people received. Historically a notification related to the outcome of DoLS had not been submitted. A notification related to an allegation of abuse was submitted during our inspection. This had not been submitted due to a misunderstanding. Statutory Notifications should be submitted to CQC as soon as the provider becomes aware of an allegation. This requirement is not altered if CQC are aware of the allegation from another source.
- Prior to our visit new staff had been appointed to support oversight and monitoring within the organisation.
- Safety audits of the different settings people lived had been effective in identifying areas for improvement and these improvements had been effective.
- The senior team were responsive throughout our inspection and acted to set timescales to the actions necessary to ensure improvement.
- The senior team were implementing the roll out of an electronic care recording system which would

enable closer monitoring of the support people received and their experiences.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People who used words to express their views told us they were happy to be supported by Milford Del Support Agency. One person told us "I am very happy with them. I have a strong core team." Another person told us "I love it here, it's a dream place and I have so much independence to do what I want." A relative told us "They are really excellent. We can't praise the staff highly enough."

● People and relatives reflected on the caring nature of staff committed to the people they supported. We heard numerous examples of the positive impact of this commitment from people, staff and professionals. This included examples of people becoming present, and beginning to participate, in their communities. People becoming more confident in their own capabilities and becoming less distressed.

● Relatives reflected similar concerns as the staff regarding who they should speak with and relayed some difficulties with communicating. One person told us that they only found out about management changes through the carers.

● Whilst staff were clear about their wish to achieve best outcomes for people, a lack of leadership and oversight meant that people's support was not always reflective of best practice.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●Where mistakes were made, the senior team acknowledged failings and omissions. They sought to make improvements and reduce the risk of repeated mistakes.

● The provider had a policy in place to support the duty of candour.

Working in partnership with others

● The staff worked in partnership with other professionals to ensure people's needs were met. This included making referrals to professionals to meet specific needs.

● Professionals were largely positive about their experience of working with Milford Del Support Agency.

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 17 HSCA RA Regulations 2014 Good governance Governance processes had not been sufficient to ensure the quality and safety of the support people received. Records were not always complete.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by sufficient, appropriately trained staff to meet their identified needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks people faced had not been appropriately assessed or mitigated. Staff competency to keep people safe had not been ensured.

The enforcement action we took:

We served a warning notice requiring the provider to be compliant with the regulation by 17 May 2023.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of disproportionate control and restraint because restrictions and physical interventions were not monitored sufficiently

The enforcement action we took:

We served a warning notice requiring the provider to be compliant with the regulation by 17 May 2023.