Care Worldwide (London) Limited

Dana Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This service provides care and support to people living in five 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Not everyone using Dana Home Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care' which is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The care service has been 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 can live as ordinary a life as any citizen.

The service had a registered manager. This 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.

At the last inspection of this service, in January 2016, the service was rated 'Good'. The service's rating is now 'Requires Improvement', the first time it has received that rating.

The service was not consistently ensuring the proper and safe use of medicines. One person had not received the medicines as prescribed, and records relating to medicines were not always accurate.

The service worked with people whose behaviour could challenge. Staff were trained to use restraint as a last resort. However, there were sometimes inconsistencies between different records of the same instance of restraint or sanction. Reviews had not identified this potential safety risk.

Staff recruitment checks were not sufficiently comprehensive, and signs of unsuitability were not always given due attention. Some staff were employed before these checks were completed. This did not assure that these staff were safe to work with people using the service.

Although some complaints from people using the service were paid due attention, the complaints system was not effectively operated due to inconsistencies with identifying, recording and responding to other complaints.

The service relied too much on our interventions to support continuous learning and improvement. For example, three police incidents and a safeguarding matter were not notified to us, as required by legislation,

until we pointed this out to the management team. Improvements to systems of reviewing sanctions and restraints were only made following our interventions.

There were a number of audit systems used at the service. However, we found that issues that were identified from these processes were not always addressed. Additionally, the provider's governance processes did not identify a number of concerns and service shortfalls we found.

Nonetheless, the service promoted a positive culture that achieved good outcomes for many people. People and healthcare professionals generally fed back positively about the service they received.

The whole service worked in co-operation with other organisations to deliver care and support that, on the whole, improved people's quality of life. People were treated with kindness, respect and compassion, and were given emotional support when needed. Attention was paid to supporting people's varied communication needs, to help them be better understood and more trusting of staff.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. Consent to care was sought in line with legislation and guidance.

People received personalised care that reflected their needs and preferences. Their independence was respected and promoted, though balanced with assessments of safety risks. People were supported to engage in preferred activities, study and employment, both at home and in the community.

People accessed healthcare services, received ongoing healthcare support, and were supported to maintain a balanced diet. For example, some people were losing weight as planned, and being encouraged to eat healthier meals.

The service provided enough staff who worked regularly with people. Staff were supported to gain the skills and knowledge to deliver the care and support people needed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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. Staff recruitment checks were not sufficiently comprehensive and timely, and signs of unsuitability were not always given due attention.

The service was not consistently ensuring the proper and safe use of medicines.

The service generally assessed and managed risks to people to balance their safety with their freedom, and protected people against the risk of infection.

The service's systems, processes and practices safeguarded people from abuse.

Is the service effective?

Good

The service was effective. People's needs and choices were assessed, to enable effective outcomes. Consent to care was sought in line with legislation and guidance.

The whole service worked in co-operation with other organisations to deliver effective care and support. People accessed healthcare services, received ongoing healthcare support, and were supported to maintain a balanced diet.

The service enabled staff to have the skills and knowledge to deliver care and support.

Is the service caring?

Good

The service was caring. People were treated with kindness, respect and compassion, and were given emotional support when needed. Staff knew the needs and preferences of people they were supporting.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support.

The service ensured people's independence was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive. The complaints system was not effectively operated due to inconsistencies with identifying, recording and responding to complaints.

People received personalised care that reflected their needs and preferences.

The service supported people to engage in activities at home and in the community.

Attention was paid to supporting the communication needs of people with a disability or sensory impairment.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Governance processes and audits were not consistently effective as they had not identified the concerns and service shortfalls that we found, or fully addressed matters that they found.

The service relied too much on our interventions to support continuous learning and improvement. For example, some incidents were not notified to us, as required by legislation, until we pointed this out to the management team.

Nonetheless, the service promoted a positive culture that achieved good outcomes for many people. It generally engaged with and involved stakeholders in the development of the service.

Dana Home Care

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.

This inspection took place on 21, 22 and 28 November 2017. It was carried out by two adult social care inspectors. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often at one of the supported living schemes as part of their managerial roles. We needed to be sure that they would be available for the inspection visit.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted the local authority and other community professionals involved in the service for their views, receiving three replies.

Inspection site visit activity took place on all three days of our visits. It included visits to three supported living schemes, to meet people living at those schemes, staff working with them, and to check records kept at the schemes. We also carried out observations of people's interactions with staff and how they were supported, as some people were unable to communicate with us due to the complexity of their conditions.

We also visited the office location on 21 and 28 November 2017, to meet the management team and review records relating to the management of the service.

There were 16 people receiving a personal care service in their home at the time of this inspection. During the inspection, we spoke with seven people, 13 support staff, three scheme managers, the multi-site

manager, and the registered manager.

During our visit we looked at seven support plans for people using the service along with other records about people's care and treatment including for medicines, incidents and care delivery. We also looked at the personnel files of six staff members and records about the management of the service such as staff visit rotas, incident summaries and the provider's policies. We also requested further specific information about the management of the service from the management team before, during and after our visits.

Requires Improvement

Is the service safe?

Our findings

Staff recruitment checks were routinely carried out, as confirmed to us by new staff. However, we found the process was not sufficiently comprehensive and timely, and signs of unsuitability were not always given due attention amongst those files checked on for staff recruited in 2017. This put people using the service at unnecessary safety risk.

One staff member's Disclosure and Barring Scheme (DBS) disclosure included some information of concern. A risk assessment about the DBS failed to show consideration of a relevant part of the disclosure, in coming to the decision to employ the person. Records showed the risk assessment occurred nine days after the person was employed. Additionally, the DBS disclosure was almost two years old, and so may not have had all up-to-date information. Records of reference requests were also dated nine days after employment started, and one relevant reference had not been received. There were therefore serious shortfalls in the robustness of recruitment checks for this staff member. We noted they were no longer working at the service, but they had been providing care and support people.

Two other staff members' application forms showed gaps in their employment histories. There were no records of exploring this, despite the interview forms prompting for that. The DBS disclosure for one of them was dated 16 days after they started their induction process. A fourth staff member's records showed they started their induction process three days before their DBS disclosure was in place. Legislation requires DBS disclosures to be in place before employment starts. A fifth staff member's DBS was almost two years old, and so did not disclose information that was on their updated DBS acquired five months after they started working. They also started work a few weeks before written references were in place.

Recruitment practices were not followed according to the provider's policy, which required clear documentation of the whole process, including exploration of employment gaps and any phone calls to referees. It also required a DBS disclosure prior to employment. We noted the use of standard forms for the interviewer to record the interview process. However, they were often incomplete, usually lacked a date, and always failed to state who undertook the interview.

The above evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not consistently ensuring the proper and safe use of medicines. Medicines were securely stored at the schemes. Medicines records for each person included allergy status, medicines profiles and explanations of what each medicine was for. We found many people's current medication administration records (MAR) had been completed correctly.

However, the MAR for one person showed staff had signed for supporting them to take their medicines five times across 20 days when care records showed the person was visiting family. Staff had twice recorded the person as being on leave when their care records showed they were using the service. There were six administration gaps for that person across seven weeks of being supported to take five prescribed

medicines. Our checks of controlled drug [a medicine that has additional storage and regulation requirements] daily stock check records also identified the person had not been given a prescribed medicine on one recent occasion due to staff error. The records showed another occasion when daily stock levels had not changed despite the medicine being prescribed once daily. Care records showed the person was visiting family. However, records had not been consistently made of how much of their medicines had been passed onto family and how much was returned. Stock checks records included crossing outs within the controlled drug register rather than additional entries to explain any identified errors. This all demonstrated medicines support had not been provided in a consistently safe way for this person.

For another person at a different scheme, we found two extra doses of one medicine compared to records of how much was in stock. Discussions with the management team established this meant stock had been inaccurately recorded for this medicine.

The management team spoke of new staff having training before being asked to give people medicines. Records showed 21 staff had completed this training. However, one staff member told us they had started giving medicines to people through on-site support and checks, but not yet completed online training, which the training matrix and other records confirmed. The management team confirmed they were not currently checking staff capability for safely supporting people with medicines. This demonstrated weaknesses in the safe and proper management of people's medicines.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team have since informed us of plans to restart medicines competency checks, provide additional training, and undertake more frequent medicines audits.

Individualised risk assessments were in place where anyone's behaviour had potential to challenge the service. Positive behavioural support plans had been put in place where needed. Staff were familiar with these plans and confirmed they had received appropriate training, for example, on safe restraint. One staff member said, "The training gave me all the information I needed to calm down [Person]." Another member of staff said, "Restraint is a last resort. We always try to avoid it. We use emotional support and distraction." A third spoke of positive reinforcements towards one person as it was recognised the person can "think things are his fault." A couple of people using the service also spoke positively of how staff supported them and others when anyone's behaviour was challenging the service. One person said, "Staff try to calm things down."

We noted there had been a reduction in incidents at the service in the two months prior to our inspection, which combined with other feedback indicated reviews of incidents were helping to minimise the risk of reoccurrence. We saw records from community healthcare professionals confirming this for individuals, for example, that one person "had decreased self-harm and aggression" through "consistently implemented guidelines." A staff member gave examples of how they worked with the person to help calm them, for example, in encouraging breathing exercises. There was guidance on this within the person's positive behaviour support plan. Another person had restarted using the service on the advice of their funding authority. Records and feedback showed good support of their specific challenging needs.

The service assessed and managed risks to people to balance their safety with their freedom. There were individualised risk assessments for each person that were up-to-date and monitored. For example, one person was at risk of choking. Staff followed instructions in line with their risk assessment for eating and drinking. Risk assessments were seen which enabled people to access the community which meant that

their freedom was promoted. One person had a risk assessment to ensure they were kept safe when in the company of a friend. The management team told us one person had rails on their bed but these were not used as there was a risk of them climbing over them. Instead the bed was kept low and there was a crash mat in place. People told us they felt safe with the service provided.

Records at schemes showed regular checks on fire safety equipment took place and fire drills were occasionally held. Personal emergency evacuation plans were relevant and up to date. There were also fire safety risk assessments and general premises risk assessments in place.

The service's systems, processes and practices safeguarded people from abuse. Staff demonstrated a good awareness of safeguarding procedures, who to inform if they were concerned about poor care, and who to escalate concerns to if needed. Staff told us of being reminded of procedures every so often, and we saw staff meeting minutes confirming this. Staff employment conditions included reference to safeguarding procedures and specifically stated a no-gifts policy, which helped ensure professional boundaries.

The management team told us they had discussed safeguarding with people using the service, and had used the local authority's easy-read guidance for this. They showed us a prompt safeguarding alert had been made in response to one person having a bruise and stating how it was acquired. Where one person had kicked another causing a bruise, this was also promptly reported to the local authority for advice as per the provider's safeguarding policy.

The service deployed sufficient numbers of suitable staff to support people to stay safe and meet their needs. Rosters at each scheme showed high levels of staffing were maintained and that the same staff tended to work at each scheme which helped ensure they understood people's needs. Staff confirmed appropriate staffing levels. For example, at one scheme, a staff member told us, "Everyone has 'one-to-one' so there are always four staff." They added people slept well despite their complex needs and so one sleep-in member of staff was enough.

The service's systems generally protected people against the risk of infection. There were no concerns with standards of visual cleanliness in the schemes. We saw staff cleaning parts of the premises, and reminding people to wash their hands when appropriate. There were systems in place to help promote infection control, including cleaning regimes and the use of personal protective equipment such as gloves, aprons and hand-gel. Most staff had received training on infection control and food hygiene. Records showed the management team reminded staff of infection control matters.

Good

Is the service effective?

Our findings

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. People indicated the service was effective. Their comments included, "I like it here" and "It's the best support of all of them" in reference to other services the person had experienced.

Feedback from the management team showed people's needs and preferences were assessed before decisions were made about using the service. As a result, one scheme had been adapted to provide a newer person with an accessible shower-room, so they could more easily and safely receive personal care.

The management team told us of setting up transition plans for supporting people to start using the service. For example, they had worked with one person, their family and their day care service for three months before the person moved into one scheme. The person had short visits and then overnight stays at the scheme beforehand, to help them adjust to the move.

Staff told us of one person no longer needing the support of three staff in the community, as per when they started using the service a couple of years ago. One staff was sufficient as long as the person was listened to. For example, when shopping for provisions, it was important to let them choose what they wanted first and allow them to keep handling their choice. The person could then help with the rest of the shopping.

The whole service worked in co-operation with other organisations to deliver effective care and support. For example, the management team told us of working closely with one person's clinical psychologist to keep their positive behaviour support plan under review. Staff told us of plans to support another person to attend a new college course. This included meeting with college staff to discuss the person's ongoing support needs.

The management team told us of working with healthcare professionals to meet one person's increasing care needs. Advice was also sought from a national organisation for the degenerative disease the person had. Staff confirmed they received relevant training for the person's increasing needs, such as for choking risk, and could describe how they subsequently supported the person. The service ultimately supported the person to move to a nursing home that had a specialist facility for their needs.

Records and feedback from the management team showed us there had been ongoing work with a psychologist and a day centre one person attended, in response to a bereavement and some behaviour that challenged the service. This had enabled a proactive and positive approach to be agreed on across services, which had helped the person have more understanding of events beyond their control and so improve their quality of life.

We found staff worked well together to ensure the delivery of effective care and support. One member of staff commented, "It's a very good team." Another said, "Everyone works well together. We help each other out."

The service enabled staff to have the skills and knowledge to deliver care and support. The management team told us all staff received classroom based training on emergency first aid, moving and handling, person-centred care, epilepsy and dysphagia. Other training was through an online training provider. A recent switch in providers had occurred, meaning staff now had to reach 100% scores in tests at the end of each module. A staff member told us of making notes during this training to make sure they passed. The management team explained senior staff helped other staff to progress when needed.

Staff said that the training equipped them for their roles. A spreadsheet was updated to show courses staff had completed. Along with standard health and safety topics, there had been training for many staff on supporting people with tooth-care, understanding depression, diabetes, effective handover, epilepsy, learning disabilities, mental health awareness, team-work, and avoiding harassment.

We saw new staff going through an induction during our visits. A staff member told us, "I shadowed for a while when I started." This meant they worked as an extra staff member with experienced staff, to understand the role and people's support needs. New staff completed the provider's standard induction process that involved them and their manager signing against a large number of topics to show the topic had been discussed. Records showed this process was sometimes completed in a day. However, the process was not in line with the national Care Certificate which is seen as best practice for ensuring each new staff member has demonstrated sufficient knowledge in a broad range of applicable care and support skills. The management team told us of plans to bring their induction process in line with best practice guidelines.

Staff said they felt supported in their roles and received supervision. One member of staff commented, "Senior staff are very supportive and approachable. You can ask them for support at any time." Records showed that staff meetings took place regularly and that discussion was open and wide ranging. Established staff received an annual appraisal of performance and development.

The service supported people to eat and drink enough and maintain a balanced diet. People's comments about the food included, "Nice!" and "The food's very reasonable." People had their nutritional and dietary needs assessed when needed. Their support plans guided on the outcomes of this, for example, on ensuring a suitable diet when there was an identified choking risk. We saw staff giving people their full attention and encouragement with eating and drinking. A fluid chart was instigated when there were concerns about anyone's fluid intake. There were systems and specific equipment in place to support people's religious and cultural dietary needs.

The management team told us when one person had started using the service, they ate only a limited range of foods. They had since been supported to improve the variety and nutritional value of the food they ate. They preferred 'finger foods' due to the sensory engagement, and they were more willing to try new foods if offered to them indirectly. They had also been supported to move to healthier drinks, which staff and observations confirmed.

The service supported people to live healthier lives through some encouragement of exercise. People were weighed regularly and food records were maintained where appropriate. A few people were steadily losing weight, in line with health action plans.

Records showed the service supported people to have access to healthcare services and receive ongoing healthcare support. People had health action plans in support of this. One person's goals from these plans included weight loss and attending further dental treatment, both of which had since been achieved. People also had hospital passports in place, to help hospital staff understand people's key needs and means of communicating.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

Staff said they had received training on the MCA and demonstrated a good understanding about what this meant for their role. Care records showed people who lacked mental capacity had a best interest assessment which informed decisions made about their health and welfare. For example, one person required decisions to be made on their behalf in relation to most aspects of their care. The service had involved their social worker and others in their best interest assessment.

Where people were deprived of their liberty in order to receive care and treatment in their best interest, records showed the service had requested the person's social worker to apply to the Court of Protection as required. Although outcomes of the applications had not yet been established for most people, this meant the service was working in partnership to follow the legal authorisation process expected under the MCA.

Staff respected people's capacity to make decisions for themselves. One staff member told us, "If people refuse personal care you give them time and space. You try later." One person using the service confirmed there were no restrictions. Where one person was regularly refusing their medicines, records showed this had been discussed with them and their GP. Their care record noted that as the person was able to decide for themselves, staff were to offer the medicines and record when the person refused.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. People told us they were treated well. One person said, "Staff are fine." Another told us, "I like everybody." A third person said, "Staff talk to me if I'm worried, they try hard to help me." The way people interacted with staff indicated they felt comfortable in the presence of staff. A newer staff member told us of understanding that some people using the service needed time to trust them. We noted staff rosters showed a continuity of staff, which helped trusting relationships to develop.

The management team spoke of ensuring 'nurturing approaches' to people. They also told us it was important prospective staff could show a caring and sensitive approach during recruitment processes. We saw staff praise someone when they took their shoes off independently because this was a skill they had been working on. Staff stayed with another person and provided reassurance when they became unwell. One staff member spoke of how rewarding it had been when a person said they liked the way they had supported them with the shower. Another staff member told us, "I have seen the service users feel uplifted, encouraged and develop positive behaviour through (our) support."

Staff knew and respected people they were supporting. Staff were able to interpret people's gestures, for example, understanding when a person indicated they wanted their soft toys and facilitating access to these. The management team said it was important to listen to and understand people as individuals. They knew how people communicated and what could trouble them.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. Records showed most people had monthly meetings with their key-worker in which they were involved in decisions about their care. One person confirmed they were asked about their support plan. Records showed the service continued to try and find an advocate for a person with complex needs who had no family.

The service ensured people's independence was respected and promoted. One person told us of being supported to develop their skills for "cooking and shaving." We saw photos of people being supported to learn cooking and cleaning skills. A staff member told us, "We encourage people to do things for themselves." One person showed us their involvement in regularly testing the fire alarms at their scheme.

Staff promoted people's privacy and dignity. One person described staff as "respectful." People had been supported with their appearance where needed, and their rooms were personalised. Staff meeting minutes included discussions on supporting people with appearance, for example, how to support people to replace clothing that was ill-fitting or worn-out. A member of staff told us, "People get good care. We know people and treat them with respect." A newer staff member explained how they were getting to know a person, including checking how the person liked things to be done.

The service enabled people's relatives and friends to visit without unnecessarily restriction and feel welcomed. Some people told us of being able to make phone calls, and of family visiting them. A staff

member told us people can have visitors "anytime" but was aware of where a formal restriction was in place for one person.

Requires Improvement

Is the service responsive?

Our findings

The service listened and responded to some people's concerns and complaints, and used this to improve the quality of care. People told us managers at the service were approachable if they had concerns. We saw occasional records of house meetings that included checking with people about safety arrangements and asking their views on service standards. Written information about the service's complaints procedure was prominently displayed at the schemes we visited. There were easy-read complaint procedures and forms available in people's files, but these would not be immediately accessible to people. The management team agreed to consider how that could be improved on.

The management team told us of recognising how one person using the service was complaining, as they were avoiding being in the presence of a newer staff member. The person's views were taken on board, in conjunction with other information, from which records showed action had been taken. We noted also that a recent complaint from another person using the service had resulted in action being taken including a safeguarding referral.

However, we found some complaints had not been dealt with in an open and timely manner. Before our inspection visit, we asked the provider to investigate a complaint that had been passed onto us and update us on their findings. Whilst we received a prompt acknowledgement, it took over two months before a further response to the complaint was received. This involved two informal requests for an update, and then a formal request using our legal powers. Whilst the provider apologised and gave an explanation for the delay, the explanation meant the response would still have taken 50 days, and so would not have met their own policy aim of a full response within 30 working days. This demonstrated ineffective operation of a system for responding to complaints.

Before the inspection, we formally asked the provider to send us a summary of all complaints received in the previous year. Their response stated there had been only one, which had been raised through CQC. However, during the inspection the management team informed us of another complaint raised during the summer in which an anonymous complainant had rang both the registered manager and the provider's office about their concerns. Whilst the management team could explain actions taken in response, there were no records of the complaint and actions taken, which was contrary to the provider's complaints policy. Additionally, the matter was not declared to us when we formally requested it. This demonstrated ineffective operation of a system for identifying and recording complaints.

The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service enabled people to receive personalised care that was responsive to their needs. People had support plans in place that reflected their needs, preferences and personality. These provided staff with some guidance on how to support the person. There was additional guidance in the form of positive behaviour support plans where needed. Plans were kept under regular review and were updated when needed.

Care records were up-to-date and reflected people's support needs. For example, one person was at risk of pressure ulcers because their mobility had declined and they chose to spend more time in bed. Care records explained how the person was supported to maintain their skin integrity and staff were seen to follow the instructions. Advice had been sought from the district nurse, who had since discharged the person from their care because the service followed their advice.

The service supported people to engage in activities at home. We saw staff encouraging people to sing and dance, offering massage and providing sensory resources and activities. Staff also supported people to go out for a walk or to the shops. Staff spoke about the importance of keeping people stimulated and said that some people may not do anything if they did not assist them.

Records and feedback from people and staff showed people were supported to access activities in the community such as for swimming, day centres and college. One person had just acquired new employment. Key-worker records showed one person was being supported to try a new activity, and another person had recently started working at a charity shop. The management team showed us photos of a number of people using the service attending a pottery class. Some people had recently been on a holiday to Centre Parks. A staff member told us, "We try and encourage people to be active. The company encourages us to try new things with people."

The service paid a lot of attention to supporting the communication needs of people with a disability or sensory impairment. We saw staff using Makaton, a sign language designed for people with learning disabilities, to help communicate with some people. Staff explained how one person used adapted Makaton signs with one hand. They showed us communication folder with pictures and Makaton signs the person used if things were not understood. There was also 'rate-your-pain' picture guidance available.

Care records provided good information about people's communications needs. For example, one person's support plan noted, 'If I don't understand or don't like something I will make a noise, become unsettled or agitated.' It went on to explain how staff should reassure the person. Staff knew this when we talked with them.

The management team told us of local authority training on 'intensive interaction' for staff working with some people. This was primarily to help with interacting with people who communicated non-verbally. As one member of the management team put it, it was as if the person was telling them, "You know my language now." The process had helped some people to interact more with staff, including one person who was now using a few words to communicate. Staff also told us the person was now using their hands as a means of communicating, and their behaviour was challenging the service less.

The service had set up 'social stories' for one person. These can help autistic people develop greater social understanding and stay safe. Topics included friendships, new courses and travel. A staff member reported being pleased the person had just asked them for the first time to use the stories.

Requires Improvement

Is the service well-led?

Our findings

Whilst we found there to be some qualities of a well-led service, our overall inspection findings including the regulatory breaches demonstrated the service was not always well-led. Quality and risk audits were not consistently effective as they had not identified the concerns and service shortfalls that we found.

Other matters also indicated ineffective audits. A health and safety audit at one scheme three weeks before our first visit had not identified and addressed that one person's bedroom lights were not working and so they could not safely and comfortably use their bedroom at night.

The same audit failed to identify that temperature records for a communal fridge for the previous seven weeks had been routinely above the maximum recommended temperature, and as high as 15 degrees Celsius on one occasion. There was seldom action recorded to recognise and address the high temperatures. The recorded temperature remained too high at the time of our first visit, albeit it was addressed by the time of our final visit.

At another scheme, fridge temperatures for the period 10 to 22 November were recorded as between 6 and 10 degrees Celsius. However, in both cases, both fridges felt cold. The management team explained the thermometers used were faulty, showed us that electronic devices had now been ordered, and said matters would be discussed in staff meetings to ensure staff knew what to do in future.

Similarly, temperature records for the fridge used to store particular medicines at one scheme were between 18 and 25 degrees Celsius for the 12 days before our visit there. However, the fridge was cold and appeared to be in working order, and the staff member we spoke with knew eight degrees Celsius was the maximum permitted storage temperature.

All these cases indicated the temperatures were not recorded accurately, either through staff misreading the equipment or the equipment being faulty. Neither possibility had, however, been identified by staff or managers at the schemes before our intervention, which demonstrated ineffective governance of safety systems at the service.

Members of the provider's quality team undertook regular audits of the service, visiting various schemes in the process. The most recent quarterly audit of 20 September 2017 indicated generally good standards at the service. However, it identified administration recording gaps at one scheme, and recruitment shortfalls particularly around acquisition of references. During this inspection, we identified the same concerns. Therefore, sufficient action had not been taken to address the risks identified, rendering the audit ineffective.

The management team told us they recently started keeping separate sanction and restraint records. They confirmed this was a result of us asking them specific questions before the inspection about how incidents involving people using the service were being managed. We found records of these incidents contained inaccuracies that had not been identified by the service. One incident report stated the person was "taken to

room" and "contained." Their daily record stated "physical restraint" was used for the person's safety. However, the incident summary that the management team sent us on request stated the person was "prompted" and "invited" to move to safer environments, and made no mention of physical restraint being used.

Another incident form stated the person was "taken to their room" and "kept" in their room for everyone's safety. However, the incident summary did not refer to the person being kept there. The management team told us these records indicated staff encouraged the person to their room for safety purposes and for one-to-one support.

The separate restraint records written for the above incidents did not refer to any physical restraint. They reiterated that only verbal prompts had been used.

These inaccuracies in the records of the person's care and treatment, and the oversight of this, demonstrated failures to effectively operate systems to assess, monitor and mitigate risks to the person's health, safety and welfare.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some relevant incidents had not been notified to us as required by legislation. The service's incident summary from July 2017 showed three instances when the police had been called or had attended one of the schemes in response to an incident of aggressive behaviour from someone using the service. The summary also showed a recent allegation of abuse of someone using the service. None of these matters had been notified to us at the time of the matters occurring. These failures to notify us of significant occurrences prevented us from monitoring the service effectively.

The above evidence demonstrates a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The management team formally notified us of these matters before our final inspection day.

We found the service relied too much on our interventions to support continuous learning and improvement. Before our visits, we had questioned how incidents and sanctions were managed. This resulted in reviews and improvements to these systems. We pointed out that our previous rating of the service was not displayed on the provider's website. This was promptly fixed. Following our visits, the management team informed us of reviewing their quality assurance processes, to better ensure they captured service delivery risks. As example, they sent a new form specifically designed for that purpose. Whilst all these cases showed a responsiveness to improve services, they all relied on our interventions to prompt for those improvements.

The service generally worked in partnership with other agencies to support care provision and development. The management team told us of attending support forums hosted by the local authority's qualities team. Community health and social care professionals told us the service worked in co-operation with them. However, we noted our requests to the management team this year sometimes needed reminders for a response or for all points to be addressed. On one occasion, the lack of response to repeated requests resulted in us making a formal request for information using our legislative powers.

The service promoted a positive culture that achieved good outcomes for many people. Staff said they felt

supported by senior staff and managers, and spoke of good team-work. One staff member told us the registered manager visited the scheme they worked at "at least weekly; she is accessible." A second said, "It is well-led because managers know what their responsibilities are and are always honest." A third told us, "We question practice all the time. We have one hundred per cent support and discuss issues and problems." Some recent staff meeting minutes positively indicated ongoing work to improve team-work at one scheme. The management team told us of instances where they had formally supervised staff members as their approach was not conducive with the good team work expected of everyone.

The provider engaged with and involved stakeholders in the development of the service. Feedback from many people's relatives and one community professional the service worked with had been acquired in 2017. Responses were very positive. Examples of comments seen were, "Very happy with placement", "Home is well run and keeps us informed" and that the family member "is very happy and settled at the home; the staff are amazing."

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 Where services were being provided in, or as a consequence of, the carrying on of the regulated activity, the registered persons failed to notify the Commission without delay of allegations of abuse in relation to a service user, and incidents which were reported to or investigated by the police. Regulation 18(1)(2)(e)(f)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that care is provided in a safe way to service users, including through the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(2)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate record in respect of each service user; Regulation 17(1)(2)(a)(b)(c)(d)(i)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure persons employed for the purposes of carrying on the regulated activity were of good character, and failed to ensure the following were available before employing anyone to provide care: •□A criminal record certificate •□Satisfactory evidence of conduct in previous care-related employment •□A full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(1)(a)(3)(a) S3 parts 3, 4, 7.