Pathway For Care Limited

# Pathway for Care

## Inspection report

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Date of inspection visit:
17 November 2020

Date of publication:
15 February 2021

## 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
Pathway for Care provides personal care for adults who have a learning disability, autism, physical disability or mental health conditions. At the time of this inspection, the service was providing personal care to 15 people across four 'supported living' settings.

People's experience of using this service and what we found
The provider had failed to ensure CQC were fully informed of all significant events. They had not demonstrated an understanding of the regulated activity which meant CQC had not been able to comprehensively assess and monitor the service provided. Relatives and professionals told us that improvements had been made to the service although communication required ongoing development.

One person's records had not been updated when their needs changed to ensure staff were aware of the correct guidance to follow. We have made a recommendation in relation to this. This risk was mitigated to a large degree as the person was supported by staff who knew them well. Core teams of staff had been developed to ensure people received consistent support. Staff were recruited safely and received the training they required to support people. Staff were aware of their responsibilities to keep people safe from abuse and reporting protocols were followed. Accidents and incidents were reported and reviewed to reduce the risk of them happening again.

Staff were positive about the support they received and felt the management team were approachable and responsive. People's care was based around their individual preferences and the outcomes they wished to achieve. There was a positive approach throughout the staff team. Systems were in place to monitor the service and, where required, action plans were developed and monitored. The service worked with a range of organisations and professionals in order to support people in achieving their goals.

We expect health and social care providers to guarantee autistic people and people with a learning disability 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 able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. 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 able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People's support was planned on an individual basis which promoted their independence. The service had developed links with the local community. This provided people with opportunities to access community resources and undertake person-centred activities. People received their support from staff who knew their needs and respected their individual preferences.

Rating at last inspection
The last rating for this service was Good (published 10 August 2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to an ongoing investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of specific health concerns and the emergency protocols in place in relation to these. This inspection examined those risks. We found no evidence during this inspection that people were at risk of harm from this concern.

In addition, we had concerns regarding the provider's understanding of their regulatory responsibilities to provide information to CQC in relation to people receiving the regulated activity Personal Care. We identified a breach of regulations in this area.
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 Pathway for Care 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

We have identified two breaches at this inspection in relation to communication, the management understanding of their regulatory responsibilities and the provider not always informing CQC of significant events.

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.

# Pathway for Care

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

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

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
We gave the registered manager 24 hours' notice of the inspection. This was because we wanted to meet with people living in their own homes and needed the provider to make arrangements for this to happen.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included safeguarding information and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We sought feedback from professionals who work with the service and spoke with one relative.

We completed a structured conversation with the registered manager in July 2020 using our Emergency Support Framework (ESF) to gain an insight into how the Covid-19 pandemic had affected 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.

During the inspection
We visited three of the supported living settings. Where the layout of the location allowed, we observed the care people received in their homes. We spoke with eight staff members, including the registered manager. We reviewed a range of records which included seven people's care records, accident and incident monitoring, and medicines administration records.

After the inspection
We spoke with seven relatives regarding the care their loved ones received. We reviewed additional documentation requested from the provider including quality audits and policies and procedures

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- We received mixed responses from relatives regarding how risks to their loved one's safety and well-being were managed. One relative said they did not feel staff always fully understood their family member's needs. They told us, "Things are improving but staff don't always communicate with each other enough which means we still have to remind them of important things." Another relative told us, "I do feel (person) is safe, but more importantly, we can tell (the person) feels the risks are managed and they understand what (the person) needs from them."
- Professionals involved in people's care told us information regarding risks and incidents had not always been communicated well. However, following discussions with the service this was now improving and leading to more positive outcomes for people.
- One person's risk assessment plan had not been updated when their needs had changed. Due to changes in the person's environment, equipment used to monitor their health was no longer in place. Systems implemented to mitigate this had not been risk assessed and recorded to ensure they were fully effective and known to staff. Following the inspection, the provider submitted updated risk assessments and evidence of health care professionals being involved in this process.
- In addition, the person's updated positive behaviour support plan had not been shared with staff to guide them in the type of interventions they should use. The registered manager responded immediately to this concern and shared the updated PBS plan with the staff team.
- The above risks were reduced to a large degree as people were supported by the same staff members who were aware of changes in the person's needs. Staff had received the on-going training they required and incidents were clearly documented.

We recommend that records are updated promptly when guidance regarding risks to people's safety changes.

- In other areas we found that risks to people's safety were assessed and control measures implemented to minimise risks. Risk assessments were specific to the person and were reflected through the person's care plan and positive behaviour support plan.
- Guidance regarding specific health conditions was available to staff. For example, epilepsy care plans guided staff on the types of seizures people experienced and the action they should take in individual circumstances. Staff were able to relay this information to us and demonstrated a clear understanding of people's emergency protocols.
- Staff were able to share information regarding people's needs, triggers to anxiety and communications styles. This information was reflected within people's written records which provided guidance to staff on

the action to take to support people in remaining calm.
● Individual risk assessments had been developed in response to the Covid-19 pandemic. This took into account people's individual needs and risks to their overall safety. Staff told us they had been supported throughout the crisis. One staff member said, "We've had good training, information and support. If I was worried about anything I would discuss it with the manager."
● Where accidents and incidents occurred, these were reported and analysed to minimise the risk of them happening again. Senior staff within the organisation reviewed all incidents to ensure appropriate action had been taken to mitigate risks. In addition, a weekly incident review meeting was held to identify any trends, training needs or changes to systems.

Systems and processes to safeguard people from the risk of abuse
● People appeared at ease in the company of staff. Relatives told us they felt their loved ones were safe from abuse. One relative said, "The reason I know he is okay there and not worried about anything is that when I say it's time to go back, he's ready with his shoes on."
● Staff understood their responsibilities in relation to safeguarding. They were able to describe the different types of potential abuse, signs of concerns and reporting procedures. One member of staff said, "We are here to be certain that the service users are kept safe from abuse. We discuss any serious matters, like safeguarding, in team meetings."
● Safeguarding concerns were shared with the relevant local authorities where required. The service continued to work closely with local safeguarding teams to ensure any additional information required was provided and action was taken in a timely manner.

Staffing and recruitment
● People were supported by regular staff who knew them well. One relative told us, "Staff have been really good at getting to know (family member) and us all as a family. It's made a difference in building up trust." One staff member said, "We match staff who are suited to each client. It's got to be about them."
● Each person supported by the service had a care package with a specific number of hours allocated dependant on their needs. The majority of people received one to one support throughout the day as a minimum. Sufficient staff were in place to meet each person's allocated hours.
● Relatives told us there had been a high use of agency staff in some locations but this had improved. Rotas showed that, where agency staff were used, the same workers were allocated to people. This meant people had a higher degree of consistency in the staff supporting them.
● Robust recruitment checks were completed to help ensure staff were suitable for their roles. All candidates completed an application form and had a face to face interview. Once accepted, checks were completed such as obtaining references, proof of the right to work in the UK and a Disclosure and Barring Service check (DBS).

Using medicines safely
● People were supported with their medicines safely. One relative told us, "There haven't been any problems. They keep us up to date if anything changes."
● Medicines were stored securely and administered by trained staff who had been assessed as competent to do so. Each person had a medicines administration chart in place which contained a photograph, details of allergies and GP contact details. No gaps were noted in administration records and the stock checks reviewed were correct.
● Where people were prescribed PRN (as and when required) medicines, guidance was available to staff regarding how and when these should be administered. Staff received training in the administration of rescue medicines to support people living with epilepsy where required.

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 now 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

- Relatives and professionals involved in the service told us that the service had made improvements. They felt the service was more organised and staffing concerns had been resolved. However, they felt further emphasis on good communication was needed. One relative told us, "You can get the information if you ask but it can be difficult at times. They say things (communication) will get better but it tends to slip back and you have to remind them." One professional told us, "Things have improved now they have more structure. We get the information but not the detail and often have to ask several times. Better communication is what's needed."
- The registered manager and senior staff told us they recognised communication had needed to be strengthened. This had been made more difficult due to a number of changes within the management team. They told us now stability had been established and location managers were in place this area would continue to develop.
- The provider did not always demonstrate understanding of the regulated activity of Personal Care. In July 2020, CQC received safeguarding concerns from other professionals in relation to a number of people's support. The registered manager informed us the people involved did not receive personal care. When we had reason to re-visit this in November 2020 the registered manager told us they had been mistaken and the people involved were in receipt of personal care. This meant we were unable to ensure the provider was effectively assessing, monitoring and mitigating the risks relating to those people's health, safety and welfare.

The failure to consistently ensure effective communication and to assess, monitor and mitigate the risks relating to people's health, safety and welfare was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events. These included safeguarding concerns, and incidents where the police were called.
- The registered manager acknowledged CQC had not been notified of all incidents are required. This was due to the scope of the regulated activity not previously being understood. This meant we were unable to effectively monitor the service provided. The provider told us they would ensure the relevant notifications would be submitted as a matter of urgency following the inspection. However, these have not been

received.
● The registered manager had submitted a notification for an incident which they told us was for information only as the person was not in receipt of personal care. CQC subsequently received information from an external source which highlighted the person was in receipt of the regulated activity of personal care at the time of the incident. The registered manager later confirmed this was the case. This led to a delay in CQC being able to carry out our regulatory function in relation to the concerns raised.

Failing to submit statutory notifications was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; 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
● Relatives told us they felt there was a person-centred culture and on-going improvements. One relative said, "(Family member) has a quality of life now; all I wanted was for him to live his life in the way he chooses to live it, and staff make that happen." A second relative said, "I'd say they are definitely getting there now. They're open to suggestion about very individual things and take things on board now."
● Where we were able to observe the support people received we found there was a relaxed, respectful and positive atmosphere between people and staff. People took part in individual activities of their choice and had structure to support them in managing their anxieties.
● Staff told us they felt part of a team and the managers supported this. One staff member said, "We work as a team; we need to trust each other here. The managers are professional but very considerate and understanding. They work with us to create a good place to live for the guys and a good place to work for us."
● Systems and processes were continually reviewed to ensure they were effective and inclusive. For example, a new process for monitoring incidents had been established to ensure staff received feedback consistently. Staff told us they had found this helpful and were now able to more fully discuss incidents in team meetings in order to learn from them.
● A range of audits and reviews were completed to monitor the quality of the service provided. Audit processes had recently been further developed to included more regular location audits by managers. Action plans were implemented and monitored where it was found improvements were noted.
● The provider had a duty of candour policy in place. This is a legal requirement for providers to give an explanation and apology following an unexpected or unintended event. Relatives told us they were informed of incidents and accidents and had the opportunity to discuss any concerns or risks going forward.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives told us that people's individual needs were taken into account when making any changes to the service. This included examples of changes to the environment which reduced people's anxieties and creating core staff teams for people to give a high level of continuity.
● Staff told us they felt supported by managers of individual locations, the registered manager and the organisation as a whole. One staff member said, "The management team are supportive and always willing to help and work alongside us. They give me confidence to do my work."
● Regular staff meetings were held to discuss developments in each location and throughout the organisation. Staff told us they found these meetings useful in being able to discuss different approaches and details regarding people's support.

● Feedback on the service was sought through individual reviews and through feedback forms completed by relatives and visiting professionals. These were collated on a quarterly basis with recent reports showing a high level of satisfaction in all areas.
● The registered manager shared information of policies being developed to facilitate greater involvement for people in how their support is provided and monitored. This included involvement in recruitment and monitoring staff performance and increasing involvement in how people's desired outcomes are measured.

Working in partnership with others
● Staff supported people to make and maintain links with community organisations which were meaningful to them. These included local colleges, work opportunities and groups of personal interest to people. Following our inspection one person wrote to tell us how staff had supported them to attend Music Fusion. They told us this had given them the opportunity to express themselves through rap music and had helped them in processing their emotions when having a bad day. The person was proud of their achievements in writing music which was available to a wide audience on-line.
● The service worked alongside health and social care professionals to support people in planning their care. This included working with GPs, community learning disability teams, care managers and hospital consultants.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to submit notifications in line with regulatory requirements |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to consistently ensure effective communication and to assess, monitor and mitigate the risks relating to people's health, safety and welfare |