Achieve Together Limited

Domiciliary Care Agency East Area

Inspection report

The Cabin, 200B Fleet Road
Fleet, Holbeach
Spalding
PE12 8LE

Tel: 01406490616
Website: www.achievetogether.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Domiciliary Care Agency East Area is a supported living service which provides personal care to younger adults, including people with a learning disability and autistic people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection, 18 people received support with personal care, in 7 supported living settings, made up of flats and shared houses.

People's experience of using this service and what we found
Right Support
People did not always receive high quality care that resulted in good outcomes for them.
People were not always protected from the risks associated with poor infection prevention and control.
Risks to their health and safety were not always managed well.
People did not always receive support that maximised their choice and control.
There were not always enough staff available to support people to do what was important to them.
People were not always supported by staff to pursue their interests and take part in activities.
People had a choice about their living environment and were able to personalise their rooms.
Staff communicated with people in ways that met their needs.
Staff supported people with their medicines safely. Some minor improvements were needed to ensure medicines processes reflected national guidance.
Staff enabled people to access specialist health and social care support in the community.

Right Care:
People did not always receive appropriate support, as the service did not always have enough appropriately skilled staff to meet people's needs and keep them safe.
The level of person-centred care that people received was not consistent across all of the supported living settings. People did not always receive care that reflected their individual needs and aspirations, was focused on their quality of life, and followed best practice.
People could not always take part in activities and pursue interests that were tailored to them.
People liked the staff who supported them, and most relatives told us staff knew their family member's needs and preferences.
People's care, treatment and support plans reflected their range of needs.
People could communicate with staff and understand information given to them because staff understood

their individual communication needs.
People were supported by staff who had been recruited safely. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture:
People did not always receive good quality care and support.
The service had had experienced staffing difficulties and people were not always supported to receive consistent care from staff who knew them well.
The service did not always work with people, those important to them and staff to develop the service.
The service did not always have a culture of improvement and inclusivity. They did not always respond to complaints appropriately.
The service did not always monitor and evaluate the quality of support provided to people.
People and those important to them were involved in planning their care. They were happy with the management of the service.

There had been a number of changes in management over the previous year or so, which had resulted in inconsistency in the level and quality of support being provided across the service. Governance arrangements were not always effective. Checks of quality and safety were not always being completed as they should have been, and where improvements were needed, these were not always being completed in a timely way.

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

Rating at last inspection
The last rating for this service was requires improvement (published 22 June 2022).

Why we inspected
We had received concerns from Lincolnshire County Council, following their visits to 2 of the supported living settings: Roman House and Willoughby Services. The concerns related to safety, cleanliness, staffing arrangements, staff training and recruitment, communication, medicines management and staff culture. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. Roman House was closed by the provider on 5 May 2023, so this setting was not included in our inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to staffing levels and training, the management of risks to people's health and safety and governance arrangements at this inspection.

We have made recommendations regarding the management of complaints, support with activities and seeking and acting on the views of people supported by the service, relatives and staff.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Domiciliary Care Agency East Area

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.

Service and service type
This service provides care and support to people living in 7 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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 not a registered manager in post. A manager was in post who was in the process of applying to become the registered manager.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we wanted to be sure there would be people at home to speak with us and that the provider or manager would be in the office to support the

inspection.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from a number of local authorities and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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. We used all this information to plan our inspection.

During the inspection
We visited 4 of the 6 supported living settings where people were receiving support with personal care; Willoughby Services, Helena Services, The Stables and Kings Ripton Services. During our visits, we spoke with 3 people supported by the service, to gain their feedback about the support provided, and we observed staff supporting some people. Some people were not able to give us verbal feedback, we observed their body language and interactions with staff to gain feedback on their wellbeing. During our inspection we also spoke with the manager, 4 service managers [responsible for individual supporting living settings], the regional manager, the operations support manager and 2 support staff. As part of our inspection, we also spoke on the telephone with 6 relatives and 7 staff members.

We reviewed a range of records, including people's care records and medicines records. We reviewed staff training records and 3 staff recruitment files. We also looked at a variety of records related to the management of the service, including policies and audits.

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 requires improvement. At this inspection the rating has remained 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.

Staffing and recruitment

● Staffing levels were not always appropriate to meet people's needs and keep them safe. Staffing rotas showed that Willoughby Services was not always staffed at the safe levels set by the provider, during both the day and night. People did not always receive one to one support as commissioned. There was high reliance on agency staff, including during the night. Staffing rotas showed that there were only 2 permanent night staff at Willoughby Services, which meant that the service was regularly staffed at night by agency staff only. Records showed that some agency staff worked at the service regularly, which meant they had become familiar with people's needs and risks. Other agency staff had not visited the service often, which meant they were not as familiar with people and how to support them well.

● Some staff and relatives told us the service was sometimes short staffed, which impacted on things like activities, outings and visits to relatives. One staff member told us, "Staffing impacts activities such as horse riding, and can affect people going to college. People get very disappointed." One relative commented, "Activities can be an issue if they are short staffed or if there's no driver available [to take people out]"

● Records showed that not all staff had completed the training necessary to meet people's needs and keep them safe. This included training in positive behaviour support, epilepsy awareness, specialist epilepsy medication, dysphagia and autism training.

The provider had failed to ensure there were always sufficient, suitably trained staff available to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the provider who advised there had been challenges recruiting and retaining staff in the area. They told us some regular agency staff had recently agreed to become permanent and the provider was hopeful this would help to improve the staffing situation.

● Staff were recruited safely. Appropriate pre-employment checks were carried out before staff started working at the service, to ensure they were suitable to support people.

Assessing risk, safety monitoring and management; Preventing and controlling infection

● Risks to people's health and safety were not always managed appropriately. Fire and water safety checks were not always completed, including checks for Legionella bacteria which can cause Legionnaire's disease, a pneumonia-type illness. Where audits identified that improvements were needed, these had not always been made in a timely way. This meant people were at risk of experiencing avoidable harm.

● Improvements were needed to infection prevention and control practices. Some flooring and furniture

were damaged, which made it difficult to ensure they could be cleaned properly. Some areas of Willoughby Services were not clean, including a mouldy shower curtain, unclean bedding and a damp smelling bathroom with stained flooring. We found paper hand towels and a person's continence aids were not being stored appropriately.

The provider had failed to ensure that risks to people's health and safety were managed appropriately. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw evidence of some improvements being made, as a result of previous concerns being raised and the provider's audits. The provider told us further improvements were planned. A detailed action plan was in place which included health and safety actions.

● Care plans included information about people's risks and needs and how staff should support them to manage those risks. Some minor improvements were needed to two of the care plans we reviewed, to ensure they reflected people's needs and risks accurately. The provider had systems to manage accidents and incidents effectively.
● We saw evidence of positive risk taking. For example, some people were encouraged and supported to cook, to go out into the community independently and to take part in activities which involved an element of risk.

Systems and processes to safeguard people from the risk of abuse
● Records showed that most staff had completed safeguarding training and the staff we spoke with understood the action to take if they suspected abuse was taking place. Most relatives told us people received safe care and were well cared for.
● Safeguarding incidents were investigated and reported to the local authority and CQC when appropriate.
● Some improvements were needed to the management of risks to people's health and safety, to ensure they were safeguarded from the risk of avoidable harm. This has been addressed earlier in this report.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Learning lessons when things go wrong
● The provider had some systems in place to support learning lessons when things went wrong, though these needed to be improved. Accident and incident records were reviewed by management to ensure appropriate action had been taken and any lessons learned were shared with staff. Most of the accident records we looked at had been reviewed by management in a timely way.
● Complaints were not always investigated and responded to in a timely way, which meant there could be a delay in sharing any learning lessons with staff. We have addressed this in the Responsive section of this

report.
● Audits of quality and safety were not always completed as they should have been, which meant that lessons were not always learnt, and improvements made in a timely way. We have addressed this in the well-led section of this report.

Using medicines safely
● During our visits we found that people's medicines were managed safely. Some minor improvements were needed to ensure medicines management processes at Willoughby Services reflected National Institute for Health and Care Excellence (NICE) guidance.
● Staff had completed medicines training and been assessed as competent to administer people's medicines safely. We noted that not all staff had completed training in administering specialist epilepsy medication. This is addressed in the staffing section above.
● Medicines stock levels and records were not consistently checked by management. We were told medicines audits were not available for Willoughby Services. We have addressed this in the well-led section of this report.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This key question was not reviewed at our last inspection. At a previous inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Most relatives we spoke told us the care provided was good, and staff supported people in a way that reflected their needs and preferences. However, we found inconsistencies in the level of person-centred support provided across the different supported living sites.
- Staffing levels meant that people were not always able to do the things that were important to them, such as visiting family members, following their interests and going out. We have addressed this in the staffing section above.
- The support provided to people to follow their interests and take part in activities needed to be improved. At Helena Services, The Stables and Kings Ripton Services, people regularly took part in a variety of meaningful activities. However, the same choices and opportunities were not available to people living at Willoughby Services. Activity planners were not always available to guide staff about people's interests and the activities they enjoyed.

We recommend the provider considers current guidance around supporting people to engage in meaningful activities and takes action to update their practice accordingly.

- The care plans we reviewed were detailed and included information about people's individual risks, needs and preferences. Most had been reviewed recently.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care plans included information about how they communicated, any support they needed with communication and how staff should provide it.
- Staff had a good awareness and understanding of people's communication needs. We observed them communicating effectively with people, repeating or explaining information when necessary.

Improving care quality in response to complaints or concerns

● The provider had processes to respond to people's complaints or concerns. None of the people or relatives we spoke with had made a formal complaint. They told us they would feel able to if they needed to. Some relatives told us they had raised concerns, and most were happy with how they had been responded to.
● We reviewed 3 complaints that had been received by Willoughby services. Only one of the 3 had been investigated and responded to in line with the provider's policy.

We recommend the provider ensures that all complaints are managed in line with the provider's complaints policy.

End of life care and support
● The provider had processes to provide people with individualised end of life care. People's care records included information about their end-of-life care wishes to guide staff. Where people were unable to make decisions about their end-of-life care, this had been discussed with their relatives.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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

- We found that oversight and governance arrangements at the service needed to be improved. Some audits and quality checks had not been completed. The audits and checks completed were not always effective in ensuring appropriate standards of quality and safety were being achieved and maintained. Audits showed that where shortfalls had been identified, the necessary improvements had not always been made in a timely way.
- Management arrangements had not always been effective. There was no registered manager at the service at the time of our inspection. The last registered manager had de-registered in June 2022. There was a manager in place who had started at the service on 6 June 2023 and was in the process of applying to become the registered manager. There had been numerous changes in the management of the service in the previous 12 months or so, at service manager level (Willoughby Services), manager level (all supported living sites) and regional manager level. One relative commented, "There have been lots of changes in management which has had an impact on the service. They need consistent management."
- Some staff told us communication from management about changes at the service and in management arrangements had been poor. One staff member told us, "Often staff are not told of changes until much later, it makes you feel unvalued. Staff leave because they don't feel valued."
- At Helena Services, The Stables and Kings Ripton Services, staff and management learnt from complaints, incidents and audits and appropriate improvements had been made. At Willoughby Services, this was not always the case. There had been a lack of consistent management, a lack of appropriate audits of quality and safety and consequently, a lack of learning and of necessary improvements being made.
- Concerns had been raised by the local authority in March 2023, following visits to two of the supported living settings: Roman House and Willoughby Services.

The provider had failed to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm. This was breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2023, the provider made a decision to close Roman House, as they felt the improvements needed in relation to standards of quality and safety could not be achieved quickly enough. At the time of our inspection, an action plan regarding the improvements needed at Willoughby Services, was in place and

was being reviewed regularly by the local authority and the provider.

● Management had submitted statutory notifications to CQC about people using the service, in line with current regulations. A statutory notification is information about important events which the service is required to send to CQC by law.

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

● We found evidence that people, relatives and staff were asked for their feedback about the support provided. However, this was not consistent across all of the supported living settings. Where feedback had been received which identified concerns, there was not always information available about whether these had been addressed and whether any improvements had been made.

● Some staff told us they had raised concerns with management about a variety of issues, including staffing, activities and infection control, but little action had been taken. Some felt that the numerous changes in management had impacted on the quality of support being provided to people. One staff member told us, "We've had a number of management changes, there's been no consistency. They've all tried to implement different changes. Things haven't always been done [by staff] as they should have been, but there was no management at times to address it."

We recommend the provider ensures there are effective processes in place to seek and respond to feedback from people supported by the service, relatives and staff.

● Most people and relatives we spoke with told us they were satisfied with the management of the service, and they found staff and management approachable. A person supported by the service told us, "I like the staff. I feel comfortable with them. I have no concerns but would feel able to talk to anyone if I did.' A relative commented, "I attend an annual review and can raise any issues. I can contact the staff about anything."

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

● The provider had not always ensured that the care and support provided was high quality, reflected people's individual needs and resulted in good outcomes for them. We found that the level of person-centred support provided was not consistent across all of the supported living settings. At Willoughby Services, staffing levels were not always appropriate to meet people's individual needs, risks to people's health and safety were not always managed effectively and people did not always receive appropriate support with following their interests and doing what was important to them.

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

● The provider had a duty of candour policy and was aware of their responsibilities. None of the incidents since the last inspection fell under the provider's duty of candour, that we were aware of.

Working in partnership with others

● Management and staff worked in partnership with people's relatives, representatives and a variety of health and social care professionals to enable people to receive the support they needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people's health and safety were managed appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were always sufficient, suitably trained staff available to meet people's needs.