Turning Point

Turning Point - Cumbria Learning Disabilities Supported Living

Inspection report

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11 December 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Turning Point - Cumbria Learning Disabilities Supported Living is a supported living service providing personal care to people living with autism or a learning disability living in their own flats within five complexes. At the time of our inspection there were 31 people receiving support.

People's experience of using this service and what we found
Infection control procedures, particularly related to Covid-19 were poor and immediate action needed to be taken.

Medicines management procedures needed to be improved. We were not assured that people received their medicines as prescribed.

Safeguarding procedures were embedded in the service and incidents and accidents were recorded and investigated. Recording systems were being reviewed as we found there had been a failure to notify the CQC of reportable incidents on some occasions.

There were quality assurance systems in place to monitor the service, including the support and care being provided were not robust and needed to be reviewed.

There were enough suitably recruited staff working at the service. It was recognised that a recent outbreak and ongoing Covid-19 restrictions had impacted on the service's staffing levels. We have made a recommendation regarding recruitment procedures.

Staff, particularly support staff, were reported to be kind and compassionate.

Communication throughout the service was described as very poor by staff, relatives and some healthcare professionals. This was raised with the senior management team to address.

People had been given the opportunity to feedback on their experiences, but it was not always clear if action had been taken. Relative feedback had not been sought for some time. We have made a recommendation in connection with this.

We expect health and social care providers to guarantee people living with autism or a learning disability have the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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

The provider had a model of support and care placing people at the centre of the choices and support they received. Relatives confirmed they were involved in decisions when people were less able to express choices themselves, although communication issues within the service had impacted on this. Staff told us the provider's ethos of maintaining people's privacy, dignity, human rights and choice were central to their daily procedures. However, the COVID-19 pandemic had placed limitations on practices because the provider was trying to follow government guidance to keep people safe but had not fully achieved this.

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

Rating at last inspection
The last rating for this service was good (published 14 December 2017).

Why we inspected
We received concerns about infection control and a recent outbreak of Covid-19. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Turning Point - Cumbria Learning Disabilities Supported Living 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 discharge our regulatory enforcement functions to keep people safe, and to hold providers to account, where it is necessary for us to do so.

We have identified breaches in relation to preventing and controlling infection, medicines and governance.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always 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

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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
This inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in five '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.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because we needed consent from people and relatives to allow us to contact them and to ensure the registered manager or representative was available for our office visit.

Inspection activity started on 3 December 2020 and ended on 11 December 2020. We visited the office location on 11 December 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We communicated with two people and 18 relatives either in person, by phone or via email. We spoke with the registered manager, a registered manager from a nearby service, the supported living manager and one team manager. We contacted 32 staff via email or text to gain their feedback. We contacted two social workers, a physiotherapist, an occupational therapist and a member of staff from the learning disabilities team.

We reviewed a range of records. This included three peoples care and support records and multiple medication records. We looked at six staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The provider did not have effective and robust procedures in place to avoid risks posed by infection including Covid-19.
- Staff did not always wear personal protective equipment (PPE) correctly and did not always follow current government guidance regarding how to put on or take off PPE.
- Staff were unclear on infection control procedures during the pandemic and training had not been robust.

People were not always protected from the risk of infection because staff were not following official government guidance. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken action outside of the inspection process on this matter and will publish the outcome of this action once it has been concluded.

Using medicines safely

- Medicines were not managed safely. People's medicine administration records (MAR's) were not completed in line with best practice guidance.
- It was not clear if people had received the medicines they were prescribed. For example, one person had creams applied but no clear MAR was in place. Other people did not have up to date medicines lists in place. Other people's MAR had incorrect entries.
- Topical (creams/ointments) MARs were not always in place to describe how staff should apply these types of medicines.
- People who had 'as required' medicines (for pain for example) prescribed, did not always have written protocols in place to describe how, when and why these should be administered.
- People and their relatives reported no concerns with medicines administration. We were made aware of one concern that was currently being investigated.

Medicines management was not robust. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's care and support records contained evidence that risks were reviewed and updated. Work was ongoing to ensure these were all up to date.
- Health and safety checks were completed regularly, including for example, fire safety checks.

Staffing and recruitment

● Recruitment procedures were in place. Risk assessments for positive Disclosure and Barring Service checks (DBS) were not always recorded. We discussed other improvements to procedures, including ensuring references are fully recorded.

Although the provider had an action plan in place to address some of these issues, we recommended the provider further review recruitment procedures to ensure they are in line with best practice and in light of feedback given during the inspection.

● There was enough staff to meet people's care and support needs. Some relatives expressed concerns over the levels of staff at times. The provider recognised that due to Covid-19, in recent months, there had been difficulties, but a recruitment drive was in place to address this. Staff raised concerns about working long hours without breaks. We raised this with the provider to address.

● Consistent staff teams were promoted, although this had not always been possible due to the current pandemic, sickness or holidays.

Systems and processes to safeguard people from the risk of abuse

● People were protected from abuse. Staff who had been trained to recognise safeguarding concerns. One person said, "I am safe, don't have any problems."

● Policies were in place to promote safety within the staff team, including safeguarding.

● The registered manager investigated and reported safety concerns to external agencies, although CQC had not always been notified as legally required.

Learning lessons when things go wrong

● Accidents and incidents were recorded and dealt with individually by the management team.

● Medicines errors were investigated, and lessons learnt to try and minimise the risk of recurrence.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance processes were in place to help identify areas for improvement, including audits and competency checks. The provider had a range of action plans in place. However, during the inspection we found concerns with infection control and medicines management had either not been identified or fully addressed to keep people safe.
- The management team were not always clear on their roles around quality assurance and there was a lack of oversight.
- Staff did not always understand their roles, particularly in connection with procedures for infection control.
- Some staff who had worked at the service for the last few months, had no previous experience in adult social care. They had recently been given Care Certificate workbooks to work through but the provider confirmed the Care Certificate should have been completed in the first 12 weeks of their employment.

Governance procedures were not robust, including to ensure issues arising were found and addressed. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their obligations in relation to duty of candour, including being open and transparent when incidents had occurred. Not all CQC reportable accidents or incidents had been notified to us in line with the registered provider's legal requirements. The provider took measures to address this immediately.

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

- Staff demonstrated a commitment in providing person centred care to people. People and their relatives told us that support staff tried really hard to meet people's individual needs. One person said, "The staff are lovely and although its different because of this Covid thing, they check on me more often and I am very happy." One relative said, "I do think support staff are very committed to providing person centred care to those they care for."

● The registered manager assisted us throughout the inspection, showed willingness to address concerns raised and was responsive to feedback.

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

● People were engaged with throughout the current pandemic to ensure their needs were met. This included care reviews. One person told us, "I have seen my records and been involved."

● Staff meetings had taken place. These were not as regular as planned due to the current pandemic. One member of staff said, "Meetings are just not regular enough. We need to be communicated with properly."

● The provider could not show us evidence to demonstrate less positive comments on returned questionnaires had been addressed and no analysis had taken place. Due to the pandemic, relative surveys had not been sent out, but we were told by the registered manager this should have occurred.

We recommend the provider reviews their feedback procedures in line with best practice.

● The provider had communicated with people, their relatives, staff and health care professionals in various ways. However, the vast majority of people, relatives, staff and healthcare professionals we contacted said communication was poor and needed to improve. One relative said, "Communication is rubbish". They also said that managers don't appear to inform staff of changes. Relatives were also not always confident issues raised would be addressed fully. One relative said, "I have lost confidence in the management team." We discussed these concerns with the provider at feedback and confirmed they had already started acting to address this.

Working in partnership with others

● The staff team worked in partnership with healthcare professionals and other external partners to ensure people received appropriate care. However one healthcare professional said, "Sometimes communication can be difficult" and "Some managers don't seem to pass on information to the staff on the ground."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Proper, safe and effective systems were not in place for the management of medicines. Regulation 12(1)(2)(f)(g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the safety and quality of the service were not robust and did not ensure the service was compliant with the requirements of the regulations. Regulation 17(1)(2)(a)(b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were failing to follow government guidance on the safe use of personal protective equipment and adhere to Covid-19 infection control procedures. Proper processes for the preventing and control of infections were not in place Regulation12(1)(2)(h).

The enforcement action we took:

We took urgent enforcement action to impose a condition on the provider to ensure proper infection prevention control procedures were in place at the service.