Upward Care Limited

The Bromford

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The Bromford is a supported living setting that was providing support to 22 people at the time of the inspection.

People's experience of using this service:

People were not supported to stay safe as risks were not managed well. Where safeguarding concerns arose, these were not consistently identified and acted upon. Records around the use of restraint did not provide assurance that this was done safely.

A lack of oversight from the provider and management meant that risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service had not identified the areas for improvement found at this inspection.

People received support from staff who had received training but did not always apply their learning in their practice. People had their dietary needs met and had access to healthcare services where required.

People told us that staff treated them with dignity and promoted their independence.

Records held personalised information about people and staff knew people's preferences with regards to their care. Complaints made had been investigated and people's end of life needs had been considered.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Rating at last inspection: Good (Report Published 09 March 2019)

Why we inspected: The inspection was bought forward following receipt of information that indicated people were not receiving safe care and treatment. Our findings at this inspection confirmed these concerns.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always Well-Led. Details are in our Well-Led findings below.	**Inadequate**

The Bromford

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 in part by concerns raised with us about how people were supported where they displayed behaviours that can challenge. The concerns included the use of restraint and the use of police where people's behaviour had escalated. Further concerns were raised around risk following the death of a person receiving care from the provider. This inspection examined those risks.

Inspection team:
The inspection team consisted of one inspector and a specialist advisor who was a nurse with a specialism in mental health.

Service and service type: The Bromford provides care and support to people living in their own homes within a supported living setting. 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.

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:
The Inspection was unannounced. Inspection site visit activity started on 10 April 2019 and ended on 11 April 2019. We visited the office location on 10 and 11 April 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:
We reviewed the information we held about the service. This included information received from the

provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority to gain their feedback.

We spoke with three people who receive support from the service. We also spoke with three members of care staff, the deputy manager and the registered manager. We looked at six people's care records as well as records relating to recruitment, complaints, accidents and incidents and quality assurance.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● We received concerns prior to the inspection that risk management systems at the service were poor and that people who display behaviours that challenge were not provided with safe care and treatment. At the inspection, we found this to be accurate and identified concerns about how risks were managed to keep people safe.

● Risks to people who may require the use of restraint had not been assessed prior to any intervention taking place. Incident logs described instances where a person had been restrained by staff for their safety. However, there was no guidance informing staff that this was safe to do. The lack of guidance for staff around the use of restraint such as, what kind of restraint was safe to use for this person meant that staff could not ensure that they were using restraint in a safe way based on the person's individual needs. In addition, records held in relation to the use of restraint did not provide assurances that less restrictive strategies had been considered prior to the use of restraint. This meant that we could not be sure that the use of restraint was appropriate or necessary for the person.

● Staff had not always responded to risks in a timely way to keep people safe. One person had a history of leaving the service and not returning. We saw an incident where the person left the service and informed staff they would return in one hour. When they did not return at the expected time, staff did not take timely action to ensure the person's safety. Staff did not report the person missing until the following morning. This meant the risk to the person who had left the service had not been responded to.

● Although staff were aware of the risks posed to people, these risks were not always formally assessed to ensure that people were safe. Risk assessments for people who may pose risks to others in the building did not give sufficient detail about the level of risk posed and how staff should act to keep people safe. Where assessments did record how staff should reduce risk, it was not clear that this action was being taken. For example, where records said that people's movements should be monitored as they posed risks to others, daily records showed that this action was not always being taken.

● Significant risks to people's safety and well being had not always been shared with staff. Where one person was at risk due to previous incidents, the details of the person's relevant history had not been shared with staff. This meant that staff did not have access to key information about risks posed to the person and how they could ensure their safety and the safety of others.

Learning lessons when things go wrong

● Lessons were not always learnt from incidents to reduce the risk of re-occurrence. For example, we found that where people had been reported missing from the service, lessons were not learnt or action taken to reduce the risk in future. This had led to people being reported missing on more than one occasion. In addition, where incidents had occurred between people living at the service, the lack of action to learn lessons from these meant that people remained at risk of further harm.

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

Systems and processes to safeguard people from the risk of abuse

● Staff did not respond appropriately to situations that left people at risk of abuse. For example, where people had made serious allegations against other people living at the service, whilst immediate action was taken, the provider had not considered the ongoing risk to the person and had not put measures in place to safeguard them in future. This had meant the person continued to be at risk of harm as staff had not been taking action to keep them safe. We raised this as a concern with the registered manager who put safeguards in place to ensure people's safety while investigations were undertaken into how the person should be protected in future.

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

Staffing and recruitment

● People gave mixed feedback when asked if staff arrived on time to provide their support. One person told us, "I have the same staff and they are never late". Another person said, "They don't come to give me my tablets on time. It happens all the time, I was upset yesterday.".

● Staff however felt that they did have enough time to get to people and deliver their care. One member of staff told us, "I have never felt like I don't have time to get around everyone.".

● We spoke with the registered manager who informed us that people did not have set times for their support and that the times staff attend people's flats would vary daily. This meant we were unable to determine if people received their required level of support as staff were not consistently recording the times they visited people and there were no systems to monitor the times people received support.

● Following the inspection visit, we received information of concern regarding the numbers of staff available to support people. We have asked the provider to send us further information around their staffing levels and will continue to monitor the information received.

Using medicines safely

● Where people received support with their medication, staff knew how to safely administer these and could explain how they support people safely. Records showed that people had received medication when required.

● People had been supported to manage their own medication where able.

Preventing and controlling infection

● Staff had received training in the prevention and control of infection and could explain how they promote this in their work. For example, staff used personal protective equipment such as gloves and aprons where required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Prior to the inspection, concerns were raised with us about staff's skills and competence when it came to supporting people with behaviours that may challenge. At the inspection, we found that although staff had received training in behaviours that challenge, they did not consistently apply this learning in their practice. This meant risks to people were not always well managed as staff did not apply their training to support people effectively. For example, although staff had received training in the use of restraint and told us they would only use this as a last resort, records we looked at showed that this was not the case and that restraint had been used potentially without applying other techniques first. In addition, although staff had attended training in safeguarding people; they had not always identified potential safeguarding incidents at the service and this meant they had not applied their learning from the training provided.

● Staff told us they had received an induction prior to starting work that included completing training and shadowing a more experienced member of staff. All new staff were enrolled on the Care Certificate. One member of staff told us, "I had to shadow a senior member of staff before I could work alone and then had to do all of their training.".

● Staff had received training relevant to their role. This included training in people's individual needs.

Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

●We checked whether the service was working within the principles of the MCA. People told us that staff sought their consent before supporting them and staff displayed an understanding of the importance of seeking consent.

● Records held around capacity and the use of restraint did not fully consider how staff should ensure that restraint was used in a safe, proportionate or monitored way. This meant that there was a risk that people's rights would not be upheld where restraint was used as the appropriate assessments around its use had not been implemented.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Assessments of people's needs had taken place prior to them receiving support from the service. These assessments looked at the level of support people required, their medication history and their current care

needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People were happy with the support they received with meals. One person told us, "Yep, the staff help me with my meals and I always get a choice".
● Records held information about people's dietary needs and staff displayed a good understanding of the level of support people required to maintain a balanced diet.

Staff working with other agencies to provide consistent, effective, timely care / Supporting people to live healthier lives, access healthcare services and support
● Records showed that the registered manager had contacted other agencies where they had concerns about people. For example, where people's needs were changing.
● Records we looked at showed that people received support from health professionals where required.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People gave mixed feedback when asked about their relationships with staff. Some people felt that they got on well and 'had a laugh' with staff, whereas others told us that staff were not always kind to them. One person told us, "Staff don't talk to me when I am upset.". The person explained the situations in which they felt this happened. This was shared with the deputy manager who informed us they would discuss this further with the person.
- Although staff had displayed a caring attitude and spoke fondly of the people they supported, the systems and processes at the service meant that the support they gave was not always done so in a caring way. For example, as staff had not been told about significant life events for one person, they were unable to provide the person with emotional support to cope with these events. We spoke with the registered manager about this who provided an explanation about why this information was not shared with staff, however, the lack of information for staff would impact on the support they would be able to provide.

Supporting people to express their views and be involved in making decisions about their care

- People told us that staff provided them with choices. One person told us, "I do get choices". Staff we spoke with understood the importance of involving people in their care and could give examples of how they do this. One member of staff told us, "People can make their own choices. We go in and ask them when they want to get up and have breakfast.".
- People told us they were supported to express their views on the care they received with the registered manager. For example, one person told us how they would have a cup of tea with the registered manager to talk about how they are feeling about their care.

Respecting and promoting people's privacy, dignity and independence

- People's independence was encouraged. Where people were able to access the community independently they had been supported to do so. Other people were also supported to learn daily living tasks such as cooking and cleaning. One person told us, "I pick my meals and staff help me to cook it.".
- People told us that their privacy and dignity was respected. One person said, "The staff always knock before coming into the flat and then wait for me to say ok.". We saw examples of staff respecting people's privacy and asking their permission to visit them in their flats. Staff provided examples of how they promoted dignity that included; closing curtains when supporting with their personal care and respecting people's preferences.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People records held personalised information about them. Records held information about people's likes, dislikes and preferences with regards to their care. For example, records recorded people's hobbies, their family members, and future hopes and dreams. However information that was relevant to people's care and support, had not always been recorded and staff did not always know the details of people's history that would impact on the care their received. This meant that the provider could not always ensure care was responsive as information had not always been shared with staff.
- People told us that staff knew them well. One person said, "The staff are ok". Staff we spoke with displayed a good understanding of people's preferences. For example, staff knew where people liked to spend their time and what television shows they enjoyed watching. However, although staff knew people's likes and dislikes, the care they delivered to people was not consistently person centred. For example, although staff knew the risks of two people spending time together, they had not adapted the care and support provided to both people to enable them to continue to spend time together but still receive their required support.
- People told us that staff supported them to pursue their individual interests. One person told us, "Staff help me with my football, they take me to the park and I always score."
- The registered manager told us and staff confirmed that they were responsive to people's changing needs and would be flexible at the times people received their care so that this fitted in with their plans for the day.

Improving care quality in response to complaints or concerns

- People told us they knew how to make complaints. One person told us, "The manager would always help. I would talk to her". Another person added, "If I had any concerns, I would go and see someone in the office. I have never had to though".
- We looked at records held in relation to complaints and saw that where these had been made, a record was kept and the concerns were investigated.

End of life care and support

- Although no-one living at the service required end of life care, records showed that people had been asked about their wishes and preferences at the end of their lives.

Inadequate

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider had not ensured that people received person centred, high quality care. Although the registered manager was aware of risks to people, insufficient action had been taken to safeguard people and reduce risks to them in future. We raised some of our concerns with the registered manager who could evidence that where they had identified risks, they had made contact with the local authority about these. However, the registered manager had not considered how they could take action internally to keep people safe whilst this was addressed by external agencies. For example, where one person posed a risk to others, the registered manager had shared their concerns but had not provided staff with guidance on how to support the person safely while these concerns were addressed. The provider's lack of oversight of their responsibility to ensure people's safety had led to repeated incidents that had potential to place people at risk of harm.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were systems in place to monitor the quality of the service. However, these were ineffective in identifying the issues we found at this inspection. Monthly reviews of care plans had not identified that where risks were posed to people, the records did not clearly guide staff on how to ensure people's safety. Monthly checks on daily records did also not identify that people remained at risk of harm despite this being recorded by staff.
- Where audits were completed, these were not consistently completed accurately. Throughout the months of January – March 2019, audits indicated that no incidents had occurred at the service. Other records we looked at showed this was inaccurate and a total of 20 incidents had occurred. This was not picked up and reflected within the audits.
- The provider and registered manager had failed to act on their responsibility to ensure any restraint used was safe to do and upheld people's rights. Although the registered manager was aware of when restraint was used, they had not reviewed this to ensure that the use of restraint was proportionate, safe and used only following less restrictive strategies. This meant there was a risk that people would be restrained inappropriately as systems were not employed to review these practices.

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

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

characteristics

● People gave mixed feedback when asked if they were given opportunity to feedback on their experience of the service. Some people told us they met with the registered manager regularly to discuss their care, whilst others told us they did not get this opportunity. One person told us, "I don't think they have ever checked that I am happy with everything", while another person said, "[Registered manager] pops in to see me and chat. If it's not her, it's the deputy manager."

● We saw that satisfaction surveys had been sent out in September 2018. We found that where suggestions for improvement had been made, action plans were devised to address these.

Continuous learning and improving care / Working in partnership with others

● Following the inspection, we provided feedback to the registered manager about our concerns about the safety of people receiving care from the service. The registered manager in response to this provided an action plan indicating the actions they intended to take to improve the care provided. Immediate action was taken to safeguard people and address the key risks posed.

● The registered manager showed us via records that they had been working with the local authority to report and address concerns raised about people receiving support from the service.

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 There were no systems in place to ensure that risks to people's health, safety and well being were assessed. Where risks were identified, these were not consistently responded to in a timely way.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents that left people at risk of harm had not always been acted on to ensure the person was safeguarded.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality of the service had not identified that risks to people were not being assessed or responded too. Where potential safeguarding incidents occurred, timely action was not taken to ensure people's safety.

The enforcement action we took:

Impose a condition