Supported Lives Services Ltd

Supported Lives

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Supported Lives provides a domiciliary care service, providing support to people in their own homes. In addition it provides service to people living in three supported living settings. In these instances people's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support. These services are provided to people with learning disabilities in the Bradford and Calderdale area. The provider of the service is called Potens.

Not everyone using Supported Lives receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do provide regulated activity we also take into account any wider social care provided.

We undertook the inspection between 20 October 2017 and 3 November 2017. The inspection was announced which meant we gave a small amount of notice of our visit to the providers office to ensure a manager would be present. At the last inspection in September 2016 we rated the service 'Good' overall. At this inspection we found the quality of the service had deteriorated. Feedback from relatives and staff was poor. They said that the service was no longer reliable, calls had been cancelled and management did not get back to them about their concerns and complaints. People said the staff delivering care and support were kind and caring.

Medicines were not managed safely as there was no proper oversight of the medicines management system to ensure staff were working safely and adhering to best practice.

Whilst people and relatives said people were safe in the company of regular staff, we received complaints that people's care was provided by staff that were unfamiliar with people's needs. We received complaints this caused upset and worry to people and their relatives.

Safeguarding procedures were in place. We saw evidence they had been followed. However, concerns about staff conduct had not been properly logged and investigated. Risks to people's health and safety had been assessed but many assessments were out of date. Staff and management told us they thought they did not reflect people's current needs. Incidents were not consistently recorded and properly investigated.

There were insufficient staff deployed in the right places to ensure a consistent and reliable service. People, relatives and staff reported missed and cancelled calls and some staff arriving without the necessary skills to deliver appropriate care. There was a lack of staff available to undertake duties such as supervision, spot checks and care reviews.

People said regular staff had the right skills and knowledge to care for them. However we saw there was no effective system in place to monitor staff training and ensure it did not expire. We saw a number of staff were not up-to-date with their required training. Staff said they did not feel supported by management. There

had been no recent support mechanism such as meetings, supervisions or appraisals.

People and relatives reported appropriate support at mealtimes, although we saw issues with the reliability of the service had impacted on the consistency of this support.

We concluded the service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) although where people lacked capacity more information needed to be recorded to robustly demonstrate this.

People said the staff delivering care and support treated them well. We saw some good relationships had developed between people and regular staff. Staff demonstrated they cared about the people they were supporting. However we found the service as a whole did not treat people well as people had been let down with cancelled visits and not being informed who would be offering care and support. People were not always listened to as the office did not always get back to people and meetings and reviews no longer took place.

People's care needs were assessed prior to using the service. However these had not been regularly reviewed and staff and management said they were no longer an accurate reflection of people's needs. Reviews and meetings had stopped early in 2017 which meant that mechanisms to respond to people's changing needs were no longer in place.

The number of complaints logged by the service did not reflect the widespread concerns reported by relatives and staff. The manager told us they recognised complaints had not been properly logged. Relatives said their complaints had not been appropriately responded to.

We identified widespread failings in the service which should have been prevented from happening through the operation of robust systems of governance. There was a lack of oversight of the service with office staff unable to tell us about people's needs and whether there was anybody who was particularly at risk due to the service's current failings. Audits and checks did not consistently take place to check the service was operating appropriately.

Mechanisms to obtain and act on people's feedback were not in place and relatives said they didn't feel listened to.

A new manager had been appointed and senior managers were regularly working at the service to help ensure improvements were made. Management were open and honest with us about the current failings and following the inspection they sent us an action plan and supporting documentation stating how they would ensure the service was improved.

We found seven breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the report.

The overall rating for this service is 'Inadequate' and the service is therefore placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Whilst people said they felt safe in the company of regular staff, risks to people's health and safety were not regularly assessed and reviewed by the service. Incidents and accidents were not properly logged and investigated.

Medicines were not managed in a safe way as there was a lack of oversight and monitoring of the support staff were providing.

There were not enough staff to ensure that people received a reliable and consistent service. A lack of staffing resources in the office had led to care reviews, supervisions and spot checks ceasing to occur. Staff were recruited safely to the service.

Is the service effective?

Inadequate

The service was not effective.

Whilst relatives praised regular staff, people had not always received consistent and familiar care workers. Training systems were not well organised and staff training was not kept up-to-date.

Staff said they felt support from management was poor. They had not received recent supervision, appraisal or any spot checks on their practice.

People and relatives said that appropriate mealtime support was provided, although we found staffing issues had impacted on the consistency of this support.

People and relatives said consent was sought before staff offered care and support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives praised the staff that delivered care and support and said they treated people well, with kindness and

compassion. Staff we spoke with demonstrated they cared about the people they supported.

People did not feel respected by the management of the service, said concerns were not acted on and communication was poor.

Key mechanisms to obtain and act on people's views such as care reviews and meetings had not taken place, creating a barrier for people to air their views.

Is the service responsive?

Inadequate

The service was not responsive.

People's care needs were initially assessed although many of these assessments were out of date. Whilst some people said appropriate care was provided, a lack of reliability and consistency meant some care needs were not met.

People did not receive regular reviews of their care and support.

Complaints were not properly acted on and many people were unhappy with the service provided.

Is the service well-led?

Inadequate

The service was not well led.

Relatives and staff spoke negatively about the way the service was run. They said the service was disorganised, it was difficult to get in contact with management and their concerns were not addressed.

There was a lack of governance of the service and lack of systems in place to assess and monitor the quality of the service.

People's feedback had not been regularly sought as meetings and reviews did not take place.

Supported Lives

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 was prompted by concerns we received about the quality of the service between August and October 2017. The inspection was carried out between 20 October 2017 and 3 November 2017 and was announced. This meant we gave the service a small amount of notice of our inspection to ensure someone would be present in the office to assist us. The inspection team consisted of four adult social care inspectors in total and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience was experienced in the care of people with learning disabilities.

Between 20 October 2017 and 4 November 2017 we made phone calls to staff and relatives of people who used the service. On 24 October and 1 November 2017 we visited the provider's offices, reviewed documentation and spoke with the management team. We looked at elements of six people's care plans and other documentation such as training records and staff rota's. We visited one of the provider's supported living premises on 2 November 2017 where we spoke with people and staff.

During the inspection we spoke with three people who used the service, 16 relatives, 3 health professionals and 13 support workers. We spoke with the current manager, the new manager, a senior manager and the chief operating officer.

Prior to the inspection we reviewed statutory notifications, complaints received about the provider and spoke with the council safeguarding and commissioning teams. We took this information into account when planning the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a document which gives the provider the opportunity to tell us about their service and any planned improvements.

Inadequate

Is the service safe?

Our findings

Improvements were needed to the way medicines were managed to ensure safe and consistent oversight. The provider had a medicine management policy in place, however a senior manager told us it was unclear whether this had been circulated to staff. They told us this would be done as a matter of priority. A staff member who administered medicines told us they were not sure if the provider had a medicines management policy in place but said they continued to work to local procedures which had previously been in place. Failure to adhere to a consistent policy can lead to inconsistencies in practice. People had medicine profiles in place; however we saw many of these were out of date. For example, one person's profile had not been updated since February 2016. Staff and management told us they were unsure whether care records including those for medicines were an accurate reflection of people's current needs.

Staff offering support with medicines completed Medicine Administration Records (MARs) which provided clear evidence of each individual medicine staff supported people with. During a visit to a supported living property we saw these were well completed and provided a complete record of the medicine support provided. These records were subject to regular audit and checks. People living in this property were assessed as to their ability to self-medicate and we saw one person did self-medicate which helped promote their independence.

However overall, we found systems for obtaining, reviewing and auditing MARs in a timely fashion were not in place. Some staff and relatives reported problems obtaining documentation to record medicine support. For example one relative said, "We've been requesting MAR sheets for [relative's] medication for a long time and haven't had them. A member of staff was threatened with disciplinary action because he took [relative] to the office to see if they had any MAR sheets while they were out shopping. [Relative] hasn't missed any medication, but only because of the staff's diligence really." There was no consistent system for bringing MARs back to the office for audit and review. For example, one person's care records contained no MAR charts from 2017, which meant they had not been returned to the office for review in a timely manner. There was no updated information on this person's current medicine support or what staff were providing for them. We asked the manager about what the current medicine support was for this person and they were unable to tell us. We looked at another person's MARs which had only been returned to the office up until March 2017. The manager told us, "There is a batch missing." A senior manager told us, "It's clear our system hasn't been operating properly regarding MAR charts." We saw one person's MAR for September 2017 had been returned to the office. We saw missed signatures for their lunchtime, early evening and evening medicines on the 24 September 2017. The reason for this had not been identified or investigated by management.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Risks to people's health and safety were not always assessed and mitigated. Risk assessment documents were contained within each person's care and support files. However most assessments we looked at were not kept up-to-date. For example, one person's documents dated January 2016 were due to be reviewed in

June 2016 but neither this nor any more recent reviews had taken place. Care co-ordinators told us they were no longer allocated office time to update care plan documentation including risk assessments. This meant staff were not ensuring risks to people's health were continuously assessed increasing the risk of harm.

We found there was a under reporting of incidents, with late or missed calls, incidents and concerns over staff not always formally reported or investigated. Staff, relatives and health professionals told us calls had been missed and/or cancelled. This was confirmed by some records that we reviewed. A relative said, "They are just not turning up, had to stop Sunday as not turning up, when they do, it's people who do not know them well." A health professional told us the service was unreliable and they had to make arrangements with their own staff to cover Supported Lives when calls were cancelled. A number of staff raised concerns about one person's care and support. The person needed assistance and hoisting from two staff members. Staff told us there had been recent instances where only one staff member had attended the call, so the person's family member had to assist. Although we were unable to review the person's most recent records as they were not brought back to the office in a timely manner, we saw instances in July and August 2017 where only one staff member had signed as attended. For example on 4 August only one member of staff had attended the call and stated hoisting had been carried out. We spoke with a staff member who confirmed they had to undertake hoisting with the assistance of family members. The person's relative said, "There have been occasions when I have had to assist."

Staff and relatives said routines were important to people and if calls were cancelled this caused upset and distress to people. There was no clear system for logging and investigating missed calls which meant it was difficult for us to ascertain the number of calls missed. Senior management told us improvements were planned in this area with the introduction of a new rota system, missed call log and electronic call monitoring.

We saw an incident had occurred in the community in September 2017. The incident record was not fully completed and did not demonstrate that an investigation had taken place with many sections left blank. The staff member involved in the incident had not received a supervision/ attended a meeting, and there was no record of any discussion about the incident. Although the person's risk assessment had been updated it did not provide adequate assessment of the risk and instruction to staff to help prevent a re-occurrence. We saw there had only been three incidents logged since July 2017. However, staff told us of many other incidents including missed calls and delays in care and support resulting in distress to people. None of these were recorded. The manager agreed there had been an underreporting of incidents.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People and relatives said they felt people were safe around familiar staff. One person said, "My son has live-in carers. I do feel he is safe with them. He started using the service seven years ago and he still has a lot of the same carers that he had at the start." Another relative said, "They do recognise his needs and they have always been polite and courteous. I have no worries in regard to his safeguarding when he is with the right staff." However relatives and staff raised concerns about staff providing care to unfamiliar people. A staff member said, "Concerned about safeguarding as support workers are supposed to read client care plans and shadow before going to support them, now we are regularly being begged to cover calls where we don't know the person. It's not fair on us or them. They are really vulnerable people so it's important you have time for them to get to know you." A number of staff said they had refused to go to calls because they did not know the person or their individual needs.

We saw a number of appropriate safeguarding referrals had been made in 2017 demonstrating the service was following the correct procedures. Staff we spoke with told us they would report any abuse straight away and they were aware of the different types of abuse. However, they said that concerns reported to management were not always dealt with effectively. We saw where concerns had been raised about staff practice there was no clear record of decisions made. The rota management system showed some staff were not permitted to work with certain people. However there was no record of why this was, for example whether it was due to a serious concern or a compatibility issue. We received complaints from relatives, health professionals and staff that some staff who were not permitted to work with people had been doing so. One person's daily records of care we reviewed confirmed this had occurred in September 2017. We were concerned that the absence of this information for rota planners meant that they were unable to know whether allocating those staff presented a risk to people. We concluded this meant that systems and processes were not being operated correctly to reduce the risk of abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We found there were not enough staff to ensure people's needs were met. Relatives and staff told us a number of calls had been cancelled and records we reviewed confirmed this had been the case. One relative said, "(Relative's) safe , the staff are good, but we were promised that (relative) would have three carers and 'never be without support' but in the last six months, we've been lucky if they've had staff for two of the five days a week they are contracted for. We have a real problem with staffing." Another relative said "(Relative) is safe with staff, but (relative) has had hardly any support in the last two weeks, and none in the last three days. We are not at all happy with the service. They've cancelled so many appointments." A third relative said, "They've cancelled calls at short notice and one time, while (relative)he was at (activity), (relative's) contracted carer was only there for two of the seven allocated hours." Office staff and management told us there had been problems with staffing; it had been a struggle to allocate calls and some had been cancelled. On the first day of the inspection we saw a number of unallocated calls for the rest of the week, some of which had to be cancelled. Staff raised numerous concerns with us about the number of unallocated calls and visits having to be cancelled. One staff member said, "Staffing crisis at the moment, off sick, lots don't turn up, phone in sick, unreliable staff. Amount of phone calls I get as staff don't turn up is unbelievable." Another staff member said, "Not enough staff, still got loads of shifts that need allocated, due to ineffective annual leave. There have been calls missed." A third staff member said, "Permanent staff are being made to work ridiculous hours. I am regularly expected to work between 40 to 60 hours. If I refuse the extra hours I am made to feel it's my fault as the calls will have to be cancelled or an agency staff member who doesn't know the client will have to cover."

The manager and staff told us there had previously been six care co-ordinators. Some of their duties included holding client meetings, undertaking reviews, updating care documentation and holding supervisions and spot checks with staff. Three co-ordinators now remained, one of these worked solely on rotas and the other two both told us they hadn't had any office time to undertake these duties, as they had to cover calls instead. We saw the impact of this was that reviews, supervision and spot checks had not being completed for the most part of 2017. There was a lack of knowledge in the office about people's care needs. Staff raised concerns that calls were being allocated by office staff who did not know people, their individual needs, risks and therefore did not know whether the staff they were allocating were suitable. During our inspection, staff and management in the office were unable to provide us with clear information on people's care and support needs. On the second day of the inspection, we saw calls were better allocated. A new co-ordinator had started and several new support workers staff which the management told us would help improve the reliability and consistency of the service.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) 2014 Regulations

We saw recruitment was safely managed to ensure staff were suitable to work with vulnerable adults. Records showed all the required checks were carried out before new staff started work. This included two written references and Disclosure and Barring (DBS) checks.

Inadequate

Is the service effective?

Our findings

Most people said their regular staff were well trained and had the right skills and knowledge to care for them. Comments included, "The staff are very well trained. They love our (relative) and (relative) loves them. The team (relative) has have been brilliant but three have left from (relative's) original package", "I feel the staff are well trained. The staff are mainly familiar faces", "Some staff have been with my (relative) for twenty years, so they know (relative) very well. They are very well trained", "The staff are very good and (relative's) dedicated carers are very well trained in my opinion. (Relative) is cared for by familiar people but the staff are hindered by very bad management", "The staff are mainly familiar to (person) and most of them know (relative's) needs well. They are well trained. A lot of good staff have finished with the service though."

The service allocated set teams of staff to people to help ensure familiarity and continuity. Whilst some relatives said consistency was maintained, other relatives and staff raised concerns about lack of consistency due to a lack of staff. A relative said, "We don't know who is coming; we are wondering who walks through the door." A staff member said, "Poor rota management. Lots of staff supported by people that don't know them." A number of staff said they had been sent to people's homes without reading care plans or meeting people. A staff member said, "They are sending us into new clients without shadowing. Last week I was put on shift with clients that I didn't know, I refused as it wasn't right." A second staff member said, "Loads of new staff being thrown in the deep end, not shadowing, so we are missing things." A third staff member said, "You do get asked to go places before shadowing and read the file but I have refused." A fourth staff member said how they had to support someone without reading the care plan or meeting the person previously. They said they had to ring another staff member for step by step guidance. Relative and staff told us routine and familiarity was important to people, many of whom had complex needs and behaviours that challenge. Whilst some staff said they had shadowed when they went into a new person, staff said this was not always the case and records did not make clear. The new manager showed us a new form that they would be introducing to make this process clearer.

Records of staff training were poorly organised and incomplete. Training records did not provide evidence staff had received an induction to the service and its policies and procedures. We asked the manager for the provider's training matrix. This is a document which lists training staff have received and the dates on which the training was completed. The manager was unable to produce this. There was no system to effectively track whether training had expired. In some staff files we saw staff had received training in subjects including infection prevention, moving and handling and safeguarding adults. However other staff files showed staff training had expired. The new manager told us, "Training was not up-to-date in the four files I have looked at. We need a training matrix." One staff member said, "I have not had training updates in over two years. I need a refresh in almost everything. I have hoisted a client and not had moving and handling training. I am worried that procedures may have changed since then." We looked at staff's training certificates and saw some training had expired such as manual handling in May 2017. Another staff member said, "Used to have training every year, not had any since Potens took over. A third staff member said, "I am so tired I don't get time to sit down to do training; all of it is at home and online, which I don't think is the best." Some people who used the service were autistic and/or had epilepsy. We found staff supporting these people had not always received training in these subjects increasing the risk that inappropriate care

would be provided.

Staff we spoke with said they did not feel well supported by management. They said they felt unable to raise issues and when they did they were not taken seriously. There had been no recent staff supervisions, appraisals or spot checks. The manager told us they had not had time to carry out these functions and care co-ordinators told us they were too busy covering calls to undertake these duties.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated) Activities 2014 Regulations.

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. In the case of Domiciliary Care applications must be made to the Court of Protection. We found no DoLS had needed to be made.

People and relatives said staff asked consent before assisting with care and support tasks. One relative said, "In my experience they have always asked permission before administering care."
We saw evidence in this in the daily records we reviewed and care planning demonstrated people's consent was taken on board. Where people lacked capacity to consent to care and support or make decisions relating to their care, we identified more information needed to be recorded to demonstrate best interest processes had been followed.

People whose care records we looked at received minimal support with eating and drinking. Some people received prompts to ensure they ate enough and staff supported people to maintain a healthy lifestyle. In most cases people told us this was done properly. One relative said, "He does have the appropriate support with eating and drinking. They are very polite and do always ask him before doing anything." In the supported living property we visited we saw menus were created based on people's individual likes and preferences. However we identified the reliability of the service had impacted on the provision of reliable mealtime support. For example, we were told by several staff that one person had to have a cold meal one evening as staff had failed to turn up and provide the required level of support.

People's healthcare needs were assessed by the service prior to using the service. Whilst care plans described people's healthcare needs, much of this information had not been subject to recent review and the management told us its accuracy could not be relied on. Relatives said regular staff communicated information on any changes in their relative's health to the management team. Some people who used the service lived in other registered services. We spoke with professionals from some of these services who described Supported Lives as unreliable and said they had on occasions had to provide additional cover and support because staff had not turned up on time or at all.

Requires Improvement

Is the service caring?

Our findings

People and relatives said staff who delivered care and support were kind and caring. Relatives' comments included, "Yes, the staff are very kind and caring. They have always been very good with (relative's) privacy and dignity", "The staff are very caring and they listen to our needs and they uphold our (relative's) dignity. They work very well with (relative)", "The one staff member that is left of the three (relative) used to have is very kind and very caring", "I think that the staff are kind and caring. I know that new staff have been introduced when they start, but I think most of them have left now. (Relative) rarely has staff changes though. I think that they listen to our needs and (relative's),yes", "Good staff, they say I can ring them if I have any problems." They went onto say this arrangement was in place because they couldn't get through to the office to discuss issues.

However relatives told us there had been numerous management changes, poor organisation of the service and rotas, complaints not responded to and difficulties getting in contact with the office. As a result many of them did not feel the service as a whole was caring. For example, one relative said, "The staff have always been kind and caring and the care is absolutely brilliant. It's the unreliability of the managers that I can't cope with. For instance, I've been away and when I finally got the rota a week ago, it showed that today was unallocated. I asked several times by phone but it wasn't dealt with. They ended up phoning round last night, trying to find cover staff. They couldn't say that they didn't know about it because they had a full week to sort out cover. It's just not good enough."

During a visit to a supported living service we saw staff knew people well and had developed good rapport with them. Relatives said regular staff had developed strong relationships with their relatives. However relatives and staff complained to us about the number of staff changes. One relative said, "Staff are kind and caring and a lot of them have worked with my (relative) for a long time. They don't always introduce new staff or get them to shadow. They just send them. This isn't good for my (relative). (Relative) doesn't always like new faces. Sometimes (relative) is okay but other times (relative) can be funny. They should know this; (relative) has been with Supported Lives for long enough. I am not happy about it. It's worrying and we are concerned about it." Another relative said, "Since Christmas (relative) has had about 12 different people and none of them are here now, so having to get used to new people, which is upsetting. When there is a new person (relative) behaviours differently to those (relative) has been with for a long time." A third relative said, "When a new carer has been brought in, in my (relative's) care plan I had put down that I wanted to meet them and get to know a bit about them before they worked with my (relative), but I've picked (relative)| up sometimes and (relative) is with people that I don't know from Adam. I don't want complete strangers looking after my (relative). (Relative) has very complex needs." Another relative said, "Lost will to live with Potens, no rotas this week so I don't know who's looking after (relative). They don't have a clue what they are doing."

Staff we spoke with demonstrated they cared for the people they supported. However staff raised concerns about how the service as a whole was treating people poorly, cancelling calls and not letting them know who would be attending calls and sending strangers. One staff member told us they had to receive instructions over the phone from a colleague when they were supporting a person with their care. Another

staff member said "Some people have problems with aggression, having continuity is important, need to shadow three times before we are confident and this doesn't always happen."

During the first day of the inspection, we saw a number of calls for the next day and rest of the week were unallocated meaning people did not know who would be delivering care and support . One relative said, "It's a worry that we don't really need. If they'd just give us the rotas on time, but they don't have the staff." Another relative said, "His needs are met, but at the moment, we don't have rotas, we just don't get them off the office anymore. It's needless worry for us about who, if anyone, is going to turn up. Communication is, shall we say, awkward. They let the phone ring and ring and it takes ages to get through to them. Also, they say things like 'we'll get back to you' and never do." We concluded these problems meant the service did not treat people with dignity and respect.

This was a breach of regulation 10 of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations.

People said staff had helped them develop their independence. For example one relative said, "They have helped with (relative's) independence by teaching (relative) new words.(Relative) knew words when (relative) was younger, but (relative) seemed to lose them but the staff have worked very hard with (relative) and (relative) now says things like 'mum', 'dad', 'please', 'thanks' and they've taught (relative) to blow a kiss to say goodbye." Whilst independence was considered within care and support plans this information and information on people's goals, objectives and progress made in achieving them was not up-to-date.

Relatives we spoke with said they did not feel listened to by the service. A number of relatives described problems with communication. One relative said, "Communication has never been very good. Just recently though, everything has gone really downhill. They send different staff, they don't update us, we get mixed messages, it's just not very good. I have made complaints." Another relative said, "Sometimes I have to ring four to five times before I get through to the office. I've complained over the phone but not officially in writing/.I'm just not that kind of person." A third relative said, "Communication is virtually non-existent. Last week, I tried seven different phone numbers to get through and someone finally gave me (manager's) private number." They went on to explain that they were not impressed with the manager and they hadn't sorted the issues they raised.

Care records showed the service used to have regular meetings with and about people. These included monthly care plan reviews, regular client meetings, service user reviews and spot checks where people's views were sought. None of these had occurred since the start of 2017. This meant that key mechanisms for listening to people and acting on their views and comments were not in place.

The Care Quality Commission checks services are working within the legal framework of the Equality Act 2010 which protects people from unfair treatment. Whilst we identified a number of concerns with the quality of the service, we saw no evidence to suggest any particular group of people were discriminated against.

Inadequate

Is the service responsive?

Our findings

People provided mixed feedback about whether care needs were met. A relative that we spoke with told us, "They do keep all (relative's) needs up to date in (relative's) package." Another relative told us, "(Relative) has a care plan. (Relative's) care needs are met. There are reviews and I've been to meetings. Communication with the office is good." A fourth relative said, "We have a care plan but it's the staff that make it work, not the management. They liaise with each other to sort out (relative's) cover and things." Other relatives raised concerns that inconsistencies in staff had meant their relatives had not always received appropriate care and support and visits had also been missed. Staff also raised concerns about visits being cancelled. One staff member said, "I am aware of 20 days this year since April when (person) has been on (their) own as the visit hasn't been covered."

People's care needs were assessed prior to using the service. We saw although people had detailed and personalised care plans in place, these had not been kept up-to-date. For example, we saw one person's care plan dated 19 December 2016 had been due a full review in June 2017 but this had not taken place. Monthly updates to the care plan had not been completed since December 2016. The review with the person and their family had been due in September 2016 but this had not taken place. The last client meeting with staff team was February 2017 and staff told us these should take place quarterly. A senior manager said "Some of the information we have isn't reflective of people's needs." They said they recognised improvements were required in this area. This demonstrated that people did not have an up-to-date assessment of their needs in place.

Other records showed similar issues with no updated full care plan reviews, client meetings or monthly updates. Recent records were not brought back to the office for review and to check care needs were met. This lack of review provided a barrier to responsive care. A relative said, "Things used to be really good but the last few months have been terrible. We asked a lot, but haven't had care plan updates or meetings. (Relative's) review has been missed." Another relative told us, "There is a care plan but (relative's) needs aren't being met. They just haven't got the staff. (Relative)was supposed to have a review months ago, but I've pestered them and it just hasn't happened." Staff told us there used to be six care co-ordinators who had spent time in the office, but on the first day of the inspection there were only three with two of these having no office time due to having to cover calls. This meant that there was no resources to ensure reviews and meetings took place. A staff member said, "Used to have client meetings, don't have them now. They were a really good opportunity to see what is going well, identify triggers for behaviours etcetera. Now we pass things on but don't see anything happening as a result." This meant the service was not enabling and supporting people to make, or participate in making decisions relating to people's care or treatment to the maximum extent possible.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations.

Most people's support packages revolved around providing person centred activities away from the home. We saw on most occasions these activities had taken place, although some had been cancelled due to lack

of staff particularly in the last month. On the second day of the inspection we saw one staff member taking two people out for a day in Blackpool. People and relatives said staff ensured varied and suitable activities took place but there had been occasions when activities had not been able to go ahead due to the lack of staff. A relative said, "Activities are the main part of (relative's) care. (Relative) has two full days and three evenings. (Relative) goes on walks, to the park, for drives, to the library, swimming, (relative) has a sauna, (relative) goes to the sports centre; they do quite a lot of different things with (relative)."

Complaints were not appropriately managed by the service. Records showed three complaints had been recorded from people or relatives between July and October 2017 with no other complaints recorded in 2017. Relatives and staff told us about numerous complaints they had raised with the service which led us to conclude records did not reflect the number of concerns raised. The manager confirmed complaints had not always been properly logged, particularly when they were raised over the phone.

Relatives told us they were very unhappy with the communication from the office, changes of staff, and not knowing if care and support was going to take place. It was clear that a number of people had complained to the office in recent times and these complaints had not been resolved and they had not received feedback. One relative said, "I complain, it goes in one ear and out the other." Another relative said, "Communication with the office is totally non-existent. I've complained time and time again but nothing seems to be done. I'm constantly having to make phone calls and chase things up, when (relative's) original care plan stated that there would be none of that. They certainly don't act on complaints." Another relative said, "(Manager) was supposed to meet us and go through the care package. She didn't come out; she was a very rude lady." Another relative said "I complained to (manager); she took all the particulars and said she would get back to me; nobody has got back to me." We looked at the complaint records and saw no evidence of a complaint from that person. A staff member said there had been, "Endless complaints," and another staff member said they were regularly called by relatives complaining about lack of care and support. Staff told us that office staff were overwhelmed with the number of phone calls and complaints coming in which meant they could not be dealt with appropriately. This led us to conclude that complaints were not appropriate logged and responded to.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in place. The manager in place on the first day of the inspection had applied to become the registered manager, however this process had not been completed and they had left the service by the second day of our inspection. A new manager had commenced and told us it was their intention to apply to become the registered manager for the service.

Whilst the commission had been notified of most incidents, we saw one safeguarding incident occurred in December 2016 which had not been referred to the commission in line with the service's statutory responsibilities.

Most relatives spoke negatively about the way the service was managed. Poor communication, changes to care workers, lack of reliability and the office not responding to issues were the main reasons people were not happy. One relative told us, "No, we don't know who the manager is now. As I said, getting through to the office can be very difficult." Another relative said, "A new manager started last week so I haven't met them yet. Communication is very poor; I have gone on and on and on about (relative's) need for a review but they come up with excuse after excuse. It has gone downhill very very quickly. The managers have said they'll get back to me on it and they haven't done." Another relative commented, "There is a new manager now. She only started last Friday. I spoke to her two days ago and met her at a meeting this morning. She was nice to speak to and she looked and sounded good, but its action we want, not words." Another relative told us, "The management used to be really good when (previous provider) was in charge. It has really gone downhill now though. They never tell us of changes and I'm at the end of the road with them, honestly." Another relative said, "They've lost so many good staff, it used to be such a good company, it's a shame." However two relatives we spoke with had better experiences. One of these said, "But I believe the management is good and I haven't had any problems communicating with the office."

Health professionals we spoke with also spoke negatively about the service. Timekeeping, inconsistency of staff and calls being cancelled were common themes. One health professional said, "It's not good at the moment, it used to be good. I can't complain about the care it's just whether someone turns up."

On the first day of the inspection we found the office chaotic with one support co-ordinator struggling to ensure calls for the week and the following week were covered. There were previously six support co-ordinators but only three remained and two of those told us they did not have time for management duties such as supervision, appraisal, spot checks, care plan reviews and client meetings due to having to cover calls. This severely restricted the ability of the service to provide good governance and respond to people's changing needs.

Staff said the service was poorly managed and co-ordinated. One staff member said, "Been given the wrong information and sent to the wrong places." Another staff member said, "It's really gone downhill since Potens took over; clients aren't getting support, missing support. They mess a lot of people about." Another care worker said, "I had to ring eight to nine times for a rota." A fourth staff member said, "Lots of tension between staff and office staff, which makes it a horrible environment to be in." A fifth staff member said,

"Awful, dreadful, never ever worked in a company as bad as it is. It was brilliant before but they have changed everything for the worse. They haven't listened to us." Staff said care co-ordinators were helpful but the senior management team were not. Many staff said they had never met any of the managers and not had any support meetings or supervision.

On the first day of the inspection we were concerned about the reliability and consistency of the service and asked the manager about the level of support people who received the service received. We asked what the impact of cancelled calls was on people and if there was anyone at high risk if they did not receive calls. They were unable to provide this information. This concerned us as it meant the service was unable to prioritise resources to keep people safe. A staff member said, "Staff in the office don't have a clue about people's needs and how to prioritise." Another staff member said, "They were unable to get the knowledge from (previous) support co-ordinators before they left." A senior manager said, "We have started analysis on what support is given to each person." This meant measures were being introduced to ensure correct support information was captured to help prioritise resources in the future.

A new rota system had been introduced. A number of staff told us the introduction of this had not been done in a safe way. They said that the rota co-ordinator had access to the system until the day before the inspection and this meant whoever was on call could not access to see what peoples' planned support needs were. This meant information was not able to be provided to people. On the first day of our inspection we had to wait for the rota co-ordinator to come to the office before rotas could be accessed, and whilst staff in the office tried their best to obtain the necessary information, the reliance on one staff member was concerning. A senior manager told us, "Nobody knows the rotas in the office apart from (person), she is on her way in." By the second day of the inspection we saw more people now had access to this system.

Systems to assess and monitor the service were not properly in place. Support co-ordinators told us they no longer had time to conduct spot checks and we saw none had been done in recent months. Staff and records confirmed this to be the case. A relative said, "There are definitely no spot-checks by managers." There was no system to bring documentation such as daily records of care, medicine charts and finance checks back to the office in a timely way. This meant that these areas were not being regularly checked to ensure people were receiving the required care and support. Audits of care plans and training did not take place and we found shortfalls in these area. The manager said, "Medicine audits should have been done regularly and they haven't. Too much turnover of staff." They confirmed staff had been too busy delivering care and support to ensure these things were in place. . One staff member said, "I used to have office time, now just out covering shifts. " Another staff member said, "In the last 12 weeks no manager has contacted me to see if things are ok." A staff member said, "Nearly all service users received a poor service; I start the day by apologising to relatives and clients about the service they are getting." Another staff member said, "Brought new staff into the office but they don't know the clients and their needs."

The lack of information to review meant it was difficult to determine whether people had received their medicines or calls at the right times. There was no system in place to effectively collate and analyse the number of missed and cancelled calls that had been experienced. A number of people and staff raised concerns about missed calls. It was difficult to establish the number of missed calls because daily records were not returned in a prompt manner and rota systems had changed. This showed a lack of appropriate oversight in this area. Incidents, accidents and complaints were not recorded and reviewed in an appropriate way. The senior manager agreed that analysis of complaints needed improving. We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations which demonstrated good governance was not in place.

In August 2017 we received concerns about Supported Lives. The manager sent us a report stating what

action would be taken to address the issues that had been raised. Many of these issues such as around calls being cancelled, unfamiliar carers, lack of supervision, lack of care plan reviews, client meetings were still a strong feature of service at this inspection demonstrating sufficient action had not been taken. For example, supervisions were only starting on 6 November 2017 despite the manager assuring us in August 2017 that these would begin in August 2017. We asked the manager if they were working to an action plan. They showed us an action plan last updated in August 2017. Many of the completion dates were stated for August and September 2017 and it had not been updated since. We reviewed the action plan with the manager and found many items had not been addressed. We discussed the issues we found with the senior manager and new manager. They accepted there had been failings with the service. They said the previous manager had been reluctant to ask for help and that is why the service had deteriorated. However this should have been prevented from happening through robust governance arrangements.

Documentation was not updated and did not always reflect people's current needs. We found daily records of care were missing where we could not establish whether they received care. For example, one person' records showed their visits on 28 29 and 30 July 2017 were missing. Another person's records showed a gap on 4 July 2017 where there was no care and support recorded. The rotas showed calls allocated but we could not confirm whether these calls took place due to the lack of records. On the second day of the inspection we looked at the daily records of a person whose family said calls were cancelled. Daily records for September 2017 showed three dates with no visits recorded. We were unable to confirm whether these calls took place. Staff raised concerns about the availability of up-to-date care plans. One staff member said, "Some places don't have paperwork." Another staff member said getting MAR charts was problematic.

Systems to seek and act on people's feedback were not properly in place. Client meetings, team meetings, reviews and monthly care plan updates and observations no longer took place. This and the lack of office staff and co-ordinators doing duties meant people had restricted mechanisms to raise issues. One staff member said, "Used to have team meetings, we don't anymore; it's very important to go through the clients."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

During the inspection, the new manager and area manager were honest and open with us about the failings in the service and told us they would take steps to improve the service. We received an action plan and supporting documentation following the inspection covering many of the above areas describing how the service was going to ensure these failings were addressed.