United Response

York DCA

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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced comprehensive inspection over three days on the 18, 19 and 20 May 2016. We gave the provider 48 hours' notice of our intention to undertake an inspection. This was because the organisation provides a domiciliary care service and we needed to be sure that someone would be at the agency office that could assist us with the inspection.

This service was registered by the Care Quality Commission (CQC) on 6 December 2010 and was previously inspected in August 2013 when it was found to be compliant with the regulations.

York DCA is owned by United Response and provides services to people with a wide range of complex needs in community settings, such as people's own homes and supported living houses. The service provides domiciliary care and support services from the registered office location in the centre of York. At the time of this inspection, the registered provider was providing personal care and support for twenty seven people in villages outside the City of York who had a learning disability or autistic spectrum disorder.

The registered provider is required to have a registered manager in post and on this inspection, there was a registered manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People who used the service told us they felt safe and we found that care workers had received training in safeguarding people from abuse and knew how to protect people from avoidable harm. The registered provider had a safeguarding policy and procedure and we saw concerns were investigated and actions implemented because of those investigations.

People received care and support from care workers who understood and responded to people's individual wishes, preference and needs. There were sufficient numbers of appropriately trained staff with the required skills and knowledge to support people and this provided people with consistency of care.

The registered provider undertook a variety of recruitment checks to help ensure care workers recruited were considered suitable to work with vulnerable people. We saw care workers underwent an induction programme to gain a fundamental understanding of providing care for people that included areas of mandatory training. Care workers received training in privacy, dignity and confidentiality during their induction. The induction was followed by a period of shadowing experienced care workers until the care worker was deemed competent to provide care and support on their own. The registered provider recognised the importance of building relationships between people and the care workers and people told us they had been involved in the recruitment process.

We saw that accidents and incidents were recorded. These were logged onto a quality assurance system

where they were investigated and analysed for trends. Feedback was provided and investigations were used as a learning tool to mitigate further instances.

The registered provider had a medication policy and procedure in place. Care workers responsible for the administration and management of medication had received comprehensive training and undertook observations before being allowed to work with medication on their own. Despite this, we saw that medication was not well managed or recorded and information was not always available to ensure people received their medication in a safe and timely way. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers had received training and understood the requirements of The Mental Capacity Act (MCA) 2005. Care workers we spoke with understood the importance of ensuring people consented to the care and support they provided. However, information in people's care files was not always up to date or consistent meaning care workers did not have the correct information available to make informed decisions and to provide care and support to people in line with their assessed needs. It was not always clear where best interest decisions had been agreed that the information documented was detailed enough to ensure that the care provided was in the person's best interest or the least restrictive option. Accurate and complete records had not been maintained and the registered provider had not robustly assessed, monitored or mitigated the risks. This was a breach of Regulation 17 (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people were kept safe from the risk of emergencies in their home. People had a risk assessment in their care files for the environment and a personal emergency evacuation plan (PEEP). PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation taking place.
People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw peoples dietary requirements noted in their care plans that included details of food likes, including any religious dietary requirements and information on supporting people with good nutrition and hydration.

The support people received varied dependent on their individual circumstances. Appropriate professional advice was identified where necessary to ensure people's health needs were supported.

Care workers told us they felt well supported and we saw good communication and relationships between care workers, management, people who used the service and outside agencies such as the local authority and health workers. We received positive feedback about the leadership and there was a high degree of confidence in how the service was run.

Management understood how to meet the conditions of their registration with the CQC.

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.

People felt safe and were protected against the risks of bullying and harassment.

Care workers had received training in safeguarding adults and understood the signs of abuse to look out for and how to report any concerns.

There were sufficient numbers of appropriately trained staff with the required skills and knowledge to support people according to their needs.

Care workers received training and policy and procedures were in place however, medication was not managed and administered in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by care workers who had access to training and information to meet people's individual needs.

Care workers we spoke with understood the importance of ensuring people consented to the care and support they provided and had an understanding of the Mental Capacity Act 2005. However, accurate and complete records were not maintained to ensure care workers had sufficient information to act in people's best interest and provide care and support using the least restrictive option.

People were supported with their dietary needs and helped to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

We observed the service provided person centred care. It was clear the care workers had an understanding of people's needs

and preferences and put their needs first.

People were treated with dignity and their privacy was maintained by care workers who were respectful when providing their care and support.

People were encouraged to be independent and care workers used support plans to help them provide personal care in line with the persons wishes.

Is the service responsive?

Good

The service was responsive.

Care plans were written with a focus on the individual and people were supported to undertake a choice of activities.

People knew how to complain. Compliments and complaints were encouraged and responded to.

People's views and opinions were sought in a variety of ways and their ideas and suggestions were responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a clear management structure in place and care workers understood their roles and responsibilities.

Care workers told us the service was well managed and they were kept up to date with best practice from open communication creating a positive culture.

Quality assurance processes monitored the service provided to make positive improvements to benefit people's experiences of care. However, we saw these checks were sometimes inconsistent and did not always bring about improvement.

People's views and feedback was sought and people told us that if they raised issues they were dealt with appropriately.

York DCA

Detailed findings

Background to this inspection

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

The inspection took place on the 18, 19 and 20 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the main office. One adult social care inspector undertook the inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur. The registered provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spent time with three people receiving services in their own home. We interviewed five care workers and we spoke with two service managers and the registered manager. We looked at records, which related to people's individual care; this included the care planning documentation for eight people and other records associated with running a community care service. We also looked at five care workers recruitment and training records, records of audits, policies and procedures and records of meetings and other documentation involved in the running of a domiciliary care agency.

Requires Improvement

Is the service safe?

Our findings

People receiving a service were protected against the risks of potential abuse and bullying. We saw from training records that care workers received up to date training in safeguarding vulnerable adults and they discussed with us what signs of abuse they looked out for and what they would do if they had any concerns about people's safety. One care worker said, "I completed a refresher e-Learning in safeguarding training last month," and "I wouldn't hesitate to report any concerns and would record what happened, where it happened, who was involved and when it happened." Another care worker told us, "We covered training in whistleblowing, I haven't seen any bad practice but if I did I would undertake whistleblowing to senior management or the Care Quality Commission [CQC]". Care workers had access to a 'Safeguarding Adults' policy based on the Care Act 2014 and other government policy in respect of safeguarding adults and children.

We looked at people's care plans and we saw that these were written based on people's individual circumstances and included assessments for areas of risk. We saw risk assessments were linked to the areas of people's lives that were important to them as identified in the person's core assessment that had been undertaken by the local authority. Risk assessments were in place for internal and external environmental factors including, sunburn, fire, assault, awareness of danger and self-injury. Other assessments included risks from and to other people and included, abuse, self-harm, medication and finance. Where people lacked capacity to make and agree to decisions we saw risk assessments were in place and reviewed by a multi-disciplinary team of people involved with the persons care. These included family, team leaders, social worker, doctors, clinical psychologists and the local authority. This meant the registered provider had procedures in place to help support people's independence using risk assessments to identify and work within the capacity of the individual to undertake daily activities in a safe way.

People were protected from harm in the event of an emergency. We saw contingency plans were in place in the event of a natural disaster that included fire, flood, illness and other events that could affect the service. The registered provider had 'Grab bags' in place containing basic essential items for people along with emergency procedures. We saw a file containing 'Missing people' information. This had been discussed and agreed with the Police to ensure a person could be identified in the event they went missing and included a photograph, a brief overview and detailed any medication the person may have been taking.

We saw that staff had undertaken training in Fire Awareness and Health and Safety and understood the importance of keeping people and their home environments safe. A care worker told us, "Some people don't always want to leave their rooms when we have a fire drill so we have installed fire doors that will close automatically if smoke is detected to help them stay safe until emergency services arrive."

We saw that accidents and incidents were recorded. These were analysed by the registered provider and we were provided with a trend analysis for 2015. Analysis showed the number and type of accident and incidents recorded each month and we saw the registered provider had put in place actions because of the findings to reduce and learn from events. Incidents recorded included the administration of chemical restraint to people identified as part of their positive behaviour support plan. We saw the recording form

provided limited opportunity to learn from these types of incidents and to reduce re-occurrence. We spoke with the senior support worker about this and they told us this had been identified in feedback from the trend analysis. They showed us a new form that the registered provider was implementing which gave the provider additional feedback on the incidents and they told us this would be re-reviewed after implementation.

We looked at staffing at a home where a supported living service was provided to three people. We saw that the registered provider had enough suitably qualified staff to meet people's individual needs. We were told that the local authority assessed the needs associated with the people living at the home and allocated hours of support accordingly. The senior support worker told us, "We have sufficient staff to work with people to provide one to one support." They said, "We set up the rotas a month in advance and adjust staffing dependant on activities with people and to meet peoples changing needs." Care workers we spoke with told us, "We never seem to have problems with staffing and we don't need to rely on agency staff either."

We looked at the recruitment files for five care workers. We saw that the dates were recorded for when references and Disclosure and Barring Services (DBS) checks had been received. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The registered manager advised us that care workers shadowed experienced workers and had recruitment checks in place before being allowed to work independently. It was clear that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. A care worker said, "We go through a strict recruitment process; we can't start to work with people until all our checks are carried out and are satisfactory." This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

The registered provider had a medication policy and guidance in place however; we saw different versions of guidance and procedures were being used in the three homes we visited. Guidance was signed by employees in one home we visited to demonstrate they understood any changes but the policy did not include procedure on the administering and management of medications where people may lack capacity to do so under the Mental Capacity Act 2005 (MCA). The registered provider had undertaken analysis on the management and administration of medication due to a high number of errors recorded on the annual evaluation of incidents recorded. They told us further work was underway to improve the process.

Care workers we spoke with told us they had received training in medication. We looked at care workers files and we saw care workers involved with medication received appropriate up to date training. A care worker we spoke with told us, "We undertake classroom based training before we observe experienced staff administering medication," they continued, "Experienced staff will then observe us and assess our competency and sign us off when they are happy." The registered manager showed us some limited information regarding documented competency checks for care workers administering medication. They told us, "Not all checks have been recorded but we are now monitoring this centrally to ensure they are all up to date." This helped to make sure people received their medication in a safe way from care workers.

We saw people had a specific file relating to their medication needs. The file was detailed and included information on the name of the medication, the reasons for the person taking the medication, any side effects, any allergies and included a profile for medication taken as and when required, known as PRN medication. People's daily medication was recorded on a Medication Administration Record (MAR). Despite the information available, we saw one person's file contained a PRN medication cream. We saw this had been applied to the person as the result of a fall but there was no additional information on how or where the cream should be applied in the persons file. We spoke with the service manager who told us, "The files

have just been updated; we will be undertaking some further checks to make sure all the information is up to date." We visited a second home and looked at MAR charts for two people. We saw one person's medical profile contained a PRN for Controlled Drugs (CD's). Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called Controlled Medicines or Controlled Drugs (CDs). Documentation in the persons file referred to the person's 'Positive Behaviour Support Plan' for guidance on administration of the drug. We looked at this document and saw there was no reference to the PRN. We looked at the MAR charts and associated records for the PRN. We saw the PRN had been recorded as administered on two occasions but only initialled on one of those occasions with a recording of 'G' for the second occasion. A 'Sign Out' stock control sheet had been completed for only one of the dates recorded in the MAR. We checked the balance of the stock and found it was correct. We spoke with a care worker about this and they told us, "Care workers should always initial the MAR and never record 'G' for 'given'." The care worker told us they did not know if the medication had been administered on both dates recorded in the MAR chart. We saw additional gaps on the MAR charts for other medication and we were told that this was because there was insufficient information on the prescription that we saw stated, "Use daily." This meant that care workers responsible for the administration of medication to people did not have enough up to date information and that records of administration were not maintained or complete and failed to ensure people received their medications consistently as prescribed in a safe way. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People received consistent care and support from regular care workers and it was clear from our observations and from talking to care workers that they knew people and understood their needs.

A care worker said, "We have good staff retention and a good relief bank of regular care workers for cover which means people know the care workers even when someone is off; which is really important for people." Another care worker said, "We do sometimes use agency but it's rare to see new faces; they are more like employees and we all know each other." We saw care workers completed a one-page profile about themselves and people receiving a service told us they were involved in the selection process at interview to make sure they were of suitable character.

The registered provider had an on-going induction process for new employees. The registered provider told us on the provider information return (PIR), 'All staff receive a thorough induction that is specific to the service they are working in.' New employees attended a one-day induction to the fundamental aspects of their role. They were then allocated to the person's house to work with and shadow existing employees where they undertook additional training and got to know the people they would be working with. A care worker told us, "The induction process is quite informal but they [Registered provider] make sure we have all the correct skills and competencies to carry out care and support activities with people." All new care workers were enrolled on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. It assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care.

Training was managed centrally and care workers received notification when it was due to expire. The system enabled the registered provider to ensure care workers had undertaken all mandatory training and that refresher training was scheduled and undertaken. The registered provider told us on the PIR, 'There are a number of courses which all staff undertake; however a training needs analysis identifies additional bespoke training that is required for each individual service, e.g. epilepsy, autism etc.' We looked at training records and saw care workers had received up to date training that included safeguarding, medication, moving and handling, challenging behaviour, Mental Capacity Act (MCA) and first aid. We also saw that service specific training had been undertaken by care workers in epilepsy, diabetes and autism. This meant that care workers were supported to have the appropriate skills and knowledge to meet people's individual needs.

We saw care workers received regular one to one meetings with their line manager who provided observations and feedback on their practice. As part of the review, feedback was documented from the people who care workers cared and supported. We saw this included, 'What the worker does well' and 'What the worker could do better'. Feedback was discussed and where appropriate additional training was provided and additional mentoring was offered to support care workers and improve their practice. One care worker told us, "I have supervisions at least every six weeks, they are a good opportunity to reflect on previous meetings without interruption and they are centred on us and the people we care for."

Care workers had received training and understood the requirements of the MCA. A care worker said, "We have to assume people have capacity and encourage people to make their own decisions." The 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. For people living in their own home, this would be authorised via an application to the Court of Protection. The registered manager told us, "Staff receive training in the MCA." They said, "Where peoples capacity is under question we work with other health professionals from systems house [The Community Team for People with a Learning Disability] GP's and the City of York council to address those concerns."

We looked at the care files for four people with severe learning disabilities. Initial assessments of need and capacity had been carried out by the local authority. These were detailed and provided a basis for the persons support package. We saw these should be reviewed annually however; one core assessment was last reviewed in November 2013 and another in September 2014. We asked the registered provider about this and they told us, "We should review the core support plan every year but we need to involve other health professionals in the review and that is not always easy to do." They continued, "To ensure people's support is reviewed regularly and continues to meet their needs, we hold person centred reviews with the person and other people they want involved; the Local Authority are always invited to these but do not always choose to attend." They said, "The Local Authority are responsible for reviewing their assessments and they state that they should review these annually." "This is not always the case however we are not responsible for the Local Authority and unfortunately have no influence on when they conduct their reviews." We saw, where people lacked capacity that this was recorded in their files. We saw 'Best Interest Assessments' that had been carried out were up to date and that these were reviewed. The assessments included detail of who was involved with the decisions, representation on the wishes and feelings from the person and we saw that any religious, cultural or moral beliefs had been recorded. Best interest assessments should include documentation that the decision is the least restrictive, that alternatives had been considered, pros and cons of the decision, and include consideration of the MCA code of practice if there is a disagreement. Option to include this information was included in the assessment form we looked at but the information was not always completed with enough information to ensure staff understood why the decision had been made. We spoke with a senior support worker about this and they told us that the information in care plans was being updated and would be included.

We asked management and care workers how they managed challenging behaviour by people. The registered manager told us, "Where it is identified as part of the core assessment that a person may pose challenging behaviour we use a British Institute of Learning Disabilities [BILD] accredited training provider to assess the level of 'Positive Behaviour Support' and restrictive training required to keep people and staff safe from harm." Training records showed that care workers had received appropriate training and those we spoke with confirmed it was at the right level to keep people safe. Care plans we looked at contained a 'Positive Behaviour Support Intervention' assessment for people. We saw this included a specific physical intervention visit by a BILD trainer and a documented training level had been applied with details of those staff involved. This information was supported with further documented risk assessments and support plans. On occasion, we saw this information was not fully completed and we were told by a senior support worker this may have been because of the updates to care plans and possible duplication of the information recorded elsewhere.

We saw the use of chemical restraint was recorded in the care plans for two people we looked at. It was

documented why chemical restraint had been used on one occasion for one person. We asked the service manager about this and they told us, "Chemical restraint was used as the person became anxious that they were not permitted to undertake an activity due to associated documented risks. They told us this information was documented and it was in the person's best interest not to undertake the activity at certain times. We were provided with a specific decision making record and a copy of the 'Best Interest' assessment but this did not indicate the restriction concerning the activity. The specific decision making record was not signed by the person making the decision or the assessor, and was not approved by the key decision maker or the person. A review by a consultant psychiatrist documented, 'Such instances can be controlled using distraction techniques and [chemical restraint] has not been used since.' There was no clear documentation to confirm if the use of chemical restraint with the person was the least restrictive option at that time of the incident or if staff on duty had access to enough detailed information to ensure they responded to the persons needs in the least restrictive way and in line with the MCA. We were unable to view the persons Core Assessment, as this was not available in their file. We asked the service manager for the additional documents and they advised us they were updating the files and had archived the most recent. They provided us with a copy of this document after the inspection that was dated September 2014. Further guidance in the persons medication file was confusing and included a medication policy dated 2016, a medication policy dated January 2016, medication guidance dated January 2016 and a medication procedure. This meant that accurate and complete records to demonstrate why chemical restraint should be used were not available in the files we inspected.

We saw information in another person's care file contained a Core Assessment dated 2013. The assessment stated, 'Should [person] be prescribed any medication they would need full support to take it.' Additional information, confirming 'any known difficulties in taking or managing medication' and 'the level of support required' were not completed. An additional care plan for 'Covert Administration of Medication' was evidenced in the persons file. Covert Administration of Medication is a process of administering medicines in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. This identified the person had 'No capacity to understand taking medication' and referenced the 'Mental Capacity Assessment.' This was not available in the persons file. We were shown a 'Functional Assessment' document that identified covert administration of medication. We asked the registered manager for this and they showed us another file from the person's home but the requested information was not available.

We looked at a care plan and saw the person had stool monitoring charts in place and an epilepsy seizure chart to record any patterns for evaluation. We saw these were not always completed. We asked the care worker about this and they told us their symptoms had improved but they told us the records should be updated. They said, "The service manager is reviewing all the files as part of changes to the care plans and this should be picked up as part of the review."

Accurate and complete records were not maintained to ensure care workers had sufficient information to act in people's best interest and provide care and support using the least restrictive option. This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with their health. Care plans included records of treatment and involvement by other health professionals. We saw that where people had communication problems the registered provider had involved a Speech and Language Therapist (SALT) and further guidance was available for care workers to reference that supported this. People were supported with their nutrition and were supported to eat a healthy diet. We saw support plans detailed what people could do on their own and what they could do with support. We observed people in their homes helping with food preparation and they told us they helped with the shopping list. A care worker told us, "I always try and encourage people to try new things to eat and

always give them options." Another care worker told us, "If I had concerns about a person's health I would discuss with the senior and we may refer them to a dietician or a GP." This helped to ensure that people gained sufficient support with eating and drinking to maintain a balanced diet.

Good

Is the service caring?

Our findings

During the inspection, we observed that care workers knew the people they cared for and that they understood how to treat them with dignity and respect. People were addressed in the way they wanted to be and we saw care workers spoke with people calmly and that people responded in a positive manner when spoken with.

We asked care workers how they got to know people's likes, history and their preferences. One care worker told us, "There is a lot of information in people's care plans but we have a small team with staff who have known individuals for a long time; they know how to care for people and are really supportive if I need any guidance." Another care worker said, "We are fortunate to spend a lot of time with people, I treat them like family; it's about building up a relationship with them." We saw where possible people had been involved in their care planning and reviews. Where people did not have capacity the registered provider had involved other professionals, family and other close people involved in the person's life.

Experienced care workers ensured that new care workers and people were matched. We were told that people were regularly asked if they were happy with their care worker and if they were not arrangements were made to ensure people received care from the most appropriate person to meet their needs. The registered provider told us on the provider information return (PIR), ' Each of the people we support have a Decision Making Profile which provides information to staff on how the person needs to be supported to make their own decisions about their support and their lives.'

We saw that people receiving a service had any disability needs documented in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw these needs were adequately provided for within the service and by peoples own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care workers told us and we saw from care plans that people, their families and advocates were involved with their care and support planning. They said, "When we have reviews we always include family members along with other care workers and health professionals involved with the persons care and support." The registered provider told us on the PIR, 'People also have a Communication Profile to ensure that staff know how to communicate effectively with that person to support them to make and communicate their decisions." A care worker told us, "Communicating with people can be a challenge, for example [Person] has limited capacity to talk but I know if I hold my hands out the person responds by taking my palm and smiling if they are happy with my suggestion." They said, "Everybody is different but most people can be understood." A care worker told us, "If a person has an identified lack of capacity to make an informed decision we can support them using an advocacy service or someone who knows them well." Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

Care workers received training in maintaining people's privacy and confidentiality and in treating them with

dignity and respect. A care worker told us how they maintained people's privacy at bathing time using towels and dressing gowns to keep them covered and said that they made sure curtains and doors were closed. The care worker told us, "One person likes to have a bath but had suffered a seizure so to meet with their preferences we run a small bath and keep the bathroom door slightly open so we know they are safe." Another care worker told us, "I always knock and wait for a response before going into someone's home, and then discuss with the person what we are going to do with regards to personal care and I ask them if its ok and encourage them to help where ever they can." We observed care workers knocked and waited for permission before entering people's homes. Care plans contained detailed information to help care workers provide personal care and included information on what the person could do themselves, what the person did with help and what staff did. A care worker said, "Care plans have detailed information that we can refer to when providing a person's personal care, it really helps if people have problems with communicating their wishes or when there are new staff helping."

We looked at how the registered provider supported people with their end of life wishes and preferences. The registered provider told us on the PIR, 'This is an area of increased focus over the next year as not everyone has an end of life plan at the moment; although it may not be appropriate for all the people we support,' and, 'We have two people who are currently considered to be at the end of life and we have supported them to have plans in place for the future.' We spoke with the registered manager about how they supported people's to make their preferences for end of life care known. The registered manager told us they were reviewing the process and were updating care and support files to include people's preferences and to ensure choices for their end of life care were clearly recorded, communicated, kept under review and acted on.

Good

Is the service responsive?

Our findings

We saw from care plans that where ever possible people were involved in discussions regarding their care. Where this was not possible, due to lack of capacity we saw that discussions were made that included individuals that were closest to the person and who understood their needs. Care plans were reviewed every six months and were updated because of feedback from people, their families and others. We were told they were reviewed on a formal basis every year and we saw the annual review included the local authority, G.P and other health professionals. The service manager at a home we visited told us they made the annual review a special event. They told us, "We encourage the person to bake cakes and we have a bit of a party to make the review as informal as possible and to encourage the individual to contribute," they said, "We use the annual review to celebrate success and achievements by the person during the year and to set new goals for the coming period."

Care plans contained a spider web pictorial that showed the individuals who were closest to the person with their names at the centre of the web and others involved in their care documented away from the centre. This was reviewed as people's needs changed and helped to ensure that the care delivered was responsive to the person's changing needs.

We looked at people's care files and we saw they were thorough and focused on the person. People's care plans we looked at contained information on 'What I like to be called', 'How I like and need my support' and, 'Things you need to know about me'. This recorded a person's preferences, wishes and useful information that helped them to receive personalised care and support.

Information on activities was documented. We saw one person 'Liked to go on the trampoline', 'Enjoyed cooked meals' and, 'Drives out.' This information was used by care workers to help provide people with the activities they enjoyed. A care worker said, "It doesn't matter what the person wants to do as long as they are safe; we encourage them to undertake as many activities and interests as possible." Another care worker told us, "We have to try new things with people; sometimes they suddenly change the activities they enjoy so we need to have other things they can do to keep them happy." In addition, "We need to understand what people like in order to reduce any interventions we have in place." We saw people's homes contained a weekly timetable of activities events and times. People we spoke with told us they undertook activities such as horse riding, going to shows and visiting a birds of prey sanctuary. A person told us, "I go horse riding every week on my own." Care workers told us, "We arrange a taxi for [person] that picks them up each week and takes them to the showground." We saw trophy's that the person had won in competitions.

The registered provider had a service in place called, 'The Boot Shop'. We spoke with the manager of this service who told us, "The Boot Shop provides adults with learning disabilities the opportunity to take up a range of employment opportunities." They told us and we saw that people helped with administration duties in the main office and were encouraged to take up paid and voluntary employment in the community. The manager said, "It's great that we can offer people the opportunity and we encourage them to achieve their potential."

We saw from care plans that the registered provider had implemented a 'Life Star.' This was used to monitor a person's progress or decline in daily living activities. A service manager told us, "The star is really useful, it is used to provide guidance on the person's journey of change; sometimes there is no improvement or decline but that can mean stability which is equally important." They added, "We can focus care and support and respond to changes where the identified need is greatest."

People were encouraged to offer feedback, share their experiences or raise any concerns. A care worker we spoke with told us, "People know how to complain and raise concerns." They told us people held their own tenants meetings where they put together an agenda, discussed a range of issues and celebrated achievements. The care worker said, "One person raised concerns at the tenants meeting that someone had been rude to them at a tea dance," they continued, "We helped the person write a complaint to the organiser."

We spoke with a care worker in a home where the people lacked the capacity to make decisions and had limited ability to communicate. We asked the care worker if they thought people understood how to complain, they told us they observed people's behaviour in particular their body language. They said, "If I noticed a change in people's behaviour, particularly if it became more challenging when I asked them if everything is ok then I would report it." The registered provider told us on the provider information return (PIR), 'United Response has a 'Complaints' policy that is followed locally and all complaints are investigated and responded to, with any actions or recommendations documented and implemented' and, 'The people we support and their relatives are given information on how to complain in a format that is accessible to them.' The registered manager showed us a comprehensive policy and procedure on recognising, receiving, managing, and responding to concerns, complaints comments and compliments. The document included information on dealing with all categories of concern from people, employees and others. We saw six complaints had been received during 2015. These were analysed and we saw that none of the complaints had come from people receiving the service but were from external parties and family members. The registered provider identified that this was indicative of other people involved in people's care and support knowing how to complain and were confident in raising complaints and concerns if necessary. We saw all complaints were substantiated and actions were implemented to help reduce re-occurrence.

People had a Health Passport in their files for use should they need to transition between services. This documented any medication, health concerns and other personal information agreed with the NHS. The registered provider told us on the PIR, 'When people move on from us, we will support the provider to develop their plans and share (with consent) the information we have built up with the person over time' and, 'For any transition we would typically work alongside the existing/new provider to ensure a smooth transition.' This meant people were supported and had their needs recognised should they have to transfer or move to services, more appropriate for their needs and that they continued to receive consistent co-ordinated care.

Requires Improvement

Is the service well-led?

Our findings

Care workers spoke of a positive culture and a registered provider that put people first. A care worker told us, "All management and staff are good at what they do; I feel valued as an individual and receive really good support both on a work and on a personal level." Another care worker told us, "The service promotes a high standard of care and ensures people have their views respected and their independence promoted." They said, "We work with a variety of health professionals to ensure that we introduce person centred care and support that works; our target is always to reduce interventions and improve people's lives."

There was a clear management structure in place and care workers had an understanding of their roles and responsibilities. The registered provider had a registered manager in post that assisted us with our inspection during our time at the main office. Each shared living home had its own service manager who supported with the inspection at the homes we visited along with senior support workers. The registered provider told us on the provider information return (PIR), 'We have a skilled and experienced management team that provides operational management, leadership and practice leadership on a day to day basis with each service having a designated service manager.' The registered manager told us they were supported with extensive training through a 'Management Development Program' that covered a range of areas that included practice based training, financial procedures and people management courses. This meant the registered provider supported employees at all levels to ensure they had up to date skills and knowledge to remain updated with best practice and maintained the visions and values of the service.

The registered manager understood the requirements of their registration with the Care Quality Commission (CQC) and they were able to discuss notifications they had submitted as part of their registration.

The registered provider told us on the PIR, 'Regular All Staff Briefings are sent out to all staff as well as magazines each tailored to share information with people, families and staff including Your Link, Easy Read News and In Touch magazine.' We saw the 'Easy Read News' contained information in an easy read format suitable for people with learning disabilities about current affairs that included the Queen's birthday and the European referendum. This meant people were able to understand and were provided with information on everyday events.

The registered provider told us how they rewarded their employees and involved them in shaping the service. A service manager told us, "We have a reward scheme for all staff and in addition they can access on-line discounts; it's not much but it does seem to be valued by our employees." They told us, "We have regular one to ones and discussions each day where share good practice and communicate changes not just about people but about the organisation, training and new initiatives." A care worker said, "It is the best place I have ever worked in particular where management are so aware of including us in discussion." They continued, "We are often asked our feedback and we often ask people for their feedback, for example people living here had a monthly tenants meeting but as they live together they didn't have a lot to discuss so we changed it, at their request, to every six weeks."

The registered provider told us and we saw they had started to review and update information in people's

care files. We saw where this had been completed information was available to support and care for people in line with their documented needs and wishes. However, we saw that where this process had not been completed there was insufficient or too much duplicated information. We saw this was confusing for care workers and service managers who were unable to evidence some information we requested. The registered manager told us there was more work to be done to ensure records were accurate and were a true reflection of the up to date needs of the individual being supported.

We saw the registered provider had appropriate recording and reporting systems in place to collate information and identify any trends or patterns such as accident and incident reporting, complaints and safeguarding alerts. We saw learning because of these processes included action plans and additional training where appropriate.

We looked at minutes of staff and service user meetings. Care workers and people using the service told us and we saw from care plans that the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people. The registered provider worked with a range of services and health professionals including the local authority, local GP practice, district nurses, CPN's, consultant psychiatrist and speech and language therapist. This helped to ensure a multi-disciplinary agency approach was used to meet peoples care and support needs.

The registered manager showed us a comprehensive range of quality assurance audits and monitoring. We saw this included annual service reviews, analysis and evaluation of training and quarterly audit review and trend analysis. The quarterly audit targeted what the service had done well, areas for improvement and what areas to focus on for the next quarter. Areas we saw feedback on were, finance, one to ones, health and safety, records checks, support planning, risk management, staff awareness and practice. Analysis found the service did well for example in 'good systems for managing medications' and 'staff knew how to respond to a complaint' and not so well for example in 'administering medication' and 'reviewing and updating documents'. Feedback from the audits was addressed in an action plan and feedback brochure for employees. This meant the registered provider undertook appropriate checks and had measures in place to evaluate and improve the service and practice for people employees and others.

Despite the quality assurance checks in place, we found during our inspection that management of medicines and care planning were being audited but we had concerns about these areas of practice. This made us question how effective the audits were.

Record keeping within the service needed to improve. Standards of record keeping were observed to be inconsistent across the homes we visited. Duplicate back up files held in the main office were not well maintained and did not always reflect the information held in people's homes. We saw evidence that medicine records, care plans and risk assessments were not always accurate or up to date. This meant that staff did not have access to up to date and complete records in respect of each person using the service, which potentially put people at risk of harm. These areas were judged to have a minor level of risk to people using the service and a low impact on people's health and wellbeing.

Although the registered manager told us about a number of planned improvements, we found that records were lacking in information and not reflective of people's care needs. This was a breach of Regulation 17 (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Processes and systems to manage medications in a safe way for people were ineffective. Accurate and complete records had not been maintained and the registered provider had not robustly assessed, monitored or mitigated the risks. Breach of Regulation 12 (2) (c)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and complete records were not maintained to ensure care workers had sufficient information to act in peoples best interest. Breach of Regulation 17 (2) (b) (c)