Tracs Limited

Tracscare Supported Living Office

Inspection report

Unit 514
K G Business Centre
Northampton
Northamptonshire
NN5 7QS

Date of inspection visit:
15 September 2017
19 September 2017

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30 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced comprehensive inspection took place on the 15 and 19 September 2017. Tracscare Supported Living Office provides personal care and supported living for people living in their own homes. At the time of this inspection the service was providing support to nine people.

There was a person registered as a manager with the Commission however, this person was no longer in post as the manager of the Service. A registered manager is a person who has registered with the Care Quality Commission 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.

People could not be assured that they would receive their prescribed medicines safely. We found examples of missed medicines and errors in the recording of the administration of people's medicines that had not been identified or acted upon by the provider.

The providers' quality assurance systems had not been effective at identifying or addressing shortfalls in the care and support that people received. The providers quality assurance systems had not identified that people's medicines were not managed safely or that accidents and incidents had not been reported or acted upon appropriately.

Accidents and incidents had not been reported appropriately by staff and this had resulted in action failing to be taken in response to incidents.

The provider needed to review the deployment of staff to ensure that people received personalised packages of care and that people consistently received their commissioned one to one care. Staff felt supported in their role however, they did not have access to regular formal supervision.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report concerns to the relevant authorities. Staff were confident in recognising and raising concerns if they felt people were at risk.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and had applied that knowledge appropriately. People were supported to make decisions for themselves and their consent was actively sought by staff.

People were supported to have sufficient amounts to eat and drink to maintain a balanced diet. Staff monitored people's health and well-being and ensured people had access to healthcare professionals when required.

Staff had access to an on-going programme of training to aid their professional development.

People had detailed plans of care that they had been involved in developing to guide staff in providing consistent person centred care and support. People had the information they needed to make a complaint and the service had processes in place to respond to any complaints.

There had been continued instability in the management of the service however, the provider had taken action to try and provide a period of stable leadership to implement improvements in the care and support people received.

At this inspection we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

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 consistently safe.

People could not be assured that they would receive their prescribed medicines safely.

People could not be assured that appropriate action would be taken in response to accidents or incidents.

Risks to people had been assessed and plans of care implemented and followed by staff to mitigate the known risks to people.

Staff were confident in the steps that they should take to protect people from the risk of harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have access to regular formal supervision.

People were supported to have enough to eat and drink and to maintain a healthy, balanced diet.

People's capacity to consent to their care and support had been assessed and was actively considered by staff on a day to day basis.

People received the support that they needed to access healthcare services.

Is the service caring?

Good

The service was Caring.

People were supported by staff that knew them well and treated them with dignity and respect.

Staff took pride in reflecting upon the achievements of the individuals they supported and were committed to enabling people to be active members of the local community.

People's right to privacy was respected by staff.

Is the service responsive?

Good

The service was Responsive.

People's needs were assessed prior to receiving care and subsequently reviewed regularly so that they received the care they needed.

People had detailed personalised plans of care that were reflective of their care needs. These plans of care supported staff in providing consistently person centred care and support.

People knew how to make a complaint and were confident that their feedback would be taken seriously and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager.

Formal quality assurance systems had not been implemented appropriately which had resulted in on-going shortfalls in the service.

People's care and support had been coordinated at a location that was not registered with CQC.

The provider was committed to taking action to address the shortfalls that we identified during this inspection.

Tracscare Supported Living Office

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 checked 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.

This inspection took place on 15 and 19 September and was announced. The provider was given 48 hours' notice because the location provides care to people in their own homes and we needed to be sure that there would be someone present in the office to facilitate this inspection.

The inspection was carried out by one Inspector.

Prior to our inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications sent to us by the provider. We also spoke with local health and social care commissioners to gather information about the service. Prior to the inspection the provider completed a Provider Information Return [PIR]. 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. The provider returned the PIR and we took this into account when we made judgements in this report.

During this inspection we spoke with eight members of staff including the Quality and Compliance Manager, Area Operations Manager, Quality and Service Director and three care staff. We also spoke with two people using the service and received questionnaires from one person's relative and another person's commissioner.

We reviewed the care records of four people who used the service and three staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that they would be supported to receive their prescribed medicines safely. We reviewed the Medication Administration Record (MAR) charts for four people and found errors in the recording of the administration of medicines for each of these people. In addition to the errors in recording we found examples of missed medicines for people.

For example, one person was prescribed Metformin which is a medicine to treat diabetes. The service had recorded that they had received 60 tablets from the pharmacy and had recorded that they had administered 44 tablets however; we found that 18 were held in stock. This indicated that on two occasions this medicine had not been administered although the MAR chart had been signed by staff as having been administered. Another person had their prescribed medicines placed into a dossette box by their pharmacy. A dossette box is a disposable plastic tray that separates medicines into individual compartments for different times of the day and week and is pre-packed by individuals' pharmacies. The medicines for Thursday the week prior to our inspection were still present in the dossette box and had not signed as being administered however, we were concerned about this as there was no reason for these not being administered and nobody had reported that they had not been.. For another individual we found six examples whereby their medicines had not been signed as having been administered. The stock levels of this person's medicines had not been recorded and therefore we could not tell if this person had received their prescribed medicines or not.

No audits of the administration of people's medicines had been completed by the provider. Staff had not recognised that medicine errors had occurred or that people had not received their prescribed medicines and therefore no action had been taken to ensure that people did not come to harm as a result of omissions in the administration of their medicines. Staff had received training in the safe administration of medicines and had been observed by senior staff as being competent to administer people's medicines. However, staff had failed to recognise and take action when people had not received their prescribed medicines.

In response to our feedback the provider completed a full audit of the administration of people's medicines. The provider identified a number of shortfalls and told us that they would take immediate action to improve the practice of staff and made referrals to the Local Authority safeguarding Team to report omissions in people's care. The provider told us that they would complete regular audits of the administration of people's medicines and recognised that people had not been supported appropriately to receive their prescribed medicines. We could not see that the action taken by the provider had yet been effective at ensuring that people received their prescribed medicines safely.

The failure to ensure the proper and safe management of medicines was breach of
Breach of Regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by sufficient numbers of staff however, the deployment of staff needed to be reviewed by the provider to ensure that people consistently received their commissioned one to one care. One person told us "There are always enough staff here. If you need someone or want to talk to one of the staff there is always someone around." A member of staff told us "There are always enough staff working in

the house. We are short staffed but use agency staff to make sure that there is always enough people working."

We reviewed the staff rotas for one supported living property that was shared by four people receiving support. Each of these individuals received commissioned one to one care hours ranging from five to eight hours of one to one support each day. Staff rotas were developed for each house where people received support rather than for each individual. Therefore, the provider could not be assured that people received their commissioned one to one care hours. One senior member of staff told us "We always make sure that there are at least two staff on duty and provide extra staff if there are planned activities. The staff just make sure that they support people to do what they want to do."

Within a supported living setting people should receive bespoke packages of care designed around their preferences and assessed care needs. During this inspection we found that people shared their commissioned care hours with the other people living in their home and could not be assured that they would receive their individual commissioned one to one care hours consistently. We discussed this with the provider who told us that they would review their staffing model for shared supported living properties. The provider told us they would ensure that people received individualised packages of care in line with their assessed needs and commissioned packages of care.

Accidents and Incidents were not always reported or recorded appropriately. This meant that appropriate and timely action was not always taken in response to accidents and incidents. The provider had recently introduced an electronic system for the reporting and recording of accidents and incidents however, not all staff were familiar with nor were using this system. One member of staff told us "We always write down accidents and incidents on a form and leave them for the Team Leader to review." This member of staff was unable to locate where the accident and incident forms were located however, they told us that there had been incidents within the home that they had reported.

We reviewed the accident and incident records that were maintained by the provider and found that the last recorded incident occurred in August 2016. We reviewed the daily handover sheets for one shared supported living property and found that there had been three occasions in August 2017 where one person had absconded from the home and the police had been contacted. This was a known risk and the person had plans of care to guide staff in providing support in the event that the person absconded from their home. However, the specific incidents of them absconding had not been reported or escalated to the senior management team for appropriate action to be taken to review the support that their person received. The provider acknowledged that accidents and incidents had not been recorded or reported appropriately and that this meant they had limited oversight over the incidents that had occurred across the service. The provider told us that they would take immediate action to ensure staff reported accidents and incidents appropriately.

Risks to people had been assessed and the staff providing people with care and support were knowledgeable about how to mitigate people's known risks. People told us that they felt safe, their comments included; "It's really good here. The staff make me feel safe." and "The staff look after me and make sure that I am kept safe." People had a range of risk assessments in place that were reviewed monthly as part of their individual plans of care that provided guidance to staff on how to minimise the risks to people. Staff told us "We work with the same people and know them well. We follow people's care plans and risk assessments to keep them safe"

People were protected from the risk of harm. Staff were knowledgeable about the steps to take if they were concerned people may be at risk. One member of staff told us "If I had any concerns about people's safety I

would report it to the on-call manager straight away. We also have a poster in the office that tells us how to contact the Safeguarding Team and CQC" Staff had received training on how to protect people from harm and records we saw confirmed this.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). The registered manager told us that she operated a thorough recruitment process and would only employ staff that she felt would be competent to work in the service.

Requires Improvement

Is the service effective?

Our findings

Prior to this inspection we received information of concern that told us staff had not received adequate supervision and had not felt supported in their role. During this inspection we found that staff felt supported in their role however, they did not always have access to regular formal supervision to enable them to reflect upon their practice and identify areas for development. One member of staff told us "I feel well supported; I can always contact the manager if I need advice or need to discuss anything. I think my last supervision was about three months ago but in between formal supervisions I can approach them at any time." We reviewed the records for the service and found that formal supervision had not been provided regularly or in line with the providers' supervision policy which stated that staff should receive formal supervision every two months. The provider's supervision matrix showed that a number of staff had only received one formal supervision in 2017 and that no member of staff had received supervision in line with the provider's supervision policy. The provider told us that they would take action to ensure that all staff had access to regular formal supervision and annual appraisal.

Staff had access to an on-going program of training to equip them with the skills and knowledge that they required to work effectively in their role. One person told us "I think the staff are well-trained. They know exactly what help we need and recognise when I need support or when it's best just to leave me alone." One member of staff told us "The training is good. When you first start it's quite intense as you have to do lots of training. I have worked here for a long time now but regularly update my training." We reviewed the training matrix for the service and found that staff had received on-going training in key areas relevant to their role such as safeguarding and health and safety.

New staff benefited from a period of induction that supported them to gain the skills, experience and competences that they needed to work effectively in their role. One member of staff told us "When I first started I had three days classroom training and then spent time shadowing and working alongside experienced staff until I knew what to do and was confident."

People were asked to give consent for their care and support and staff were knowledgeable about their responsibilities in relation to the Mental Capacity Act 2005. One person told us "They always check with me what help I need and what I want to do each day." 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 received the support that they needed to have sufficient amounts to eat and drink and were encouraged to develop independence in the preparation of their meals. One person told us "I have my own fridge in the kitchen and I get help every evening to cook my own meals. You can make whatever you want and the staff will help." People were supported to eat a balanced diet and staff promoted healthy eating. People were supported to plan their menus and shop for the groceries.

People's healthcare needs were carefully monitored and staff worked proactively supporting people to have access to healthcare professionals. One person told us "The staff take an interest in how you are. If you didn't feel well they would do something about it." For example, staff had liaised closely with one person's social worker and dentist to develop strategies to enable the person to be able to access dental services to maintain good oral hygiene.

Good

Is the service caring?

Our findings

People were supported by staff that knew them well. People had developed positive relationships with the staff providing their support. One person told us "All of the staff are lovely." Another person told us "The staff are so friendly and they are always about for me to talk to if I need to." During our visits to people's homes we observed that people were comfortable in the presence of staff and that staff interacted positively with the people they were supporting.

Staff supported people to live busy and fulfilled lives and to be as independent as they wished to be. One person told us "At very short notice I was told that I needed support if I wanted to go to college. The staff immediately worked out what to do and they come with me when I go to college now. I couldn't go without them." We observed staff working with people to find out what they wished to do in the day and supporting people to access the community and enabling people to become active members of the local community. The staff we spoke to took pride in the achievements of the people they supported.

People were treated with dignity and respect. Staff were aware that they were supporting people in their own homes and ensured that people were able to spend time in private should they wish to. People's personal information was stored securely and staff were aware of the importance of storing people's personal information securely to maintain their privacy. We observed that staff interacted with people respectfully and were discreet when asking people if they required support. The provider sought people's consent prior to visiting them at home and on the day of inspection sought people's consent for our visit and explained the purpose of our visit.

People were involved in developing their support plans which were written in a way they could understand. People's assessments and plans of care considered their life history, culture and personal beliefs. The support plans described how people wanted to receive their support and told staff what was important to people and the things they liked to do. One person told us "The staff asked what help I need and I know that I have a care plan that has all of that information in. The staff spend time with me checking that I am happy and asking if I need any other help."

Good

Is the service responsive?

Our findings

People were assessed before they received care to determine if the service could meet their needs. Initial care plans were produced to guide staff in providing support before new people began to use the service; staff then monitored and updated them as necessary. People had detailed plans of care in place that focussed upon their preferences, interests and individual needs. These plans of care set out the individual goals, aspirations and achievements of each person who used the service. Records were comprehensive and included descriptions of activities, health and behavioural support needs together with details of any concerns. One member of staff told us "The care plans are useful. When I first started I read them and when I met the person I knew what I had to do to support them."

Tracscare Supported Living provided care to a number of people living with autism. The provider supported staff to provide skilled intervention and support through the introduction of an 'Autism Lead' that provided support to services when required. The Autism lead provided support and advice to all of the services provided by Tracs Limited when their intervention was requested. We saw that the Autism Lead had facilitated focus groups with staff that provided support to one person in their own home to offer suggestions and ideas about how to support this person differently. The aims of the focus groups were to reflect upon how to enhance this person's sense of well-being and to minimise the number of incidents that were occurring within the home. We saw that staff had implemented the Autism Leads' suggestions of intensive interaction, the use of specific community activities and the introduction of garden activities. Subsequently the number of incidents in this persons' home had decreased significantly. One member of staff told us "It was really useful to have those focus groups. We have made lots of changes to [Person] support and it is amazing that we haven't had any incidents recently. They seem much calmer and more content at home now."

People had detailed positive behavioural support plans to provide guidance to staff in supporting people who display behaviour that may challenge services. These positive behavioural support plans were focussed upon identifying and reducing the triggers to people's behaviour to try and prevent incidents from occurring. Staff reported that these plans were successful in providing them with guidance to increase people's sense of well-being and in reducing the numbers of incidents occurring within the home. We observed staff successfully deescalating an incident with one person who was becoming unsettled by providing calm reassurance and focusing the person upon a specific task.

People knew how to make a complaint and had confidence that any complaints would be taken seriously and acted upon. One person told us "I haven't needed to make a complaint but I would if I ever needed to. I would tell one of the support staff or ask to speak to the manager. I know it is ok to complain if I need to." We reviewed records relating to complaints maintained by the service and saw that there was a system in place to manage complaints and to ensure that they were responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

People could not be assured that the quality of care and support that they received was appropriately monitored, that shortfalls in their support were identified or acted upon in a timely manner. During this inspection we identified a number of shortfalls that the provider was not aware of. There was no system in place that was being utilised to audit medication administration or to ensure that people had received their prescribed medicines safely. There was no management oversight of the administration of people's medicines. Medicines records were not reviewed and as a result of this, omissions in the administration of people's medicines and errors in the recording of the administration of medicines had not been identified or acted upon.

We found that incidents had taken place within people's homes but these incidents had not been reported and the provider's system to maintain an oversight and monitoring of incidents had not been used appropriately within the Tracscare Supported Living Service. The provider's internal quality assurance systems had not identified these shortfalls and nor had staff acted upon them and this had resulted in appropriate, timely action failing to be taken in response to incidents.
We identified that formal supervisions had not taken place regularly however; the providers' internal quality assurance systems had failed to identify this or to take action as a result of this shortfall. This meant that the systems that were in place to monitor, assess and improve the quality of the service had not been effective in identifying and addressing these concerns.

This was a breach of Regulation 17 (1) (a) and 2 of the Health and Social Care Act 2008. The provider had failed to implement effective systems to monitor, assess and improve the quality of care provided to people.

At the time of our inspection there was not a registered manager in post. The person who was registered with the Commission as the registered manager had left their post in August 2017 and a new Area Operations Manager had been recruited. During the inspection this person told us that they would not be making an application to become the registered manager. The provider had not informed the Commission that the registered manager was no longer in post and had not provided information to the Commission in relation the interim management arrangements that they had implemented.

In response to our feedback during this inspection and as a result of the shortfalls that we identified the provider took immediate action to review the management of the service. They told us that the Area Operations Manager would be making an application to become the registered manager. This was to provide stability to the service and appropriate management oversight to focus upon implementing improvements in the leadership, governance and monitoring of people's care and support. Following the inspection the provider made the appropriate statutory notification to inform us of the changes in the management of the service.

The provider acknowledged that there had been instability in the management of the service and a high turnover in managers. They told us that they were committed to improving the quality of care and support

that people received and to provided stable, consistent management. They told us that they had reviewed the way in which the service had been managed and the management structure for their supported living services to aid the retention of managers.

The provider was coordinating people's care and support from a location which was not registered with the Commission. The provider had recently accepted packages of care in Gloucestershire and had coordinated people's care and support from a location in Gloucestershire under the registration of the Tracscare Supported Living Office based in Northampton. Records of the care and support provided to the individuals supported in Gloucestershire were not available at the Northampton Office at the time of our inspection. People's plans of care as well as the scheduling of staff had not been coordinated from the location that was registered with the Commission nor by a person registered as a manager for the Northampton Office since August 2017. The Area Operations Manager confirmed during our inspection that people's care and the records associated with their care and support were not stored within the registered location in Northampton and were not available for us to review. They also told us that they believed an application had been made to register the office in Gloucestershire as a new location however; an application had not been made.
A condition of the registration for Tracscare Supported Living Office is that the regulated activity (personal care) may only be carried out from the location that is registered with the Commission. We found that the regulated activity was being carried out from a location that was not registered with the Commission.

Following our feedback as a result of this inspection the provider has confirmed that they have taken action to ensure that individuals support is coordinated from a location that is registered with the Commission. There had also been delays in submitting other statutory notifications following incidents and accidents because staff had not reported accident and incidents to senior staff in the appropriate manner.

Staff knew how to raise concerns and how to utilise the provider's whistle blowing policy. We saw that when concerns had been raised the provider took these seriously, investigated thoroughly and attempted to provide feedback to the individual who had raised the concerns. It was evident that Tracscare promoted an open culture and encouraged staff to feel secure in approaching senior staff to report concerns and to provide feedback without fear of recrimination.

Senior representatives from the provider were present with us throughout this inspection and have had regular contact with the Commission to provide updates on the action they have taken since our inspection to drive improvements within the service. The provider is committed to reflecting upon what action they can take to learn from this inspection and to support staff to provide consistently high quality care and support to the individuals they are supporting.

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 People could not be assured that they would be supported to receive their prescribed medicines safely. We reviewed the Medication Administration Record (MAR) charts for four people and found errors in the recording of the administration of medicines for each of these people. In addition to the errors in recording we found examples of missed medicines for people. This was a Breach of Regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to monitor, assess and improve the quality of care provided to people. This was a breach of Regulation 17 (1) (a) and 2 of the Health and Social Care Act 2008.