Fortress Supported Living Services Ltd

# Fortress Care Services

## Inspection report

80 John Davis Way
Watlington
Kings Lynn
Norfolk
PE33 0TD

Tel: 01553811995
Website: www.fortresscare.com

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The unannounced inspection visit to the office to look at records and speak with the nominated individual and the registered manager was scheduled to take place on 20 June 2018. However, when the inspectors arrived they found the offices shut up and staff unable to access them. The nominated individual and the registered manager were both away from the service for a few days special leave. We arranged by phone to carry out a visit to a person who used the service on 20 June and to return to inspect records at the office the following Tuesday 26 June on their return. We also carried out a visit to another person who used the service on 27 June and returned to the office that day to provide high level feedback on the inspection.

We last inspected the service on 8 and 9 February 2018 and 2 March 2018. At that inspection we rated the service as Inadequate and we identified seven breaches of regulation relating to safety, staffing, recruitment of staff, person centred care, complaints, displaying the rating and overall leadership. The service remained in special measures having been previously placed into special measures after the inspection carried out in August 2017. When a service is placed in special measures the expectation is that providers found to have been providing inadequate care should have made significant improvements by the time we carry out our next inspection. Following the August 2017 inspection we also placed conditions on the provider's registration which were designed to ensure people who used the service were safe. The provider remains bound by these conditions and is not free to taken on any new care packages without the permission of the Care Quality Commission (CQC).

Fortress Care Services is a domiciliary care agency. It provides personal care to people living in their own homes. It provides people with both daily care visits and also live-in care. At the time of our inspection five people were using the service.

The service had a registered manager in post but day to day leadership of the service was provided by the nominated individual of the business due to the registered manager's continued ill health. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

It was clear to us at this inspection that the provider had worked hard on certain areas of the business and we found some significant improvements. We also found that, as with previous inspections, in the majority of cases people received good quality care from regular carers who knew them well. We did however identify concerns around people's safety, the management of risk and the promptness of the response to incidents and safeguarding matters. These areas continue to need further improvement and we have identified a continued breach of regulation relating to the safety of the service.

We noted a positive change in the way staff were safely recruited, inducted, trained and supported. Staff all received training in core subjects from a recognised training provider. This equipped them to carry out their

roles and some had additional training. All staff felt supported and good systems were in place to provide supervision and support, although one staff member was not well supported in managing care for one particular person.

Staff received training in safeguarding people from the risk of abuse. The provider had raised no safeguarding concerns since our last inspection. However, they had not acted promptly to refer someone, who may have been at risk of neglect. The provider had tried to raise the concern but they, and the staff on duty, had not acted promptly and effectively which left the person at further potential risk.

Risks to people's health and safety were assessed and managed but some information was not accurate which could give staff a confusing picture. This was especially the case related to one person's risk of falls. Information about risk was confusing and new staff would not have all the information they needed to protect people. Other risks were better managed but we did identify that storage of one person's medication may have placed them at risk. The provider took prompt action when we raised this issue and reduced the risk.

Medicines were administered by trained staff and their competence to do this was checked. A lack of robust stocktaking measures meant we could not be assured that people always received their medicines correctly. The provider did not carry out a robust audit of medication records and did not have sufficient oversight of the safety of medicines at the service. However they introduced a new audit system in response to our feedback and put it in place immediately.

Staff who supported people regularly, demonstrated a very good understanding of people's needs and there was now a clear strategy for covering staff absence, including that at short notice.

The provider carried out an assessment of people's needs and encouraged people to be involved in decisions about their care and support. Care plans were comprehensive and were designed to be person centred. However, some information was not accurate and had not been promptly updated after a change in circumstance. This meant there was a risk that people would not receive care and support which met their individual needs. Regular staff knew people's needs well.

Staff supported people to manage their healthcare needs and access the care they needed. Care plans did not always clearly record the involvement of other healthcare professionals and some key information had been archived. This was an issue at our previous inspection.

People received good support related to their eating and drinking, although guidance for staff could be clearer. Staff worked with other healthcare professionals to support people's eating and drinking but records had been archived and so their advice and guidance was not clear. People's preferences with regard to their eating and drinking were respected.

People or, where appropriate, their relatives, consented to their care and their choices were respected. Staff had received training in the Mental Capacity Act 2005 (MCA). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. There remained some confusion in records with regard to consent to care and treatment but it was clear that people, or their relatives if appropriate, were being asked.

Staff treated people with patience and kindness and relationships were good.  Staff respected people's

privacy and maintained their dignity and people were happy with the way staff treated them. Staff promoted and maintained people's independence which enhanced their dignity and self-esteem.

A complaints procedure was in place, but no formal complaints had been received. People felt able to raise issues with staff or with the provider. Information about how to complain was available.

There was a system of audits and spot checks in place to monitor the safety and quality of the service. Spot checks were good and supervision of staff, especially live-in staff, had improved considerably.

The provider did not fully understand all their responsibilities with regard to the regulation of the service. They had not notified CQC of some relevant matters regarding the health and welfare of people who used the service. However the rating from our previous inspection was now clearly displayed on the service's website.

Previously we had found that the provider was not always open, honest and transparent with us. Sometimes we had identified concerns and key information by chance when looking at other matters. We found this was not the case at this inspection and the nominated individual and the registered manager were both keen to work with us and were honest about the further work they needed to do to continue driving improvement at the service.

We recognize that the provider has made some clear improvements since the last inspection and we welcome these. We are encouraged that regular carers are providing a good service to people although we remain concerned that some practice is continuing to place people at risk. We are not yet fully assured that the provider understands all their responsibilities and are not confident in their ability to be proactive in the management and oversight of risk. We would have expected there to be no areas for further improvement after such a long time. However, we recognise the hard work which has gone into making the improvements we did find and expect this to be sustained.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Risks to people's safety were not accurately assessed and managed and some staff practice placed people at risk.

Recruitment procedures ensured staff were safely employed and did not pose a known risk to people who used the service.

The provider had a contingency plan for the unforeseen absence of regular staff and there were sufficient numbers of suitably trained and experienced staff to provide appropriate cover arrangements.

Medicines were not always managed safely and continued poor stocktaking procedures meant errors could not be highlighted.

Staff were trained in keeping people safe from abuse but one potential safeguarding issue had not been effectively or promptly managed.

Staff were trained in infection control and understood their responsibilities to protect people from infection.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The provider involved people, and their relatives if appropriate, in assessing their needs. Assessments did not always reflect people's most current needs.

Staff received appropriate induction, training, supervision and appraisal. Staff felt well supported.

Staff worked with other professionals to support people with their healthcare needs. Records did not always provide a clear picture of this partnership working. Staff handovers had improved.

Staff supported people well with their eating and drinking but records could be more detailed.

People consented to their care and staff had received training with regard to the Mental Capacity Act 2005. Some care plans contained conflicting information about people's capacity to give informed consent.

## Is the service caring?

Good

The service was caring.

People who used the service praised the caring nature of the staff who regularly supported them. Staff interacted with people warmly and with respect.

People were involved in decisions about their care and support.

Staff supported people to be as independent as they could be.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans still contained some contradictory and inaccurate information. Staff demonstrated a good understanding of people's needs and preferences.

People were provided with opportunities to follow their own interests and hobbies.

A clear complaints procedure was in place and people were aware of it.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider failed to send CQC the required notifications for incidents affecting the health and psychological welfare of people who used the service.

The oversight and management of risk did not sufficiently protect people who used the service or staff. Audit systems to monitor quality and safety were in place but they were not always effective in highlighting the issues which needed addressing. The provider gave this matter prompt attention and developed a new audit

The provider had introduced an electronic record system which worked well but paper records still contained inaccuracies and important information was not always easily accessible.

Staff training and support was much improved and staff employed demonstrated that they had the skills and expertise to carry out their roles. Systems were now in place which were designed to ensure people were supported consistently by staff who were trained and who knew them well.

# Fortress Care Services

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visit on 20 June 2018 was unannounced but the provider was away from the office and no other staff had access to the office and so we rearranged with the provider to return the following week. We carried out a visit to a person who used the service on 20 June and to a second person on 27 June. We carried out an inspection visit to the provider's office on 26 June and spoke to a relative by phone on that day also. A visit to provide feedback was undertaken on 27 June.

Two inspectors carried out the inspection visits on 20 and 26 June and one inspector carried out the other visits.

Before the inspection we reviewed the information we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We had received no notifications since the last inspection.

We visited two people who used the service and spoke with one relative by phone. We spoke with the nominated individual and the registered manager who were both directors and owners of the business. We also spoke with the care co-ordinator and two members of the care staff, one of whom was a live-in member of staff. We looked at four care plans, two medication administration records, three staff files and other records relating to the quality and safety of the service.

Requires Improvement

# Is the service safe?

## Our findings

When we last inspected the service in February 2018 we found that people were not kept safe and were not protected from risk. We also had significant concerns about the failure to ensure consistent staffing by experienced and skilled staff. We identified breaches of regulation relating to the recruitment, skills and availability of staff and the management of risk. We rated this key question Inadequate, as we had at the previous inspection in August 2017. During our current inspection we found some improvements but also found some issues continued to require further attention to ensure people were supported and cared for safely.

Risks continued to be poorly managed in some cases. We found that information about risk was not comprehensive and was not always promptly updated when a person's needs changed. One person's falls risk assessment (which was not dated) recorded that the person had had no falls in the previous year and rated them as low risk. Their moving and handling risk assessment stated 'No moving and handling is involved in supporting [person]'. However incident forms showed that the person had in fact had three falls since April 2018, one of which required a paramedic to attend. The live-in carer told us that the person's mobility had declined in recent times but the care plan did not reflect this and was due only for an annual update. They told us that they took the person out in a relative's wheelchair but this had not been assessed as being safe for the person.

The provider told us that some old information had been left in the person's care plan. This had been the case at our previous inspection also. When we returned to provide feedback on the inspection on 27 June they showed us evidence that the falls risk assessment had been updated and the old information removed. However, we could not be assured when this would have been done had we not identified the issue. We explained that the risk of inaccurate information would be raised if staff supporting the person were unfamiliar with their needs. The provider pointed out that a stable staff team supported this person and knew their needs well. Rotas confirmed this.

We also identified another risk relating to the same person. When we spoke with staff they told us that they sometimes left the person they were caring for unattended while they went out shopping or to collect medicines. They were not aware that this placed the person, who was living with dementia, at risk. There was no risk assessment present and the provider was unaware that this had happened. Once we had alerted them they took prompt action in line with their disciplinary procedure to address this with the member of staff concerned.

We noted that this person, who was living with dementia and had live-in carers, kept their medicines in a carrier bag which was easily accessible to them as they were independently mobile. We raised this concern with the provider who bought a lockable medicine cabinet the following day for this person's medicines.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

There was a mixed picture with regard to how medicines were managed. Staff had received training in the administration of medicines. Senior staff and the registered manager carried out spot checks occasionally to ensure staff were administering medicines safely. Staff completed medication administration record (MAR) charts and these were reviewed by the registered manager at the office on a monthly basis. We noted occasional gaps in signing these charts but staff said these related to when a different agency supported the person. Rotas confirmed this.

However, procedures for checking stocks of medication were not robust and were not designed to ensure that the provider could be sure all medicines were administered as prescribed. Stocks were not accurately recorded and it was not possible to track records to ensure that correct stocks of tablets were in place. By the time we visited to give feedback on the inspection the provider had altered their medication stock control audit so that would now highlight clearly when stocks did not match records, which would indicate the person had not had their medicines as prescribed.

Staff demonstrated a good understanding of people's medicines and knew how people liked to take them. Information about medicines and how people liked to receive them was not recorded. One person had recently been refusing some medicines and staff had consulted the GP for advice and guidance but there was no record of the outcome of this consultation. They had also been experiencing swallowing difficulties with their tablets and it was not clear from records, or from the member of staff, if other alternatives, such as liquid medicines had been suggested.

At our previous two inspections we found that the provider did not have a robust procedure for staffing care visits and live-in care packages when staff were unexpectedly on leave. We found that in these circumstances the provider had arranged cover with staff who had not undergone appropriate training or had suitable checks in place. This placed people at risk. At this inspection we found considerable improvements. Staff now had back up staff who would cover shifts and all staff were aware of who to contact should they not be able to come into work. Procedures were now in place to cover staff annual leave and rotas confirmed that this was planned in advance. However people who used the service, relatives and staff were not always clear about who would be supporting them next. One live-in carer was not able to tell us who would be taking over from them in a few days time. A relative also told us that they were not always introduced to new staff saying, "Not always, but it hasn't been a problem. It hasn't happened very often."

We saw that there were now enough staff to ensure people were mostly supported by a stable staff team who knew them and their needs well. One relative told us that one afternoon visit had been missed but this was the only missed call that we identified and other feedback was very positive. We asked one relative if carers stayed for the full length of the care visit and they told us, "Yes. [They] have been absolutely marvellous….[Staff member} notices things that need doing and just does them. We've worked well together."

New staff had been safely recruited and had all the required pre-employment checks in place. This included references, eligibility to work in the UK, employment histories and Disclosure and Barring Service checks to make sure staff were safe and suitable to work with this client group.

We found that measures designed to safeguard people from the risk of abuse still required some further improvement. Staff had received training in keeping people safe from abuse and were able to tell us about how they would raise a concern if they suspected someone was at risk of harm.

However we became aware of a situation where staff were working in partnership with another agency and

were concerned about a person's welfare. They suspected that staff from the other agency, which supported the person at the weekend, had not been giving the person all their medicines or all their meals. They were also concerned about a person's health condition which had deteriorated. Although staff had raised the concern with the care co-ordinator further action had not followed promptly and staff were waiting for the provider to return from a period of leave. There had been no contact with the agency concerned since the concern had been raised and staff had not thought to make any safeguarding referral to the local authority. This meant there was a risk of the person not receiving the care they needed for a second weekend.

We discussed this with the provider who told us that they had tried to raise this concern with the local authority on their return to work. Records confirmed this, but they had not contacted the correct department or thought to make a safeguarding referral themselves. There was also a time delay in raising the concern. However, we did note that staff from Fortress had offered to carry out a second handover to staff from the other agency to ensure consistent care was provided for this person.

Staff received training in infection control and regularly employed staff had recently had this refreshed. We noted that staff working as live-in carers kept the kitchens clean where they were preparing food. They told us they used equipment such as aprons and gloves to minimise the risk and spread of infection.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in February 2018 we rated this key question Requires Improvement. We identified a breach of regulation relating to person centred care. At this inspection we found improvements throughout this key question, especially with regard to training and support for staff.

People who used the service told us they were happy with the way staff supported them. One person said, "[Carer] comes every morning and looks after me. She's lovely." A relative commented about the skills of their regular carer saying, "I don't think [carer] had much training with dementia and I think[they] learned on the job….[Carer] has been brilliant."

All the people who used the service had had their care needs reassessed in recent months and care plans were comprehensive. Although a variety of needs were assessed, care plans were not always updated to ensure staff had the most current and accurate information about how to care for a person. For example one person's life history section of their assessment made no mention of their long term partner who had recently gone into full-time care. There was no consideration in the records of how this may have affected the person and staff had no particular guidance to follow relating to managing any emotional response the person may have to this event.

Staff demonstrated a very good understanding of people's needs and had received the training they needed. New staff had undertaken a structured induction and told us they felt well supported. All regularly employed staff had undergone recent refresher training in a variety of subjects including moving and handling, safeguarding, infection control, confidentiality, epilepsy, fire, food hygiene, dementia care and continence promotion. The training was online and supplied by a recognised training provider and staff were very positive about this. We did note however, that no training had been provided to help staff support a person whose distressed behaviour was very challenging for staff. This had the potential to place staff, and the person themselves, at risk.

Staff told us that they felt well supported by the care co-ordinator and could ring them and the provider for advice and guidance. One staff member commented, "Things are better – [I] feel more supported." Another staff member told us about their training saying, "I have done them all – moving and handling. All the usuals… I have been a carer since 2004."

In our previous inspection we had been concerned about how important information was handed over as records were not clear. At this inspection we found improvements. Electronic records made it much easier to see the significant issues relating to a person's care and live-in staff told us there was an effective handover procedure in place. One staff member said that there is always a face to face handover, "We see each other… All new things have to be known."

We considered whether the service was operating in line with the Mental Capacity Act 2005 (MCA).The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves appropriate professionals, relatives or legal representatives should be

involved. This aims to ensure that any decisions are taken in people's best interests according to a structured process.

At our last inspection we had some concerns about conflicting information in people's care plans with regard to consent. Some of these concerns remained. Staff had all received training related to MCA and those we spoke with had an understanding of its principles. We found that people's capacity to consent to their care had been assessed and recorded in their care plan. Some records had been signed by the person they concerned or by the person who had lasting power of attorney (LPA) for them. Staff understood who had LPA and what this meant. However, some records were still unclear. For example, one person had an assessment which stated they did not have capacity to understand information and retain it while elsewhere in their plan it stated that they did. Another person had been assessed as lacking capacity to understand and retain information but had agreed to information being shared. This could be confusing for staff. The provider assured us they would review the records.

Staff supported people with their eating and drinking and we observed staff preparing meals and drinks for people. Food was nicely presented and kitchens were clean where food was being prepared. Staff received training in food hygiene. Care plans contained information about people's likes and dislikes related to food and staff knew people's preferences very well. We looked at records related to one person's eating and drinking and found information was brief and not detailed. It would be difficult for staff to be sure that the person was eating and drinking enough to remain hydrated and keep at a healthy weight. This was because there was very limited guidance and no targets set for food and fluid intake.

We found that people received good healthcare support from staff who understood their healthcare needs well. It was clear from records that staff worked well with other healthcare professionals to try and keep people well. Staff told us that some people had received support from the dementia intensive support team, speech and language therapists (for swallowing difficulties) and from the falls team. However records relating to the specific advice these healthcare professionals may have given were not always present and staff were not clear. For example one staff member told us that the falls team had been out to assess a person but there was no care plan relating to this or any record of the visit. We asked the staff member when this had happened but they were not able to tell us and records had been archived. This was not good practice as the person had sustained three falls in the last two months and so was at high risk of further falls.

Good

# Is the service caring?

## Our findings

At our previous inspection we rated this key question as Requires Improvement because we had concerns about how staff managed people's distress and maintained their dignity. We found matters had improved at this inspection. The majority of the daily care calls were carried out by one member of staff. They confirmed that the length of calls gave them enough time to complete their tasks and have time to chat to people. All the people we spoke with gave us extremely high praise for this carer and we found them to be caring, patient and kind. We noted that they went the 'extra mile' with each of the people they supported and a relative commented on their commitment very favourably. The carer clearly had excellent relationships with the people they were caring for and their relatives. In turn they were very committed and clear about the importance of the job they carried out saying, "[Person] could be my [relative]."

The service now had a better system for providing cover for daily staff and live-in staff who were on planned and unplanned leave. This meant people experienced more consistent care from staff who knew them well. This had a positive impact on their wellbeing.

Feedback about the live-in carers was positive and we saw surveys which had been sent out to people who used the service and their relatives. These were very positive about the kindness and caring nature of the staff.

Care records included a section called 'A little about me....' Information recorded here stated things like the person's preferred name and where they used to work. It also recorded what was important to the person and key relationships. This helped staff gain a better knowledge of the person and what was important in their life. We did note that some sections were very brief and contained only basic information but staff demonstrated that they knew people's histories, family relationships and previous jobs very well. This was clearly very important to one person who liked to talk about the past and their previous employment.

People who used the service, and sometimes their relatives, if appropriate, had been involved in drawing up care plans. Care plans included people's likes and dislikes and their preferences with regard to their care. A relative confirmed that they had been consulted about their relative's care plan and had regular opportunities to discuss it if they wished to.

We saw evidence of staff promoting people's independence and enabling people to remain independent in as many aspects of their life as they could. Some people were responsible for administering their own medicines but just needed some physical help from staff while others did their own cooking with minimal assistance from staff. One staff member said, "[Person] likes to do it [themselves]. [They] like to keep mobile."

Staff promoted people's dignity and ensured their privacy. Staff asked people if they were happy to talk to us and made sure they understood that they could stop talking to us if they chose. This demonstrated a respectful attitude towards people and the choices they made.

Requires Improvement

# Is the service responsive?

## Our findings

At our previous inspection in February 2018 we rated this key question as Requires Improvement and found breaches of regulation relating to the management of complaints. At this inspection we found some improvements.

A complaints policy was in place but, in common with some other policies and procedures at the service, it referred to the now obsolete regulations dating back to 2010 rather than the current 2014 regulations. People, and their relatives, understood they could speak with the care co-ordinator or the provider if they wished to make an informal or formal complaint. Information about how to complain was also clearly displayed on the service's website. Informal issues were often raised with care staff initially who told us they would pass them onto the provider on behalf of the person. The provider had not had any formal complaints since our last inspection.

People's needs had been recently reassessed and a person centred care plan format was in place. Plans contained some specific details about how people liked to receive their care and their individual likes and dislikes. For example one care plan stated 'Important to my wellbeing? My cleanliness and integrity'. Staff knew people's needs well and demonstrated to us how they used this knowledge to help them provide person centred care. One staff member described how they supported one person to have a shave, although they often refused initially. They told us that they respected the person's decision but were patient and often the person would ultimately change their mind and ask for a shave. They also told us, "[Person] likes chatting a lot. [They] like you to be around them. [They] are missing [their relative]."

A second carer was able to tell us in great detail about another person's needs. They demonstrated an understanding of the elements of care that were very important to this person but the information was not always captured in the person's care plan which would have been very helpful to any new staff who might support the person in the future.

We found that although the new format covered a lot of areas of a person's life, information was not always detailed enough and was not always promptly updated when people's needs or circumstances changed. This could be confusing for staff. For example, one person was living with advanced dementia and this was affecting their behaviour due to their distress. There was very little guidance in the care plan telling staff exactly how to support this person successfully or what distraction techniques to employ. The only information we saw stated 'The carer must remain alert and vigilant'.

Care plans documented people's needs in a variety of areas including communication, psychological needs, mobility, social needs, personal care and security. People's routines were recorded to help guide staff through each care visit the person received. We saw that where people had expressed a preference for certain social activities staff aimed to provide these. One person was very happy to chat about their particular hobby with us and clearly did so often with their regular member of staff. Another person's care plan stated that they liked to go out occasionally and their carer told us they had gone out the previous day to the seaside.

The provider's website stated that the service was able to provide end of life care, however they were not actively providing end of life care at the time of our inspection. Staff records showed that one member of the care staff had received specific end of life training but this was not planned for others. People's end of life wishes were not recorded in their care plan, although it was clearly recorded where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place and staff knew if people had this in place.

Requires Improvement

# Is the service well-led?

## Our findings

At our two previous inspections in August 2017 and February 2018 we rated this key question as Inadequate. After our inspection in August 2017 we placed conditions on the provider's registration, one of which stopped Fortress Care Services from taking on any new care packages without CQC permission. We had multiple concerns about the leadership of the service at both previous inspections and during our last inspection we identified seven breaches of regulation. Breaches included one which specifically related to the overall management of the service. We found the provider failed to be honest and open with us and did not provide us with the information we required and failed to act promptly on known risks. We also found that the provider had not displayed their Inadequate rating on their website which had the potential to mislead the public.

At this inspection we identified some clear improvements throughout the service. However, some key areas still require further improvement to ensure people always receive safe, effective care which meets their individual needs.

We found that the service was clearly displaying their current CQC rating and were aware of their responsibility to do this. Other CQC requirements had not always been complied with and we found that one incident which required paramedics to attend and one potential safeguarding incident had not been notified to us. Records showed that one of these incidents took place when a live-in member of staff called paramedics as they were 'unable to cope' with the person they were supporting and caring for. It is not clear why they did not ring the service's own out of hours number, although they did report this afterwards and the provider arranged for a second member of staff to be present until matters calmed. This demonstrated that systems to support staff, especially live-in staff, need some further improvement.

Similarly we found that one member of staff had been placed at risk of harm from a person's unpredictable behaviour related to their deteriorating health condition. We saw that this member of staff logged incidents on the electronic record on a very frequent basis but the provider had not been effective in addressing the situation. We noted, for example, that during April 2018, 22 incidents of the person pinching, grabbing, hitting and pulling staff had been recorded. The staff member had recorded that they did not feel safe and were particularly concerned about the person, and themselves, being at risk on the stairlift due to the person's unpredictable behaviour.

Although the staff member themselves told us they felt very well supported by the provider, we believed the provider could have acted more quickly and more effectively to address the situation. They had ultimately given notice to the person who used the service but had not adequately supported their staff to protect them from the risk of injury. Although the provider showed us documentary evidence of their efforts to raise a concern with the local authority, their actions were not effective and staff were not well supported during a period of some months which had an effect on their health and wellbeing.

Since our last inspection in February 2018 the provider had employed a part-time care co-ordinator to be a liaison between the registered manager and the staff. They also carried out unannounced spot checks

(sometimes at weekends or in the evenings), supervision sessions and assessments of staff practice. They acted as a back up carer, a role model and a source of advice and guidance. We found this person to be very competent and to have the skills and experience needed for this role which was a very welcome addition to the staff team. Staff were very positive about the care co-ordinator and found her helpful and approachable.

Staffing of the service was much more structured and ensured, as much as possible, that people received consistent care from staff who knew them well. Out of hours cover was in place, although we did find some confusion as to the whereabouts of the provider when we arrived for our unannounced visit on 20 June 2018. Staff did not know where the nominated individual and registered manager were or how long they would be away for. In addition, nobody had access to the area where archived records were kept. This could be significant should staff need to find out some information in response to a request from a paramedic or hospital for example. Information was archived each month and so only the most current information was stored in some people's homes.

The care co-ordinator carried out some spot checks along with the registered manager. However the registered manager had not been working full time at the service for several months due to ill health. They told us that they oversaw the spot checks and audits that the care co-ordinator carried out. We asked the registered manager to explain how they assured themselves that medicines were being safely administered as we found the medicines audit to be poor. They could not explain this to us and we were not assured that oversight of all aspects of the service was robust.

We noted that the provider had worked hard to raise the standards at the service and we saw some genuine improvements. The electronic daily records were easy to navigate and effectively highlighted significant issues. The provider had regularly engaged with people who used the service and their relatives via quarterly quality assurance surveys and these were very positive.

However some issues, such as conflicting or incomplete records and poor oversight of risk remained. We saw that where we raised concerns the provider addressed them promptly but these should have been issues the provider noted for themselves, especially given the now significantly reduced number of people using the service.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure that they accurately assessed risks to people's health and safety or to ensure risks were reduced. Regulation 12. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure they operated effective systems to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service and others. Regulation 17. |