Wave Supported Lives Ltd

Waves Supported Lives Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Waves Supported Lives Ltd offers personal care only as a domiciliary care service. They support younger people with a learning disability, physical disability or sensory impairment living in their own home. The main office is based in a business park near Blackpool Airport. At the time of our inspection, the service supported five people who received a regulated activity in their own homes.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Waves registered as a new service on 29 November 2017. Consequently, this was their first inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to people of all ages. Waves also provides care and support to people living in a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing were not always provided under separate contractual agreements. However, we saw the provider was acting to ensure housing was provided under a different agreement so that people's independence could be optimised. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The care service was not always developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service did not consistently live as ordinary a life as any citizen.

During this inspection, people and relatives we spoke with confirmed they felt safe whilst using the service. However, we found the management team failed to continuously ensure people were not exposed to the risk of harm. There were multiple incidents where they used physical intervention without legal authorisation. Records we looked at identified disproportionate management of behaviours that challenged the service. This placed individuals at risk of unsafe and inappropriate care because staff could not be assured they employed permitted, correct and safe measures.

People were not always supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible. The policies and systems in the service did not reflect important up-to-date guidance to inform staff practices. There was no accurate oversight and monitoring of behaviours that challenged the service. Consequently, the registered manager could not effectively identify clear triggers, successful support actions and improved outcomes. Care records did not include effective, evidence-based best practice to diffuse escalating behaviours.

You can see what action we told the provider to take at the back of the full version of the report.

The registered manager completed detailed risk assessments to guide staff about protecting people from unsafe care in their own homes. However, we found staff and the management team did not always follow risk assessments fully through in the management of behaviours that challenged the service. Unauthorised restraint was used on multiple occasions with no management strategies or monitoring systems to achieve safe outcomes. The management team failed to do all that is reasonably practicable to mitigate risks to maintain people's safety.

You can see what action we told the provider to take at the back of the full version of the report.

When we reviewed the provider's recruitment procedures, we found DBS checks and references had been acquired after staff started in post. We saw there were gaps in records and reasons for leaving had not been fully explained. Where staff pre-employment checks identified risks, the registered manager had not implemented measures to mitigate them. These practices exposed people to the risk of unsafe care because the management team failed to ensure the safe recruitment of suitable staff.

You can see what action we told the provider to take at the back of the full version of the report.

We found there was no clear process from pre-assessment to care plan development, monitoring and review. Behaviour management plans were particularly poor because staff guidance only covered when people were at crisis point. Consequently, treatment responsiveness and outcomes could not be properly measured to assess their impact on people. The management team failed to consistently maintain quality records to guide staff responsiveness to people's needs.

The continued safety and wellbeing of everyone at the service could not always be assured because the management team did not have clear oversight. Audits were not completed regularly and they failed to consistently follow their policies and procedures. Protocols were missing, such as recruitment risk assessments, and did not always follow current national guidelines.

You can see what action we told the provider to take at the back of the full version of the report.

We reviewed the administration of people's medicines in their own homes and noted these were stored safely. People said they received their medication on time and as prescribed. However, the management team had not always followed good practice in safe medicines administration. This was because protocols to guide staff about the use of 'when required' medicines were not in place.

We have made a recommendation the provider seeks guidance about safe medicines administration.

Staffing levels to meet each person's requirements had been assessed and were sufficient to ensure a safe and timely approach. The management team strengthened staff skills and support through training and supervision. A staff member said, "I feel well-trained and able to carry out my duties. The managers are very good at making sure we get the training we need."

The registered manager developed care planning with people and their relatives to reduce the risk of malnutrition. Information, including details about diet and healthy eating, assisted staff to understand each person's nutritional requirements.

Staff demonstrated a good understanding of supporting people with diverse needs. Support planning was

personalised and focused on retaining people's independence. Care records held good levels of guidance to help staff understand and manage people's privacy. The management team endeavoured to include people and their relatives in the development of their care plans. A staff member stated, "This is my second home and I am really pleased to see how much [the person] has progressed along the way."

Throughout our inspection process, we found the provider was keen to work closely with CQC and other health and social care services to improve. People and their relatives responded positively in satisfaction surveys about their experiences of using Waves. Staff said they felt there was good communication and the management team encouraged them to share ideas and good practice.

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.

We found staff and the management team did not always protect people from harm or potential abuse.

Staff did not consistently respond with an approach that minimised risks and harm.

The provider could not be assured employees were suitable to work with vulnerable adults because they had not followed safe recruitment procedures.

The management team provided medication training and staff had a good understanding of relevant procedures.

Staff told us they felt staffing levels were sufficient to meet the requirements of the agreed packages of care.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not fully informed about safe and the least restrictive practices to consistently and effectively support people who used Waves.

We found staff had a range of training to support them in their roles and responsibilities.

The registered manager, where applicable, had care planned and risk assessed people's nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered manager had not always ensured people's human rights were protected.

Care records reflected important information in relation to each person's dignity and privacy.

We saw staff were courteous towards those they supported and had a good awareness of their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Treatment responsiveness and outcomes could not be properly measured to assess their impact on people because clear oversight was not always in place.

There was a strong focus to deliver a programme of activities to provide social stimulation for those who used the service.

Information was made available to people that described how to make a complaint and relevant steps to follow.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management team did not always maintain good quality assurance oversight and standards in governance.

People and relatives were complementary about the leadership and organisation of Waves.

The management team were supportive of staff and valued them as employees of the service.

Waves Supported Lives Ltd

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 visit at Waves was undertaken on 29 October, 02 and 08 November 2018 and was announced. We gave 48 hours' notice of the inspection to ensure people who used the service, staff and visitors were available to talk with us. The inspection team consisted of two adult social care inspectors.

Before our inspection on 29 October, 02 and 08 November 2018, we checked the information we held about Waves. This included notifications the provider sent us about incidents that affect the health, safety and welfare of people who lived in their own homes. We also contacted other health and social care organisations, such as the commissioning department at the local authority. This helped us to gain a balanced overview of what people experienced using Waves. We were informed about an ongoing safeguarding incident being investigated by the local authority. This related to the use of physical intervention on a person who used the service. We used this information as part of the inspection visit because we wanted to assess people's safety whilst using Waves.

Furthermore, we looked at the Provider Information Return (PIR) the provider had sent us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with a range of people about this service. They included one person who used Waves, a relative, four staff and three members of the management team. We did this to gain an overview of what people experienced whilst using the service.

We examined care records of five people who used Waves. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing. We checked staff training and support documents. We reviewed recruitment records related to four staff and looked at documentation relevant to the management and

safety of Waves.

Inadequate

Is the service safe?

Our findings

In planning for this inspection, we received information of concern from the local authority about a serious incident that had occurred at Waves. Consequently, we used this information to assess people's safety whilst using the service during our inspection visit.

People and relatives we spoke with confirmed they felt safe whilst using the service. One person told us, "Waves have been great, the best thing that has happened to me. I feel really safe and comfortable with them." A relative discussed how Waves addressed their concerns about managing issues that could arise out-of-hours. They added, "They have an excellent on-call system, the best I have ever seen in all these years."

The registered manager's training matrix evidenced staff had or were in the process of completing safeguarding training. When we discussed this with personnel, they demonstrated a good awareness of principles related to protecting people from poor care and reporting abuse. One staff member said, "I would not hesitate to report or whistleblow to CQC if I had concerns. The people I support always come first."

However, we found staff and the management team did not always protect people from harm or potential abuse. There were multiple incidents where they used physical intervention without legal authorisation to do so. The service's restraint policy did not include important information as set out in current guidelines to guide staff on safe, appropriate practices. Assessments and other care records had been completed in relation to triggers and keeping people safe. We saw these were based on outdated information. This placed individuals at risk of unsafe and inappropriate care because staff could not be assured they employed permitted, correct and safe measures.

Additionally, records we looked at identified disproportionate management of behaviours that challenged the service. For example, punitive actions included the removal of personal technology and use of restraint that did not reflect the seriousness of incidents. Consequently, staff and the management team did not always use the least restrictive practice to maximise people's retention of control over their lives.

Waves' safeguarding policy had not been updated to reflect current safe practice and guidelines. Additionally, we found the service was not always based on up-to-date guidance related to the specific and specialist needs of people who used Waves. For example, they were using 'Valuing People - A New Strategy for Learning Disability' guidance instead of the more current information under 'Positive and Proactive Care: reducing the need for restrictive interventions.'

These are breaches of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to continuously ensure people were not exposed to the risk of harm.

The registered manager completed detailed risk assessments to guide staff about protecting people from unsafe care in their own homes. They covered potential concerns, the level of risk, actions to manage them and safe outcomes. Assessments included road safety, transport, accident and injury, privacy and dignity,

medication, behaviours that challenge the service and fire safety. A staff member commented, "Their safety is paramount, that is why I am here. I keep updated to the risk assessments and bear them in mind in everything I am supporting them with."

However, we found staff and the management team did not always follow risk assessments fully through in the management of behaviours that challenged the service. For instance, daily logs indicated where a person's behaviours started to deteriorate, staff did not always respond with an approach that minimised risks and harm. Unauthorised restraint was used on multiple occasions with no management strategies or monitoring systems to achieve safe outcomes. Where physical restraint was used, such as following one person throwing a plate, this was not always proportionate to the incident. Staff frequently recorded in daily logs 'restraint used' without documenting how, what and where risk was reduced. This meant risk was not continuously mitigated to protect people from potential harm and an unsafe environment.

These are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to do all that is reasonably practicable to mitigate risks and continuously maintain people's safety.

We reviewed how the management team recruited suitable staff to work with vulnerable adults. Two staff we talked with said they did not commence in post until required documentation, such as references and criminal record checks, was obtained. One employee stated, "My recruitment was really great. I did not start until the DBS (Disclosure and Barring Service) and references were in place."

However, we found in three staff files DBS checks and references had been acquired after staff started in post. Furthermore, records showed the management team had not checked each candidate's full employment history. We saw there were gaps in records and reasons for leaving had not been fully explained. A complete and thorough documentation of their work-life was not documented as required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the provider could not be assured employees were safe and suitable to work with vulnerable adults. Where staff pre-employment checks identified risks, such as convictions or cautions, the registered manager had not implemented measures to mitigate those risks. These practices exposed people to the risk of unsafe care.

The provider had not followed their recruitment policy, including the induction of new staff in post. One staff member told us, "I had a good induction to the ethos of the service, how it works and my role." There was no indication they were supported to complete and sign off their induction as per Waves' relevant set of procedures. The specific induction policy covered the requirement to complete a checklist of various procedures. However, this was not evidenced in any of the four employee files we reviewed. This showed staff did not have the necessary information and guidance about the service during the commencement of their roles.

These are breaches of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to consistently follow safe practice in the recruitment of suitable staff.

We reviewed the administration of people's medicines in their own homes and noted these were stored safely and securely. Weekly audits completed by the management team identified multiple occasions where staff had not signed and dated when medication had been given. This was addressed through supervision, reminders in the communication book and a sign displayed next to the medicines cabinet. We found this was a good system because follow-up records showed a reduction of incidents.

Staff checked stock was correct and we observed they ensured medicines dispensed matched up to the

medication record. People told us they received their medication on time and as prescribed. One person stated, "I wouldn't remember to take my medication, so I am really glad the staff do it for me, I feel much safer. They always give me my medication when it is due." Care plans included details about each medicine prescribed, such as directions and potential interactions, to enhance staff awareness. The management team provided training and staff had a good understanding of relevant procedures. A staff member said, "Yes, I know what I am doing with medication because I have been well-trained and understand why [the person] is taking what they are prescribed."

However, we saw people's records did not always contain protocols to guide staff about the use of 'when required' medicines. Without such procedures, staff were not always made aware of how and when these should be dispensed. The management team had not always followed good practice in safe medicines administration.

We recommend the provider seeks guidance from a reputable source in relation to the safe use and administration of 'when required' medication.

Staffing levels to meet each person's requirements had been assessed and were sufficient to ensure a safe and timely approach. The management team were keen to ensure a consistent deployment for people to be supported by staff familiar to them. For example, they covered sickness and leave by rostering other staff also known to each person. This assisted people and their relatives to build up meaningful relationships. A person who used Waves commented, "I get the same carers, which has helped me to trust them and get on with them." Staff told us they felt staffing levels were sufficient to meet the requirements of the agreed packages of care. One staff member stated, "[The person] gets the right level of staff to meet her support needs."

We saw staff washed their hands before and after assisting people with personal care, such as meal preparation. Staff we spoke with confirmed they had sufficient personal protective equipment and training as part of their infection control procedures. One staff member said, "Part of my job includes some cleaning of the client's house. I know what I'm doing because of the infection control training I had." A communication book in each person's own home was used to provide staff with information about various areas of care. This included identified maintenance issues and we saw these were followed up to ensure the continued safety of people who used Waves.

Requires Improvement

Is the service effective?

Our findings

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. The Deprivation of Liberty Safeguards (DoLS) do not currently apply in settings such as domiciliary care where people are resident in their own homes and so any deprivation of liberty may only be undertaken with the authorisation of the Court of Protection (CoP).

Care records we looked at demonstrated good evidence of the management team assessing people's mental capacity and best interests. The registered manager had implemented Management of Actual or Potential Aggression (MAPA) training. They provided this for all staff working in situations where people had the potential to display aggression and agitation. One staff member told us, "The MAPA training was excellent and I was not allowed to support someone with complex behaviours until I completed it. It was really valuable training because it gave me the confidence to support people with challenging behaviours safely." When we discussed the principles of the MCA with staff, we found they had a good understanding. The staff member added, "Our clients have a difficult life and one of the best ways we can help them to enjoy themselves and have meaning to their lives is by always giving them options. It helps them to have more power and control."

At the time of our inspection, the management team were applying for a CoP for one person to safeguard them. However, we saw multiple incidents of restraint was used without proper and legal authorisation to do so. The registered manager could not be assured the least restrictive practice was used at all times. This was because there was no accurate oversight and monitoring of behaviours that challenged the service. Consequently, the registered manager could not effectively identify clear triggers, successful support actions and improved outcomes.

We found the management team had poorly care planned for people who displayed behaviours that challenged the service over periods of months. Information to guide staff focused on the management of situations in which individuals had reached crisis point. Care records did not include effective, evidence-based best practice to diffuse escalating behaviours. This meant staff were not fully informed about safe and the least restrictive practices to consistently and effectively support people who used Waves.

The policy on restraint at Waves did not reflect important up-to-date guidance to inform staff practices. There was limited evidence to demonstrate the management team referenced current legislation, standards and evidence-based guidance to achieve effective outcomes. We found they embedded out-of-date direction in the delivery of care to people who used the service.

These are breaches of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to continuously assist people to have as much control over their lives

as possible.

Care records included documented consent to people's treatment, including agreed packages of care between the person and Waves. We observed staff consistently offered options to people and helped them to make their day-to-day decisions. A person who used the service stated, "I know I need encouraging, but the staff try their best to help me decide what I want to do. They have never done anything I felt uncomfortable with." Staff demonstrated a good understanding of the principles related to consent in care. One staff member said, "[The person] plans their day, but then always changes this and it is my responsibility to run with what they want to do."

We found staff had a range of training to support them in their roles and responsibilities. This included, for example, fire safety, first aid, food safety, infection control, medication and safeguarding. Additional specialist training specific to people Waves supported covered epilepsy and autism. A relative commented, "Absolutely lovely and highly-skilled staff." The management team strengthened staff skills and support through supervision. Supervision was a one-to-one support meeting between individual staff and a member of the management team to review their role and responsibilities. A staff member told us, "I am having my first one next week. I'm really looking forward to that because the managers are really supportive and keen to discuss our progress and help us develop in our roles."

Care records we saw evidenced staff and the management team had involved other healthcare professionals in the continuity of people's care. This included their GP, learning disability nurse, dentist and social worker. There was a multi-disciplinary approach to the update of care and people's progress through monthly review meetings. This enabled the assessment of treatment outcomes and kept those involved up-to-date about changes to care planning and health. Staff maintained a communication book within each person's home to inform shift handovers. This detailed planned appointments and changes to medication. Staff showed a good understanding to follow if someone's general health deteriorated. One staff member told us, "If someone became unwell I would discuss their concerns with them. If necessary we would get them up to the doctors and then contact the family. It's just about making sure we follow the procedures."

The registered manager, where applicable, had care planned and risk assessed people's nutritional needs to reduce the risk of malnutrition. Support plans included details about diet and healthy eating, as well as, for instance, risk assessment of choking hazards. Information assisted staff to understand each person's nutritional requirements. One staff member told us, "I support [the person] with meals. We cook together to manage her safety and develop her skills and independence." Staff records confirmed they received food safety training to enhance food hygiene and meal preparation. Another staff member said, "I discussed with [the person] about food safety and asked if it was ok to buy a fridge thermometer. She understood why and now we check this together and date the food so that it can be thrown away if it has gone off."

Requires Improvement

Is the service caring?

Our findings

We observed staff had a kind and respectful approach to people they supported. People and relatives we spoke with confirmed they had good relationships with staff. One person told us, "I get the same carers, which has helped me to trust them and get on with them." A relative said, "They've got great staff, who are very caring."

Staff and management understood and respected the diverse needs of people with a protected characteristic as defined in the Equality Act 2010. This included staff training in relation to sexual orientation. They also worked with an advocate, who the registered manager stated, "Does training for staff and clients around sexuality and staying safe in relationships." Advocates provide independent support for those who require assistance to express their views. Pointing people towards advocacy services helped to promote their rights to make decisions about their care. Staff demonstrated a good understanding of supporting people with diverse needs. One staff member told us, "Everyone is different, with different personalities, behaviours, interests, cultures and needs. It is my duty to respond to this and work with each person's individuality."

However, the registered manager had not always ensured people's human rights were protected. Documentation evidenced the use of restraint without legal authorisation to do so. Additionally, where staff and the management team deployed physical intervention we saw this was not consistently proportionate to behaviours displayed. Staff also used language in daily logs to describe people as, for instance, 'defiant,' 'compliant' and 'performing.' Such terms did not consistently describe individuals who used the service in a respectful way.

Care records reflected important information in relation to each person's dignity and privacy. The management team documented in one care plan we saw, 'staff to provide [the individual] with a towel to cover his lap to maintain his dignity.' Support planning was personalised and focused on retaining people's independence. For instance, risk assessments covered infringement of rights to privacy where a person was not able to maintain them. This showed good levels of guidance was made available to help staff understand and manage people's privacy. We saw staff were courteous towards those they supported and had a good awareness of their needs. One staff member stated, "I'm fully aware of the clients' needs and their care plans. They're very detailed and give us a good understanding of who the person is and what support they require."

The management team endeavoured to include people and their relatives in the development of their care plans. One relative explained their family member had struggled when they first accessed Waves because of the introduction of new staff. They told us they were consulted about the care plan and added, "It's about getting that right and improving trusting relationships between him and the staff." Staff we talked with were clear about how important the involvement of families was to good standards of care. We observed they enjoyed their work and they told us they valued the job satisfaction they experienced. One staff member stated, "I love my job. I spend much more time with the clients so I can develop a deeper relationship with them, based on trust and mutual understanding."

We observed staff engaged with those who used Waves on their level, using eye contact, appropriate humour and gentle tones. They understood the importance of getting to know people to develop caring bonds between them. One person told us, "I like the staff, they care about me."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staff responded well to their needs. One person said, "The staff are great. They get me and we can have a good laugh, that's the most important thing to me." A relative added, "[My family member] is definitely starting to get better since Waves have been supporting him."

However, we found there was no clear process from pre-assessment to care plan development, monitoring and review. Behaviour management plans were particularly poor because staff guidance only covered when people were at crisis point. Care plans did not evidence how staff should de-escalate situations and support individuals who displayed lower levels of agitation. Although staff documented people's general mood levels, there was no well-defined oversight of behaviours. For example, charts were not used to aid the management team to review triggers, patterns and themes. Additionally, where restraint or other interventions were deployed, staff did not consistently document why or how. Consequently, treatment responsiveness and outcomes could not be properly measured to assess their impact on people who used the service.

Staff did not always use the least restrictive practice and we saw multiple instances of restraint used without due process and recorded authorisation. A relative said, "I found Waves were initially too quick to use restraint, out of the need to protect [my family member]." Care delivery was not always underpinned by up-to-date national guidelines. For instance, policies, procedures and care planning did not constantly reflect current evidence-based best practice.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to maintain quality records to guide staff responsiveness to people's needs.

A relative we spoke with told us they felt Waves was placed in a difficult situation when they commenced the package of care. They added this was because of issues they had with a previous provider. The relative commented, "They are working really to understand [the person] and help him get back to how he was. I am really impressed with how Waves are sticking by him, despite the all-round difficult situation they are facing."

The management team system to update people's care planning involved initial notification of changes by staff supporting the person in their own home. The assistant care manager would visit them and review their needs. The registered manager stated, "It allows the person to be fully involved in their care planning and review." People and their relatives told us they were consulted about the evaluation and update of their care planning. A relative commented they were, "Involved in the review of and care plan development."

Waves did not provide end of life support at the time of our inspection. However, we noted documentation was available to record people's related wishes if this became necessary. For example, one risk assessment covered action to take if a person's relative, who was their main carer, passed away. This was a responsive approach to maintain the continuity of their care.

We found the management team recorded people's life history to guide staff to better understand their background. This included their wishes in relation to their care and support. Recorded information reflected their preferences about, for instance, toiletries, sleeping times, food and drink likes/dislikes, activities and personal care. One staff member stated, "You have to be intuitive to the person's needs in this job, especially with the type of people we work with."

The registered manager strove to pair people who used Waves with staff with similar interests. They said, "We work hard at the matching process, checking people's preferences, interests and how they want to be supported to provide staff best-suited to them." When we discussed this with people who received a package of care, they confirmed there was good consistency of staff deployment. One person told us, "I get the same carers, which has helped me to trust them and get on with them." The service provided a minimum of two-hour care packages to develop stronger relationships with people and maintain continuity of their support. The registered manager added, "We do not want to do pop-ins because it's not a speed-driven process. The clients are paying for the service. We don't want our clients left feeling they are wanting more."

Waves was keen to utilise information technology to benefit people who used the service. For example, they stored everyone's details and service information on back-up systems to prevent data loss in the event of equipment failure. Additionally, they were in the process of transferring their recordkeeping to an electronic system. This would create a system whereby staff could keep information up-to-date and live to assess the responsiveness of care.

There was a strong focus at Waves to deliver a programme of activities to provide social stimulation for those who used the service. This included baking, information technology and other equipment to match each person's preferences. Additionally, staff supported people to attend a dating service called 'Meet and Match.' This involved regular social sessions and discos. The registered manager told us, "We provide training for clients on staying safe in relationships and staying safe on line." People were also supported to access local services and amenities to be more inclusive within the community. This comprised of, for example, day centres, college, volunteer services, the cinema and shopping. A staff member said, "I love seeing the clients enjoying their lives, improving and just having a life worth living."

We saw information was made available to people that described how to make a complaint if they wished and relevant steps to follow. The registered manager told us they had not received any formal complaints. A person who used Waves told us about an informal complaint they raised and how satisfied they were with how it was addressed. They added, "I spoke with [the registered manager] and he sorted it no problem. That's an example of how things are dealt with here, quickly and confidently. They listen to me and sort things out."

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they felt Waves was well organised and had good leadership. A relative said, "Waves has a strong management approach. The managers have been very approachable and have gone out of their way. They'll listen to me." A person who used Waves commented they had a good relationship with the management team and added, "I have no concerns, but if I did I would be straight on the phone to [the RM] and he would sort it out."

Policies at Waves were not constantly followed, such as recruitment procedures. The registered manager failed to ensure references and DBS checks were secured before employment of staff. The policy referenced an induction checklist, which we found had not been completed for all staff. Other relevant, important procedures and protocols were missing or did not follow relevant guidance. For instance, 'when required' medication protocols had not been implemented, where applicable, and the safeguarding policy was not updated to current best practice.

There were multiple incidents when staff and the management team used restraint without documented legal authorisation. There were no monitoring charts to oversee people's behaviours that challenged the service. This meant the effectiveness of support could not be properly assessed. We saw not all records correlated with each other to ensure correct information was shared between services. For example, one person's details identified they had an allergy that was not documented in their hospital passport. Staff made use of abbreviations in daily logs and other records, which did not follow national guidelines on recordkeeping.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to maintain good standards in recordkeeping and quality assurance oversight.

Throughout our inspection process, we found the provider was keen to work closely with CQC and other health and social care services to improve. They responded quickly to concerns we raised to enhance service management, staff effectiveness and people's welfare. For example, we discussed one person's care and housing not being provided under separate contractual agreements. This limited their independence and housing choice. However, on the last day of our inspection visit the provider evidenced they were acting to correct this situation. Additionally, a new recruitment policy and staff risk assessment had been introduced to augment the safe recruitment of suitable staff. People and relatives confirmed, in their feedback, they were assured about good leadership at Waves. Comments seen were, 'The gentlemen that run this service are highly qualified and are both very nice and understanding people,' and, 'I have every confidence in your company and am very grateful personally for your valuable support.'

The provider was keen to ensure the development of its management team to deliver a well-led service. For example, they funded the care manager to complete a level five management qualification. All personnel we spoke with expressed they experienced a much better work-life balance since their employment at Waves. One staff member commented, "My work-life balance has improved dramatically since I came to work for

Waves because the managers are so good at working around what I need as well." Staff told us the management team were supportive and they felt valued as employees of the service. One staff member stated, "The managers are always there on hand to help or answer any queries. I'm happy with everything." Another staff member added, "They're good managers, very open, approachable and understanding."

The management team completed a variety of audits to assess the quality and safety of the service. These included staff files, care records and medication. They further regularly undertook a 'workplace inspection' to monitor and retain clear oversight of the service. A member of the management team told us they were in the process of developing a new audit better suited to the service. We saw this was being designed and were told it would be implemented.

Records we looked at evidenced monthly meetings were held between a member of the management team and care staff. We saw minutes from the last meeting covered, for example, people's progress and care, recordkeeping, medication and staff training. Staff commented they felt there was good communication at the service and the management team encouraged them to share ideas and good practice. One staff member confirmed, "I feel very valued by Waves. They listen to my ideas and are keen to provide the best possible service."

We found the management team sought people and relatives' feedback about their experiences of care through satisfaction questionnaires. A person who used Waves said, "The staff and [the management team] have checked how things are going. They ask about my care and if there is anything else I need." We reviewed responses from the last survey completed in 2017. This checked a range of areas, such as personal care, staff attitude, dignity and respect, staff training, continuity of staff and complaints. The provider ensured transparency by making publicly available an analysis and overview of patterns, themes and feedback given. We noted responses were positive about the service. Comments seen included, 'Good service,' and, 'I am completely satisfied with the level of support I receive from Wave Supported Lives.' Also, 'Listen to all the family. Understanding, caring and supportive,' and, 'You have helped to keep her stable and, very importantly, motivated since joining your team.'

The management team worked in partnership with other organisations. They were keen to ensure they follow current practice, provided a quality service and maintained people's wellbeing. This included engagement with local social services, healthcare professionals and health and social care community teams.

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 The management team failed to do all that is reasonably practicable to mitigate risks and continuously maintain people's safety. Risk assessments were not always fully followed through in the management of behaviours that challenged the service. Regulation 12 (1), (2 [a, b])

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The management team failed to continuously ensure people were not exposed to the risk of harm. There were multiple incidents where they used physical intervention without legal authorisation to do so. Staff could not be assured they employed permitted, correct, proportionate and safe measures. Staff and the management team did not always use the least restrictive practice to maximise people's retention of control over their lives. Regulation 13 (1), (2), (4 [b, d]), (5), (7 [b])

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The management team failed to maintain quality records to guide staff responsiveness to

people's needs. Treatment outcomes could not be properly measured to assess their impact on people because there was no well-defined oversight of behaviour management. Staff made use of abbreviations in daily logs and other records, which did not follow national guidelines on recordkeeping. The management team failed to maintain good quality assurance oversight. Audits were not completed regularly. Policies at Waves were not constantly followed, were missing or did not follow relevant guidance.

Regulation 17 (1), (2 [a, b, c, d i, ii])

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The management team failed to consistently follow safe practice in the recruitment of suitable staff. Required checks had not been acquired until after staff started in post. There were gaps in records and each candidate's full employment history was not evidenced. Where risks were identified the registered manager had not implemented measures to mitigate them. Regulation 19 (1 [a, b]), (2 [a]), (3 [a])