

Face 2 Face Care Limited

Face2Face

Inspection report

Unit 17
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Tel: 01452520011

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Face2Face is a supported living and domiciliary care service providing personal care and support to adults with learning disabilities and/or mental health needs. At the time of the inspection five people using the service were receiving the regulated activity of personal care. These five people lived with others who received support which is not regulated.

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

Systems in place to monitor the quality and safety of the service people received had been improved. However, more work was needed to ensure these systems were fully effective in addressing shortfalls. Lack of consistency in management of the service had meant advice from health care professionals about the support people needed had not always been followed-up as expected. People, relatives and staff were positive about the provider and the support people received from staff.

The service was safe. Improvements had been made to medicines management and review of incidents and accidents, to ensure people received a safe service. Health care professionals were involved in reviewing people's support needs.

The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. People's opportunities to follow their goals and live as full a life as possible had been impacted by COVID-19. The service had reviewed restrictions on people's activities and movements in line with national guidance.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

When people's capacity to consent to their care and support was in question, capacity assessments had been carried out. Where people's liberty was restricted, the provider had informed the local authority who had commissioned care and updated them regularly.

The provider worked openly with others and reported incidents to external agencies as required.

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 29 July 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they

would do to improve and by when. At this inspection we found not enough improvement had been made and the provider was still in breach of the regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

We carried out an announced inspection of this service on 12 and 18 June 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when, to improve safe care and treatment and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has stayed the same. 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 Face2Face on our website at www.cqc.org.uk.

Enforcement

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 to discharge our regulatory enforcement functions, required to keep people safe and to hold providers to account, where it is necessary for us to do so.

We have identified one breach in relation to good governance at this inspection.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-Led findings below.

Face2Face

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 Care Act 2014.

Inspection team

The inspection was carried out by one inspector.

Service and service type

This service provides personal care and support to people living in seven '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 service is also registered to provide domiciliary care. Face2Face's 'outreach' service provides support to people living in their own houses and flats. People using the outreach service were not in receipt of personal care at the time of the inspection; Therefore, this inspection did not include the domiciliary care service.

The service did not have a manager registered with the Care Quality Commission, but an application had been submitted by the manager. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. 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 25 August 2020 and ended on 10 September 2020. We visited the office

location on 26 and 27 August 2020.

What we did before the inspection

We reviewed information we had received about the service since the last 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 requested documents related to infection control and management of the service from the provider. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection site visit

We visited one supported living house and spoke with two people who used the service about their experience of the care provided. We observed two staff members while they were supporting people at the house. We spoke with four members of staff including the manager / area manager, service manager, peripatetic manager and quality auditor. We reviewed a range of records. This included four people's care records and three people's medication 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 rotas and incident records were reviewed.

After the inspection site visit

We spoke with three people's relatives about their experience of the care provided. We spoke with a further five members of staff including two senior care workers and three care workers. We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies, business continuity plans and quality assurance records, including those related to coronavirus. We received feedback from five professionals who regularly visit the service.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Using medicines safely

At our last inspection the provider had failed to manage people's medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People received their medicines as prescribed. The provider involved health professionals in reviewing people's existing prescriptions and use of homely remedies. Medicines administration records and 'as required' protocols had been updated to ensure they reflected current prescriptions and recommendations.
- Systems for ordering, checking, safe storage and returns of medicines had been reviewed. Timescales and staff responsibilities in each area had been defined and implemented.
- Systems for checking medicines practices were in place. This included medicines counts, weekly in-house audits, provider audits, staff training and competency checks. Provider audits had identified when further improvement was needed to ensure expected standards were met.

Systems and processes to safeguard people from the risk of abuse

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.

At our last inspection the service had not always applied principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

- Sufficient improvement had been made to meet the principles of the MCA, however more training was needed to improve MCA assessment records and related guidance for staff in people's support plans. MCA

assessments had been completed and where people had been deprived of their liberty, social services had been informed and kept updated by the provider.

- Systems were in place to protect people from the risk of financial abuse. This included referral of people who needed support with managing their money to a financial advocacy service. Records and receipts were kept by staff assisting people with their shopping and social activities. Regular checks were done to ensure balances were correct, spending was appropriate and accounted for.
- Staff received safeguarding training at a level appropriate for their role. Staff knew how to respond if a person raised a concern to them, what to do if they found any injuries, or had concerns about how others interacted with the people they supported. Staff knew which external agencies should be involved and how to contact them.
- The provider kept records of safeguarding incidents, action taken and agencies notified. A log of safeguarding concerns was maintained so trends could be reviewed. All incidents had been notified to the Care Quality Commission (CQC) as required.

Learning lessons when things go wrong

At our last inspection we recommended the provider review their management of accidents and incidents and ensure reporting responsibilities were understood within the service as a priority. The provider had made improvements.

- Managers had ensured staff understood their reporting responsibilities. A weekly audit was completed in each household to ensure all accidents and incidents had been reported. An accurate log of incidents and accidents had been maintained for the service from April 2020.
- All accident and incident reports were reviewed by a manager and action was taken to prevent a reoccurrence and manage emerging risks. This included review of support needs and plans, involvement of health and social care professionals and reporting to external agencies.
- A monthly review of accidents and incidents was done by the provider to identify trends and ensure all appropriate action had been taken by managers. Following a safeguarding concern, the provider arranged additional training for staff supporting people in one household, in response to a person's escalating anxiety related behaviours.

Assessing risk, safety monitoring and management

- Risk assessments and support plans had been reviewed and rewritten for all people who used the service in May 2020. People the service supports and staff who knew them well had been involved in this process and reference had been made to social care needs assessments.
- Actions staff should take to meet people's more complex support needs were not always clear in support plans. Advice from health professionals was missed when one person's risk assessments and support plans had been updated. This was rectified immediately and manager's took action to ensure staff understood how to support this person safely, in-line with these recommendations.
- Staff we spoke with understood the risks to people and described how these were managed. Staff said, "Sometimes there are things that you need to check, grey areas" and "People need time and patience and not too much swapping around of the staff team. The more you stay with them, the more you learn". Healthcare professionals and relatives had no concerns about people's safety. A relative said, "He's very very safe. They're [staff] really really careful."
- Health and safety checks were completed in supported living houses to ensure people's homes were safe. This included fire checks and regular reviews of people's emergency evacuation plans.

Preventing and controlling infection

- The provider's contingency plans, policies and procedures had been continuously reviewed and updated in response to coronavirus and related national guidance. The provider ensured easy read versions and social stories were available to help people understand and adapt to the additional measures put in place to protect them. Relatives had been informed about the changes needed and told us they were happy with the action taken by the service.
- Risk assessments and audits ensured infection control risks to individuals and service provision were managed effectively. When one staff member tested positive, appropriate measures were taken to control the risk to others including reducing staff movements amongst houses and informing stakeholders. The service had not experienced an outbreak of COVID-19.
- The provider ensured enough personal protective equipment (PPE) was available to staff and staff were using PPE in line with government guidance. Staff and visitors were checked for symptoms on arrival at the service and staff ensure they followed the procedures in place.

Staffing and recruitment

- Sufficient staff had been recruited to meet people's funded support hours. Staff covered additional shifts whenever possible to avoid use of agency staff. A senior staff member was allocated to each supported living house, their role included completing audits, staff support and supervision and implementing changes requested by managers.
- The provider's recruitment team were responsible for flagging any areas for follow-up to managers, such as ensuring evidence of previous conduct was obtained. The manager understood recruitment requirements and sought an explanation when we noted one staff member's previous conduct and reason for leaving their previous employment in care had not been recorded. New staff completed an induction and three-month probationary period where their suitability for the was monitored.
- People and their relatives were complementary about staff. We saw people were relaxed in staffs' presence. One relative said about Face2Face, "Their strongest part is definitely the staff. They choose the most amazing staff."

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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

At our last inspection the provider's systems to monitor the safety and quality of the support people received had not always been robust enough. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had improved the systems in place to monitor its services. This included regional and national level reviews and introduction of internal quality auditors. However, there had been some delay in making the required improvements at service level due to changes in the service management team,
- Significant progress in establishing processes and audits to monitor quality and safety of the service had been made in the four months before the inspection. However, the effectiveness of the newly introduced monitoring systems still needed some improvement to ensure shortfalls would always be identified and acted on promptly to reduce risks to people.
- People with more complex needs and higher risks had not been prioritised for scrutiny in provider audits completed from June to August 2020. Hence the opportunity to identify shortfalls which could have a higher impact on management of risk in the service had been missed. It had not been identified that support plans around people's more complex needs did not always include advice from health professionals or have enough detail about action staff should take. We did not identify any impact on people as staff knew how to support people safely. Where risks to one person had reduced, overnight monitoring had not been reviewed to ensure this remained appropriate.
- Improvements needed to the recording of MCA assessments and consent were identified in a provider quality audit in July 2020. We found the service had not taken effective action to address this shortfall prior to our inspection.
- Areas for improvement found on the provider's audit on 12 August 2020 had not prompted checks to establish whether these were isolated to one household, or indicative of a wider need in the service. We identified similar areas for improvement in the household we visited, as had been found at the provider audit. This included missed healthcare appointments not being followed-up. Effective action had therefore

not been taken when audits did identify issues.

We found no evidence that people were not supported safely, however, we found the systems in place to monitor and improve the quality of the service were not always effective and complete records had not always been maintained. This was an ongoing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to ensure all recommendations from health professionals had been included in people's support plans.

Working in partnership with others; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Lack of stable management within the service had presented challenges in establishing effective working relationships. Health care professionals said continual management changes had also an unsettling effect on some people the service supported. External professionals lacked confidence in the service's ability to implement their recommendations. A health care professional said, "We have often agreed action plans which have been 'lost' or failed to be carried through, leading to us essentially having the same meeting several times over with different managers, or the team getting in touch to request further support around clients without having enacted previously agreed plans".

- The provider had sought the views of people and staff, feedback from relatives had been requested. Feedback from people was positive and action had been taken in response to staff surveys. Staff were positive about the management team and recent improvements they had made. A staff member said, "Things that are meant to be in place are now in place. They are keeping tabs on it. They are coming to the houses, have a structure. We know what needs to be done and what is expected from staff."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. 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 worked openly with others including CQC. They had provided requested updates on action plans and participated in regular monitoring meetings with the local authority.

- Relatives could access an online portal where they could view information about their relative's daily care and activities. When one relative said they were unhappy with their level of communication with the service, the manager told us they would contact them and ensure they had access to the portal. Relatives were kept updated of significant changes to the service and of any incidents which may impact their relative.

- Staff and relatives were positive about the service. Two relatives described the level of support and caring their relative received from staff as being, "the best" they had experienced. A staff member said they were enjoying working for Face2Face and added, "It's one of the better companies to work for".

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider's systems to monitor and improve the quality of care and support that people received had not always been effective. Complete and contemporaneous records had not always been maintained.</p> <p>Regulation 17(1)(2)(a)(c)</p>