Optima Care Limited

Manston

Inspection report

Unit 6
Invicta Way, Manston Park
Ramsgate
Kent
CT12 5FD

Tel: 01843822508
Website: www.optimacare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on the 23, 24 and 31 August 2016 and was announced.

Manston is a service registered to provide personal care to people living in their own homes. People were all living in supported living services, and had their own tenancies. The service supports adults who have learning disabilities, physical disabilities and mental health needs throughout East Kent. At the time of the inspection nine people were receiving a personal care service.

The service did not have a registered manager in post. A registered manager is a person who is 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. The agency had an acting manager who was also the registered manager at another service.

There was a number of staff vacancies so people often received support from temporary agency staff. People, their relatives and external professionals all raised concerns about the lack of consistent staff and the fact that people did not always know who would be supporting them. Some people had been given a written rota but they did not know all of the staff on it, other people had no information about the staff supporting them.

People, and others, were at risk of harm as staff did not support them to manage their behaviours safely. Some people had no behavioural support plan or risk assessments in place, although they displayed behaviours that challenged. Staff did not engage or interact with other people in a meaningful way, even though an identified trigger for their behaviours was 'boredom.' Risks to people's health and well-being had not always been identified, assessed and mitigated. Accidents and incidents were not analysed to look for trends or ways of reducing them.

People's medicines were not managed safely. People did not always receive their medicines when they needed them. Staff regularly did not sign medicine administration records, so they could not be certain when medicine had been given. Staff were not trained to administer emergency medicine, and one person had been hospitalised when this medicine had not been given.

Senior staff had reported a large number of safeguarding alerts relating to missed medicine, the conduct of temporary agency staff and the management of people's behaviours. Some of these investigations were ongoing. Not all staff were trained in safeguarding and there was a lack of information for people about how to report any issues.

Staff had not received the training they needed to support people effectively. Staff told us they did not always understand their role in a supported living service. Some people had mental health needs and staff had not received any specific training about this. Staff had not had the opportunity to meet regularly with

their manager to reflect on their practice or discuss any areas for improvement.

Some staff lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Decisions had been made on people's behalf without considering the least restrictive option and there was no record of any best interest meetings regarding these decisions.

Staff did not have information or guidance about some people's health care needs. We saw people attending healthcare appointments on the day of the inspection. Some people were supported to plan and prepare their meals. Other people were restricted as they were not allowed to access their kitchen or help with cooking. There was no information for people about what they were going to eat that day.

Some people could not communicate verbally. One person had a picture book in place to help them communicate with staff, but other people had nothing. Staff were polite to people but had not received the appropriate guidance or induction to engage with people in a meaningful way.

People and their relatives told us they wanted to learn how to do new things and increase their independence yet there were no plans in place to help them to do this. Staff based at the office of the agency were re-writing people's care plans without involving people or their relatives. Some of these re-written care plans contained inaccurate information, and we were told a meeting would be held with staff to discuss the errors. There were no further plans to involve people in writing their care plans.

Reviews had not been held to see how people were settling into the service or if they required any changes to their support. Assessments of people's needs were usually carried out but arrangements were not made to ensure staff had the skills to support people before they were offered a service. People had no agreements with the agency so they, and staff, were not clear about what was provided and what was not. This inconsistency had led to some incidents.

External professionals had raised concerns about the lack of activities for people so activity plans had been recently introduced. Some people were not able to do the activities they wanted, such as cycling, as they were not always supported by staff able to do the activity. Staff did not always have the skills or knowledge to engage people with complex needs in activities they enjoyed.

People told us they had complained about the service. Staff confirmed that they were aware of a complaint, but there was no record of it or of any actions taken. We found a record of one other complaint that had not been investigated and responded to.

Staff were unclear about their role within supported living services. People did not receive the support they needed as a result. There was no registered manager in place. Incidents had occurred which, by law the Care Quality Commission (CQC) should be notified about but we had not been informed.. The provider had not requested health declarations during the recruitment process so had not established if any reasonable adjustments were needed.

People and their relatives had not had the opportunity to formally feedback their views about the service. An independent consultant had carried out audits of the service. 54 issues had been identified in October 2015 and 71 in February 2016 with no action plan to say how and when the issues would be addressed. We found the same issues were still occurring. There was a lack of oversight and scrutiny of the service being provided by agency.

The provider sent us an action plan and has kept us informed of the action they are taking to rectify the

concerns identified.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People were supported by a high number of temporary agency staff. People, their relatives and external professionals told us this lack of consistency meant people were not always supported in a safe way.

People's behaviours were not always managed safely, putting people at risk of harm. There was a lack of guidance and risk assessments relating to people's behaviours.

People did not always receive their medicine when they needed it.

Staff had not all received safeguarding training. Senior managers had reported a large number of safeguarding issues to the local authority and these investigations were on going.

Checks were completed to ensure staff were suitable to work with people. However, staff had not completed health declarations so the provider had not established if any reasonable adjustments were needed before staff started work.

Is the service effective?

Inadequate

The service was not effective.

Staff had not had the necessary training to support people effectively. They were unclear about the purpose of supported living.

Staff had not had the opportunity to meet with their manager to reflect on their practice. There was no evidence permanent staff received an induction into the service before they started work.

Staff were unclear about the Mental Capacity Act and Deprivation of Liberty Safeguards. Decisions had been made on people's behalf without involving them and considering less restrictive practices.

Staff did not have the information and guidance they needed

about everyone's healthcare needs.

Some people were supported to plan and cook their meals.

Is the service caring?

Requires Improvement

The service was not caring.

Staff were in control of the environment, not people. Areas of some people's home were locked and some people could not access their kitchen.

There was a lack of accessible communication in place for people who had difficulty communicating verbally. Staff had not received the appropriate guidance or induction to engage with people in a meaningful way.

There were no plans in place to increase people's independence. Staff based at the office of the agency were re-writing people's care plans without involving people or their relatives.

We observed some kind and caring interactions between staff and people.

Is the service responsive?

Inadequate

The service was not responsive.

Some people's care plans and risk assessments had been updated but staff had not yet read them to ensure their knowledge about people was up to date.

Some people's care plans were missing important information about how to support them. A lack of consistent staff meant people did not always receive the support they needed.

Reviews had not been held to see how people were settling into the service or if they required any changes to their support.

Staff lacked the skills to engage people in activities throughout the day.

Complaints were not always documented or investigated.

Is the service well-led?

Inadequate

The service was not well-led.

Staff were unclear about their role within supported living

services. People did not receive the support they needed as a result.

There was no registered manager in place.

Incidents had occurred which by law the Care Quality Commission (CQC) should be notified about, but this had not happened.

People and their relatives had not had the opportunity to formally feedback their views about the service.

An independent consultant had carried out audits of the service. They had raised multiple issues regarding the service which had not been resolved.

Manston

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 23 August 2016 at the sites where care and support was provided and on 24 and 31 August 2016 at the registered office of the domiciliary care agency (DCA). The provider was given 48 hours' notice of our visit to the DCA office so that someone would be available to help us access the records required. The provider was unavailable on 24 August so we went back to meet with them on 31 August.

The provider had not had the opportunity to complete a Provider Information Return (PIR) as we brought this inspection forward after receiving concerns from the local authority. 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 reviewed information we had received from the local authority and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Before the inspection we spoke with the local authority safeguarding and commissioning teams.

At the office of the DCA we spoke with the nominated individual and three senior members of staff. At the service we spoke with two team leaders, five members of staff and two people.

We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance audits. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

After the inspection we spoke with four relatives about the service.

Manston registered as a new service on 6 April 2016, this is the first comprehensive inspection of the service.

Inadequate

Is the service safe?

Our findings

Some relatives told us they felt their loved ones were safe. One relative told us, "Oh yes I think [my relative] is safe. They are happy there." Another relative said, "I feel [my relative] is safe. They cannot get out of the house and the garden is secure." However, another relative told us, "I don't feel [my relative] is safe and we're thinking about removing them." One person told us, "I'm anxious about all the changes here, I don't know how I feel."

There was a lack of consistent staff which meant people did not always receive the care and support they needed to keep them safe. Staffing was inconsistent and unreliable. There was a high use of temporary staff from another agency due to the number of staff vacancies and people told us they did not always know who would be supporting them. One person said, "Staff show up and they say they are working here but we don't know who they are."

Relatives told us they were concerned by the lack of regular staff and that this impacted on the consistency of the support provided. One relative said, "There's just so many agency staff and they don't know my relative. I keep saying, why can't they have regular staff? " Another relative said, "It's all about the consistency and trying to make sure there's a regular routine. That consistency is not quite right at the moment" and "If they could sort out the staffing I think it would be ok. I think I've only seen about three people that are the same when I've been and visited."

The provider told us that although there was a high usage of temporary staff from another agency they were trying to ensure they had the same, regular staff providing support. On the day of inspection there was a new member of temporary agency staff working with a person for the first time. The agency staff member received some guidance from other staff about how to support this person, and accompanied them when out in the community. However, we also observed them following the person around and not engaging with them. We went through the rota with one person and they told us there were three temporary agency staff members due to be providing support in their home in the upcoming week that they did not know.

Staff were not managing incidents of problem behaviour consistently and not all staff had attended training in managing behaviour that might challenge. Staff were unclear about how to manage some people's anxiety and anger and this inconsistent support had led to incidents increasing and getting worse. People had been harmed and had been placed at risk from the negative impact of others' behaviour. External professionals told us that they were concerned about the poor management of some people's behaviour.

Some people had one to one support and staff were in close proximity to people at all times. Some staff did not engage with people and just followed them around. There had been occasions when this upset people and they became angry which had led to further incidents. This person became anxious if they were 'bored', however, there was a lack of structured activities for the person to take part in to prevent them becoming bored. Agency staff did not always know the person well and were not always prepared to support activities.

Risks relating to people's care and support had not always been adequately assessed and clear and

accurate guidelines were not always in place to help staff manage these risks. One person could be angry at times. There was no behavioural support plan for this person so no guidance for staff to follow to show what triggers to avoid and how to diffuse or divert situations before they happened. This had led to an incident when the person became frustrated and threw something. Staff reacted and called the police rather than using other proactive methods of engagement and distraction. Calling the police was not a strategy recorded in the person's support plan.

Accidents and incidents were not analysed to identify why they had occurred and if anything could be put in place to prevent them from happening again. All of the incidents within the supported living services were collated at the agency office.. A summary of each incident was produced and the number of different types of incidents such as 'aggression verbal/threatening behaviour', 'aggression physical' and 'other' were noted. There was no analysis of any trends, people involved or action taken.

Some people had previously been in trouble with the police as they had difficulty understanding relationship boundaries. They were assessed as requiring one to one support when out in the community, but there were no risk assessments or guidance to tell staff how to support people with understanding boundaries. We saw one incident form were staff had been asked to 'arm wrestle' with the person and this had made staff feel uncomfortable.
Other risks relating to people's vulnerability such as absconding or refusing medical treatment had not been assessed. One person had an operation and had refused support from medical professionals afterwards and there was no guidance for staff on how to deal with this. Other risks relating to people's epilepsy had been thoroughly assessed.

Care and support was not provided in a safe way to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A 'risk management plan' had been written in relation to the supported living services. This covered fire, lone working and infection control, however, it was generic across all of the sites where support was provided and was not person or service specific. Staff regularly lone worked with people who presented behaviours that challenged or had unstable health conditions. As a result they may have required additional support at times but there was a risk this may not occur as the plan was so generic.

Not all staff had been trained to administer medicines and some staff were not working in line with the provider's 'medication policy'. There had been a number of medicines errors when staff had not given people the medicine they were prescribed and had not completed medicines records accurately contrary to the provider's policy. One member of staff told us that they thought staff were not aware they had to sign medication administration records (MAR) despite the provider's policy, they said, "Staff do the meds and don't think that they need to go back and sign the MAR as it is in the person's engagement plan."

A consultant, employed by the provider, had carried out an audit of medicines in June 2016 and noted some shortfalls; there were no names against the actions to show who was responsible for that action and there were no timescales attached. We picked up the same issues with medicines at our inspection as picked up by the audit in June. The issues had not been rectified and continued; including unexplained gaps in medicines administration records and a lack of specialist medicines training for staff.

Some people required emergency medicine to help them recover from a seizure. Staff told us that none of the staff working with the person had attended training in how to administer the emergency medicine and records confirmed this. The person had suffered a seizure which lasted over half an hour before the emergency services arrived. Seizures lasting that long can place people at risk of becoming very unwell.

Administration of the emergency medicine by staff would have helped the person recover sooner.

People were not receiving their medicines safely and in line with the prescriber's instructions. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had attended training in how to recognise and respond to abuse and how to safeguard people from harm. We spoke with staff and they told us they understood the different types of abuse and what the potential signs and symptoms were. They told us they knew who to report potential abuse to. One member of staff said, "If I am concerned I would speak to my manager. If my manager is not the right person I would go up the line. I could also go to social services." There was a whistleblowing helpline which staff could use to confidentially report any concerns to. The information about this number was included in the induction pack for staff held at the service.

Senior staff had reported a large number of safeguarding issues to the local authority relating to people's missed medicines, the conduct of temporary agency staff and the management of people's behaviours. Some of these investigations were ongoing.

There was no information displayed at the service informing people who to speak to if they had any safeguarding concerns. People told us they felt comfortable speaking to some members of staff, but sometimes they did not feel as though they were listened to. There was a poster with pictures displayed at the office that had numbers for people to call if they were concerned, however, these numbers were out of date.

We looked at information and recruitment checks for three staff. Each staff member had completed an application form and given a full employment history. Any gaps in employment had been checked. Staff's identity was verified and two written references were obtained for each staff member. Staff had not completed a health declaration so the provider had not established if any staff needed reasonable adjustments due to their health needs.

People were not always involved in recruiting the staff who may support them. One staff member had been employed before meeting the people they would be supporting. We recommend that the provider reviews their recruitment procedures to ensure that staff they employ have any reasonable adjustments they need and to ensure people have a say about who might support them.

Inadequate

Is the service effective?

Our findings

External professionals, relatives and people all raised concerns over the competency of staff. They said that staff were trying their best but had a lack of skills and knowledge to be able to support people effectively. Two team leaders had been introduced to mentor staff but historically there had been a lack of permanent management presence to guide and mentor staff to ensure they had the support they needed.

Staff did not have the skills and competencies they needed to support people effectively and safely. Not all staff had attended basic training in subjects including fire safety, first aid and health and safety. Even less staff had attended training related to people's specific needs including epilepsy awareness, mental health awareness, Autism and communication.

Relatives told us they felt that staff tried to do a good job but the lack of permanent, competent staff meant their loved ones received inconsistent care and support. This had led to increases in problem behaviour and incidents. Senior staff confirmed there were vacancies that were being filled by temporary staff from another agency. Nobody could tell us what competencies and skills the agency staff had, and what training they had attended.

Staff did not know what their roles and responsibilities were relating to the supported living scheme. Only two out of 24 staff had attended supported living training and ten had attended a seminar on supported living. One staff member told us, "Staff are uncertain what they can and can't do. There is still lots of uncertainty. Staff cannot differentiate between supported living and residential support." In some people's home, relatives told us they were concerned people were not receiving the right, or enough support due to this uncertainty. In some people's homes we observed staff doing things for people rather than with them. One person told us, "This isn't supported living, we get treated like this isn't our home."

We looked at records relating to three staff and found no record of an induction. The training manager said she could not explain this and the induction into the service was the responsibility of the deputy manager who was on sick leave. Some new staff were working towards the Care Certificate facilitated by the training manager and then signed off by a manager. The Care Certificate is an identified set of standards that social care workers work through based on their competency.

There was a lack of supervision and oversight of staff practice. There was no registered manager and the deputy manager had been on sick leave for some time. Staff had not had the opportunity to meet with a line manager on a one to one basis to discuss any concerns and have some mentoring and coaching. There was no manager on site to observe staff and give them feedback.

There was a lack of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. In supported living an application must be made to the Court of Protection. Some applications for people had been made to the Court of Protection, and these were waiting to be authorised.

The training manager said that all staff including managers have basic training (called levels 1 and 2) in MCA. Not all staff had a clear understanding about the MCA and DoLS. One member of staff said, "If people lack the capacity to make decisions, either about their daily life or something more complex then we must assist them. Decisions should be the least restrictive." Another staff member said, "As much as they can, people should make their own decisions." However, other members of staff told us that they found the topic confusing and were unclear how to apply the concepts in practice. One member of staff said, "I have had training but it puzzles me a bit." We asked another member of staff if a person had a DoLS in place, and they replied, "I think so." We then asked what that meant for the person, and they said, "I don't really know."

Two people who had previously enjoyed spending time together had been told they were no longer allowed to see each other. One person said, "I get along really well with [the person], we used to chat but I'm not allowed to see them anymore. They are my friend." We saw an incident form where one person had asked to go and see the other and they had been told, "It is not allowed." This person had then presented with behaviours that challenged. Staff told us this decision had been made to protect people, but there had been no best interest meeting regarding this decision. There had been no consideration of less restrictive ways to protect people and their views had not been taken into account. Staff could not show us any documentation regarding the decision making process.

People who did not have capacity to make decisions about their care and support had moved into the service without any best interest meetings being held to determine if it was the right place for them to live. These meetings were now being held retrospectively so applications could be made to the Court of Protection.

Staff did not have a clear understanding of the MCA and DoLS and had made decisions on people's behalf without seeking their consent or a less restrictive option. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always provided with the information they needed to support people with their healthcare needs. One person's care plan stated they had kidney condition and required a blood and urine test every two years. This a condition is where small, fluid-filled sacs called cysts develop in the kidneys. This can cause abdominal pain, high blood pressure, blood in the urine, potentially serious upper urinary tract infections and kidney stones. Kidney function can gradually deteriorate until so much is lost that kidney failure occurs. There was no guidance regarding this potentially unstable condition, how it could affect the person and what staff needed to look out for in case of deterioration. We asked senior staff why there was no information or guidance available to help support this person with their condition and they did not know.

Other people were living with epilepsy and for some, there was information in place for staff on different types of seizures, what they looked like and what action staff should take.

People did not always receive the support they needed to manage their mental health effectively. Staff had not received training in mental health awareness, even though several people required support with this. Although there were some risk assessments and guidance for staff there had been incidents where people had harmed themselves and staff had either not been aware or not taken any action. One relative told us, "I'm not upset, I'm angry. My relative needs better support with their mental health."

Care and support was not provided in a safe way to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to see a variety of healthcare professionals. One person needed a blood test and staff were working with them and the district nurses to help them understand the process and desensitise them towards the needle. Another person told us, "Staff take me to the doctors, my leg is all healed now." On the day of the inspection one person had a doctors appointment and then collected the medicine they had been prescribed.

People were supported to eat a range of healthy and nutritious foods. Some people were encouraged to plan and prepare meals for themselves. In some people's home we saw them preparing a range of different foods for dinner. One person told us, "We have a weekly menu, we do that and then we do a shopping list so I know what to buy and what I need to take for lunch." There was a visual prompt in the kitchen reminding people what they needed to take for a packed lunch if they went out.

However, in other people's homes they were unable to access the kitchen and staff told us people were unable to help with meal preparation. These people were unable to communicate verbally. Staff told us they used pictures to help people choose what they wanted to eat and plan the menu in advance. However, we did not see them in use throughout the inspection. There was nothing displayed to show people what was for lunch or dinner. Staff did offer people choices of different drinks, such as tea and coffee by showing them the different options. There were no support plans to increase people's access to the kitchen and involvement in their meals.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that some of the staff were kind and caring. One relative said, "Some of the staff are lovely and are trying hard" and one person said, "The staff do the best they can." However, other relatives said, "I am not happy with the service at all. My relative is not listened to."

Staff, and not people, were in control of the environment. Areas of some people's homes were locked and some people could not access their kitchen. There was no assessment of the environment to determine if this was the least restrictive method of support. Staff told us this was to protect people, as "otherwise they got in everything." People pointed at the kitchen door if they wanted a drink or something to eat and staff then unlocked the door. People were allocated one to one support throughout the day so there would always have been a staff member present if the kitchen had been unlocked but some kitchens remained locked.

There was a lack of accessible communication in place for people who had difficulty communicating verbally. There were no visual prompts in place to tell people who would be supporting them or what they would be doing that day. Some staff used objects of reference to help people choose between different things, but these were not formalised so only some staff used them. People pointed at staff keys when they wanted different things. One person asked for their clothes by pointing at the keys and another person asked to go out in the car by pointing at the keys.

We observed staff sat beside people or following them around but not interacting with them. Staff were polite but were uncertain about how to communicate with people who were non verbal effectively. Although two new team leaders were in post, historically there had been a lack of visible leadership within the service to show staff how to communicate with people. Staff told us they did not have supervision, and were not supported to learn how to communicate with people. No one had received training in alternative communication methods.

One person had a picture book that they had brought with them when they moved in. This contained different pictures of things they liked to do and enabled them to make choices between them. They recognised their picture book when we were looking at it and pointed to pictures within it. Staff told us that they wanted to introduce these for other people who had difficulty communicating.

Suitable means of communication was not provided for people on a consistent basis. This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not aware of the terms of their support and what was included; this had led to confusion, mixed messages from staff and incidents. There were no agreements between the agency and people about what the agency would and would not provide for example, the use of a vehicle. People were told different things by different staff members and this inconsistency had led to them becoming confused and angry and had led to a number of incidents.

One person had put a note on the door asking staff to knock and introduce themselves before entering their home. They told us they had done this as they were 'fed up' with staff arriving that they did not know. Some people who could read had been given a paper rota with staff names on. They told us this had little meaning as there were names on it they did not recognise, so they still did not know the staff who would be providing their support.

People and their relatives told us they were not being supported to be as independent as possible. One relative told us, "My relative does not get the support they need with regards to hygiene or keeping his room clean. It comes down to having staff explain things to [my relative] in the right way, and they are just not doing that." People told us they wanted to learn new skills, and try doing new things but they were not currently being supported in this way. One person said, "I thought when I moved in I'd be busy learning how to do things on my own, but that is just not the case." There were no formalised plans for staff to follow to assist people to learn new skills.

People were not involved in updating or re-writing their care plans. Some people's care plans had been recently updated or re-written by staff based at the office of the agency. We asked how people and their relatives had been involved in this work. We were told that one relative and no people had been contacted whilst updating them. We highlighted that some people's care plans contained inaccurate information about the things they liked. For example, one person's behavioural support plan said they did not like it when other people went out and they were left on their own with staff. The opposite was true, and we saw and were told by staff that when people left, the person became visibly calmer. We were told that the provider would be organising a meeting with staff to check that the new care plans were correct. There were still no plans to involve people or their relatives.

People's care plans did not contain ways of maintaining or increasing people's independence. People and their relatives were not involved in updating their care plans or making decisions about their support. This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they could visit people whenever they wished. They said they were offered a cup of tea and were always made to feel welcome.

We observed some good interactions between staff and people. One person was sitting on the sofa laughing and making good eye contact with staff. Another person was anxious as they did not want to go to work and staff spoke with them calmly and patiently and offered them reassurance.

Inadequate

Is the service responsive?

Our findings

Some relatives told us they felt that staff were responsive. One relative said, "They're very responsive when I have had issues. [Staff member] was my first point of call, but I think they're off at the moment so now it's [staff member], and [senior staff member] is in the background." However, everyone we spoke with raised concerns about the high number of temporary agency staff in use and the impact this had on the consistency of the support provided. One relative said, "The consistency of staff approach with regards to processing and prompting is the key issue."

Some people's care plans had been updated by staff at the agency office, and contained detailed risk assessments and guidance on how to support people. These were dated August 2016. However, one of the team leaders told us that staff still needed to read and sign the updated documents. They said, "With everything that has been going on, we've been busy, so I know we're behind on reading the new plans." We checked the signing sheets at the front of the plans and in some cases just one member of staff had signed to say they had read them. People had not been involved in updating their care plans. A staff member told us "We have no plans to have them involved."

Other people's care plans were out of date, inaccurate or did not contain all of the information that staff needed to support people effectively. Formal reviews to check how people had settled into the service or if any changes needed to be made to their care and support had not been held.

The high usage of temporary agency staff and a lack of consistent staff meant that people did not always get the right support. Staff did not always know people well, and correct information and guidance was not always available to ensure people got the support they needed. Relatives told us they had repeatedly told staff important things about their loved ones, such as what medicine they needed and that they needed prompting to maintain their personal hygiene but they said staff did not always know how to support them. A short introduction to each person had been introduced for agency staff to read before supporting people.

Staff working in commissioning and safeguarding in the local authority told us they were concerned about the lack of activities in place for people. Activity plans had been introduced as a result of these concerns. On the day of the inspection one person attended a day service, and another person had the option of going to work but decided not to go. One person went out for a walk with staff and played an interactive game on their phone.

Other people had basic activity planners in place with one activity written in the morning, one in the afternoon and maybe one in the evening. Due to their complex needs they needed a variety of different activities that were of short duration, for example 10 or 15 minutes, so the planners did not relate to what they actually needed or what they did each day. One person had 'boredom' listed as a trigger for behaviour that may challenge. They had a basic activity planner in place and we saw that the activities listed in the morning or afternoon would not fill the time allocated to them. This person went out in the morning and on their return spent time in the garden on the trampoline and in the paddling pool. They did not focus on any one activity for a particular length of time. There were times when staff followed them around without

interacting with them. The person was not occupied or engaged. We spoke with staff about this and they told us they were going to review the activity plans for people with more complex needs.

People and their relatives told us they did not always get to do the activities they wanted as staff were not prepared to support them. One person said, "I like cycling when there is the right staff. Some of the agency don't cycle…and I'm not always getting the right staff to be able to do it." Their relative said, "[My relative] can go off and do a 15 mile bike ride, and some of the agency staff are great, one in particular will take him out no problems, but a couple of times I've been in and if they tried to go on a bike ride they'd be dead! My relative is active so needs someone who can keep up." We spoke with staff about this, and they said they did offer to take the person on bike rides but only when they had the right staff on shift, but the person did not always want to go. We checked the person's daily notes and it did not show that the person had been offered a bike ride regularly.

Staff lacked the skills to fully engage with people and encourage them to participate in activities. One person was offered the chance to make a cake. They were taken into the kitchen and then walked out again. Staff did not use any communication aids to reinforce what the activity would be or know how to encourage the person to participate.

People told us that they did not always feel occupied and this was having a negative impact on their mental health. One person said, "I don't feel I'm being kept active so my anxiety is going down hill."

People did not receive care that reflected their preferences. This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be sure their complaints would be listened to, investigated and resolved. The provider had a complaints procedure but it was not followed. There had been a written complaint about the service dated February 2016 that was in a file at the office. There was no record of any investigation, response or resolution. No one could tell us what had happened about the complaint. A person told us that they had made a complaint and had not heard any more. They had not been responded to and their complaint had not been resolved, staff at the office said they were unaware of what had happened about this complaint.

There was no tracking or monitoring of complaints to check they had been investigated and resolved.

Complaints were not investigated and necessary and proportionate action had not be taken as a result. This was a breach of Regulation 16 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they felt there was a lack of management oversight of the service. One relative told us, "They need someone co-ordinating things to ensure consistency, as it's just not there at the moment."

There was no registered manager in place as required, the deputy manager was on sick leave and there was lack of direct management support and oversight. An area manager said they were overseeing the service; they were also responsible for overseeing the provider's other eight services and they were the registered manager for one of those services. Two team leaders had recently been appointed to oversee staff on day to day basis.

Staff did not understand the aim of the service and sometimes staff were in control rather than supporting people to be in control. At other times staff did not act or support people as they were uncertain about their role. People and their relatives both told us that they felt staff did not understand supported living. One relative said, "I think the bottom line is the understanding about what supported living is. They're supposed to assist them to be independent, but sometimes I think they're afraid to say no or get involved." Staff told us they felt they needed more direction from the management of the service to understand what supported living entailed, they told us "it had been difficult" and they were "feeling their way." An audit by an external organisation looking at tenancy and supported living related matters noted "Some areas need urgent attention. Some fundamental issues place you (the service) at risk. Some aspects contradict the ethos of the supported living process." There was no action plan or update by the provider following the audit.

Staff lacked guidance, training, supervision and direction to give good support. There was a lack of oversight and scrutiny of what was happening in each location and staff practice was not being observed or monitored to make sure it was safe and effective. The management team told us they had not visited one person's home for some time, since the deputy manager had been off sick.

There had been some incidents that should have been reported to the Care Quality Commission (CQC) so we could check that the right action had been taken in response. Some of these incidents had not been reported to CQC.

The provider had failed to inform CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

People and staff were not actively involved in developing the service. There was a lack of staff meetings, staff supervision and meetings with people to talk about any issues and listen to people's views and opinions. Some people told us they had spoken with the management team about changes they wanted in the service, but had not been told what the outcome of those discussions had been. Other people had no opportunity to formally share their views.

Relatives told us they had met with staff earlier in the year and raised concerns about the lack of consistent

staffing but nothing had changed. The provider had not formally sought the views of people, their relatives, staff and other stakeholders in order to improve the service. We asked the provider if they had sent surveys or given any consideration to gaining these views and we were told they had not.

There was a high use of temporary staff from another agency which impacted on the consistency of people's support. People said they did not always know who would support them and this had impacted on their access to and involvement in the local community. People felt their views and complaints were not listened to and acted on.

The provider had arranged for an independent consultant to carry out audits of the service. Audits had been carried out in October 2015 and February 2016 and covered all aspects of the service. Despite shortfalls being identified, 54 issues at the October audit and 71 issues at the February audit, there was no action plan and no one responsible for ensuring the actions had been completed. A medication audit had been carried out in June 2016 and a number of shortfalls were found relating to medicines safety. We found some of the same issues, two months later at our inspection including lack of staff training to give emergency medicines and gaps on administration records.

Some records were not accurate and not up to date, such as people's behavioural support plans and health action plans. Complaints had not all been investigated and responded to. Incidents and accidents had not been analysed to look for any similar themes or patterns in order to adjust support to reduce further incidents. None of this had been picked up by the provider and this placed people at risk.

The provider had failed to assess, monitor and improve the safety of the service. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user. The provider had failed to seek and act on feedback from relevant persons. This was a breach of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our concerns we met with registered provider on 31 August. The provider sent us an action plan which we will monitor.

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 The provider had failed to inform CQC of notifiable events.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Suitable means of communication was not provided for people on a consistent basis. People's care plans did not contain ways of maintaining or increasing their independence. People and their relatives were not involved in updating their care plans or making decisions around their care. People did not receive care that reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not have a clear understanding of the MCA and DoLS and had made decisions on people's behalf without seeking their consent or a less restrictive option.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Care and support was not provided in a safe way to people.

People were not receiving their medicines safely and in line with the prescriber's instructions.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not investigated and necessary and proportionate action had not be taken as a result.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the safety of the service. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user. The provider had failed to seek and act on feedback from relevant persons.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of suitably qualified, competent, skilled and experienced staff to meet people's needs.