Affinity Trust

Affinity Trust Specialist Support Division North

Inspection report

Webb House, Mayman Lane
Batley
WF17 7TB

Tel: 07919480698
Website: www.affinitytrust.org/

Date of inspection visit:
24 March 2022
30 March 2022
13 April 2022

Date of publication:
12 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Affinity Trust Specialist Support Division North is a supportive living service registered to provide personal care for people who have learning disabilities. Affinity Trust Specialist Support Division North accommodates 15 people across three separate sites, each of which has separate adapted facilities. At the time of our inspection seven people were using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support
People were not supported in having choice and control over aspects of their lives. Staff were restrictive and did not promote the best interests of the people using the service. Risks to people were not always recognised, assessed and managed safely. Systems in place did not always protect people from abuse and improper treatment. The provider had not always acted to manage risks. People's needs were not always assessed to consider what they wanted and needed.

Right Care
Staff did not always offer people choice or involve them when supporting with activities or meals. Some staff were knowledgeable about the people they supported and had established good rapport and therapeutic relationships, one relative said, "I like the staff, they know [them] so well". However, the service relied on agency staff who did not always know the people.

Right culture
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure all people using the service could lead confident, inclusive and empowered lives. People were not supported to regularly identify, or review, on-going individual aspirations and life goals. There was a lack of management support to assist staff in improving practice. Staff told us that morale had been low and they had felt the impact of poor staffing. One staff member said "I just feel undervalued".

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

Rating at last inspection

This service was registered with us on 19 May 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns raised by stakeholders regarding safeguarding and leadership. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, person- centred care and good governance at this inspection. We have made recommendations for the provider to improve staff training, supervision and use feedback from people, relatives and staff to inform improvement within the service.

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 Affinity Trust Specialist Support Division North on our website at www.cqc.org.uk.

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? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Affinity Trust Specialist Support Division North

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors, a specialist advisor and an Expert by Experience carried out the inspection. 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 three '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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was not a registered manager in post. A new manager and deputy manager had been

recruited and were due to start in April 2022.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 23 March 2022 and ended on 13 April 2022. We visited the location's service on 24 March, 30 March and 13 April 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority, local safeguarding team 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 all this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with the regional manager, the operations manager and 10 members of care staff. We reviewed a range of records, this included four people's care records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Safeguarding systems were not established. At one of the locations there was ongoing safeguarding issues and the leadership were not able to clearly evidence how these were being managed.
• We were not assured all safeguarding concerns were raised. Prior to our inspection, the Clinical Commissioning Group (CCG) told us the provider was prompted to raise safeguarding concerns that otherwise could have gone unreported.

• Not all staff were up to date with safeguarding training.

The provider had failed to ensure there were robust safeguarding systems in place. This 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 safeguarding policy was in date and relevant to the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risk assessments to identify and protect people's health needs were lacking. This resulted in an instance of a person requiring hospital admission. Following the inspection, we asked the provider to immediately review and act on their current practice regarding risk management.
• There was a record of accidents and incidents. However, the provider was unable to evidence how they mitigated related risk identified following analysis of these records.
• Fire safety was not managed appropriately. There was no evidence of fire drills completed or checks on fire safety equipment. The fire risk assessment was out of date and not signed. Following the inspection, we asked the provider to immediately review and update the documentation.
• Health and safety checks and related risk assessments had not always been completed. The provider was not able to demonstrate how checks were carried out for gas safety, legionella and water temperature.

The provider had failed to ensure risk assessments were completed in relation to the provision of people's care and health and safety checks. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Moving and handling assessments provided insight into people's mobility needs. Staff had completed the relevant moving and handling training.
• Staff used preventative strategies before administering as required medicines.

Using Medicines safely
• Medicines were not managed safely. This CQC inspection and two previous inspections by the Clinical Commissioning Group (CCG) identified medicine files containing information regarding discontinued medicines. This inspection also identified discrepancies in medicine doses given. Following the inspection, the provider demonstrated these issues had been resolved.
• Medicines were stored safely in individual locked safes, however, they were not stored in the individual's home as per policy. There was no rationale to support this decision.
• Medicines were not recorded safely. Important information was missed from medicine record charts including allergy status. Following the inspection, the provider demonstrated positive changes.
• Management completed medicine competency checks on staff.
• We felt the issues regarding the safe management of medication related to poor governance. Please see the well-led section of this report.

The provider had failed to ensure the safe management of people's medicines. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• There were concerns regarding staff behaviours at one of the locations. There were various incidents which were in the process of being investigated.
• Staffing levels were often kept to the minimal level. Rota's and staff feedback suggested a lack of support was in place for staff on shift. Staff were not always able to take breaks and people who used the service were sometimes left alone without support.
• The service relied on agency staff. One person told us, "I don't like that, they [agency staff], don't know me". Agency staff did not receive an induction or training. Management informed us this will be addressed.
• The provider told us measures were in place to mitigate risks associated with COVID-19 related staff pressures.

Preventing and controlling infection
• We were not assured the provider was taking steps to effectively prevent and manage infection outbreaks. There was no infection prevention audits.
• We were not assured the provider was accessing testing for people using the service and staff. There was no system in place to record or monitor staff testing.
• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was meeting shielding and social distancing rules.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using PPE effectively and safely. We observed staff wearing masks correctly during our inspection.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured the provider's infection prevention and control policy was up to date.
• The provider was facilitating visits for people in accordance with the current guidance.
From 11 November 2021 registered persons must make sure all workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.
• The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
• The provider did not recognise the risk of reduced fluid intake. People were not supported to drink enough fluid and there was not enough evidence to show people were supported with accessing or encouraging fluid intake.
• The consideration of people's health needs was not evidenced with meal planning.

The provider had failed to ensure monitor and consider information related to hydration and nutrition. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff knew each person's dietary needs regarding allergies, religious preferences and the consistency of food they could eat safely.
• Following the inspection, the provider improved monitoring records to support hydration.

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 authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• There was no evidence the least restricted option was considered. There was no mental capacity assessments or best interest decisions completed.
• Staff received mental capacity act and DoLS training, however not all staff were up to date.
• People were not always given choice about how they liked their care and treatment to be given.

The provider had failed to ensure the care of people reflected their preferences and were in their best interests. This was a breach of regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• People had been supported to personalise their rooms with pictures, items and furniture.
• The atmosphere and appearance of the home was homely and people looked comfortable and relaxed in their surroundings. At one location, there were communal areas where people could spend time with others. People also had space in their own room to relax should they want privacy.

Staff support: induction, training, skills and experience
• The providers training matrix showed the majority of staff had completed and were up to date with mandatory training courses. However, staff felt they were not sufficiently trained in respect of the support they provided. one staff member said. "we do not get enough training, it's definitely not enough for the job".
• Not all staff had physical restriction training. People using the service sometimes required support from staff to keep them safe during periods of heightened anxiety, this included physical restrictions. Following the inspection, we asked the provider to immediately review their practice and act accordingly.
• Staff told us they did not feel supported by the service. Staff did not attain regular supervision as per the provider's policy. Some staff stated no supervision had been received since commencing employment at the service.

We recommend the provider reviews staff supervision, compliance with training and takes action to update their practice accordingly.

• New staff received an induction to the service, its policies and expected ways of working.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service had made referrals when people needed support from external professionals, such as occupational therapists, physiotherapists and social workers.
• Advice given by healthcare professionals was recorded in people's care records and linked to people's care plans.
• The leadership team told us the GP visited promptly when contacted.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People were treated with kindness, compassion and their rights protected. One person told us "I like a laugh and banter with staff who know me and that does happen now."
• Staff were not always knowledgeable about the people they supported. The provider relied on agency staff who did not always know the people using the service.

• Relatives spoke positively about the care their relatives received. One relative said. "Some [staff] are right good with [them] and manage to get [them] up".
• Staff were trained in equality and diversity and there was an up to date policy. Staff were aware of people's protected characteristics and promoted respect when providing support.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
• Staff supported people to make decisions about their care, however this was not consistent. For example, we did not see evidence of people being involved in activity planning.
• People were treated with dignity and respect by staff. We observed staff interacting with kindness and compassion throughout our inspection. People's privacy was respected, we saw staff knocked on bedroom doors before entering and spoke about people in a respectful manner.
• Systems were in place to maintain confidentiality and staff understood the importance of this, people's records were securely stored.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Communication care plans were followed by staff. Staff were familiar with people's communication needs.
• People's needs and any changes in their care and support was not always shared with staff. One staff member said "Sometimes, we don't get told important updates".

This was a breach of regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were personalised to reflect peoples care needs. They identified people's specific support needs and preferences.
• People's communication needs were planned in a person-centred way.
• People's likes and dislikes were recorded in people's care plans. However, in the records we reviewed there was no documented evidence of the person being involved with their care plan or care plan review.

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
• People's preferred activities were indicated in their care plans. However, activity schedules and daily notes did not always evidence activities were taking place.
• There was no evidence of people being encouraged to take part in activities to improve the learning and development of new skills and interests.

Improving care quality in response to complaints or concerns
• There was an appropriate complaints management system in place.
• When people had raised concerns, they were investigated and the provider checked people were satisfied with the outcome.

End of life care and support
• End of life care arrangements were in place to ensure people had a comfortable and dignified death.
• The service worked with families and people to assess and document their end of life wishes.

Inadequate

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.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Leadership was inconsistent and there was a lack of managerial oversight. Information which should have been readily available was not accessible or shared with us in a timely manner. There were significant gaps in records; these included gaps in medication records, people's communication plans and activity plans.
• The Internal audit completed by management found discrepancies with people's finances. We asked the leadership for a response regarding this but were provided with no further information.
• The service has been without a registered manager since November 2021, a new manager had been recruited and were due to start in April 2022.
• Staff informed us the inconsistency of managers over recent times had impacted on the quality of the service. One staff member said, "It's so poor, no consistency, no support, no leadership.".
• The service did not ensure all staff were current with training.

The provider had failed to ensure they assessed, documented and monitored quality assurance checks. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
• The provider audited the service on a periodic basis, to help share learning, ensure standards and identify trends. However, the audits were not robust, learning and trends were not reliable. For example, the key quality audits were not detailed, and actions did not have a review date.
• The service improvement plan was not robust. The service improvement did not clearly document how the provider would address the issues needed to improve the service.

The provider had failed to ensure learning was used to inform improvements associated with risk and the provision of people care. This was a breach of 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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 management team understood their duty of candour, to be open and honest when things went wrong.
• The provider was sending statutory notifications to CQC.

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

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

• Team meetings were not held at regular intervals. For example, there were two team meetings in March 2022 and one team meeting in October 2021. One staff member stated "team meetings are held now and again, when they happen they are helpful".

• The culture was not always open and inclusive. The staff we spoke to told us they did not feel valued and respected. Some staff told us morale had been low and they had felt the impact of poor staffing.

• The provider completed staff surveys. The last staff survey indicated poor staff satisfaction. There were no recorded actions following the survey.

• The provider did not collect feedback from people who used the service.

We recommend the provider uses feedback from staff, people and relatives to inform improvement within the service.

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 9 HSCA RA Regulations 2014 Person-centred care The service was not working within the principles of the MCA

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risk assessments were completed in relation to the provision of people's care and health and safety checks. The provider failed to safely manage medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure there were robust safeguarding systems in place.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure they assessed, documented and monitored quality assurance checks.

The enforcement action we took:

We sent the provider a warning notice.