Enable UK (Midlands) Limited

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Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 15 September and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service at an office location and at supported living services.

This was the first inspection of the service which was registered in April 2015.

Enable UK (Midlands) Limited is a private organisation. This branch of the organisation provides personal care and support to adults who have a learning disability living in the London Borough of Hillingdon. At the time of our inspection they provided support to eight men who lived in three different homes.

The provider had a registered office location which we visited. We also visited one location where four people lived as part of our inspection.

There was not a registered manager in post. The manager of the service had applied to be registered the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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 and associated Regulations about how the service is run.

The recruitment procedures for staff did not always include making checks on their criminal record or obtaining references from previous employers.

Relatives of people using the service felt that the staff were not always deployed in a way to best meet their needs and sometimes the staff worked long shifts on consecutive days.

The staff did not have the support, training and supervision they needed to care for and support people.

The provider did not always respond and take appropriate action when people complained about the service. People did not always feel well informed or involved.

The relatives of people who used the service and staff did not feel the service was well managed or led. They told us they were not able to get the information and support they needed. They were concerned about changes in management and the lack of managerial support for the services.

The provider did not operate an effective system to monitor, assess and improve the quality of the service.

There were risk management and support plans for each person which identified where they might be at risk and what the staff needed to do to support them.

People were supported to have the right medicines and these were stored and recorded appropriately.

People's capacity to make decisions had been assessed and where they lacked capacity, other relevant people made decisions in their best interest and these were recorded.

People's nutritional needs were met and they had a choice and variety of meals. However, relatives were concerned that people did not always receive freshly prepared food and did not always have enough fruit and vegetables.

People were supported to meet their health care needs. The staff were kind, caring and polite. People's privacy and dignity was respected. The staff and the people who they were caring for had positive relationships with each other.

Each person had a clear and up to date support plan which described their needs and the support they required from the staff. Relatives of people who used the service felt that some of their needs were not being fully met.

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

Summary of findings

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.

The recruitment procedures for staff did not always include making checks on their criminal record or obtaining references from previous employers.

Relatives of people using the service felt that the staff were not always deployed in a way to best meet their needs and sometimes the staff worked long shifts on consecutive days.

There were risk management and support plans for each person which identified where they might be at risk and what the staff needed to do to support them.

People were supported to have the right medicines and these were stored and recorded appropriately.

Is the service effective?

Requires improvement

The service was not always effective.

The staff did not have the support, training and supervision they needed to care for and support people.

People's nutritional needs were met and they had a choice and variety of meals. However, relatives were concerned that people did not always receive freshly prepared food and did not always have enough fruit and vegetables.

People's capacity to make decisions had been assessed and where they lacked capacity, other relevant people made decisions in their best interest and these were recorded.

People were supported to meet their health care needs.

Is the service caring?

Good

The service was caring.

The staff were kind, caring and polite. People's privacy and dignity was respected.

The staff and the people who they were caring for had positive relationships with each other.

Is the service responsive?

Requires improvement

The service was not always responsive.

The provider did not always respond and take appropriate action when people complained about the service. People did not always feel well informed or involved.

Summary of findings

Each person had a clear and up to date support plan which described their needs and the support they required from the staff. Relatives of people who used the service felt that some of their needs were not being fully met.

Is the service well-led?

Inadequate 

The service was not well-led.

The relatives of people who used the service and staff did not feel the service was well managed or led. They told us they were not able to get the information and support they needed. They were concerned about changes in management and the lack of managerial support for the services.

The provider did not operate an effective system to monitor, assess and improve the quality of the service.

Enable UK (Midlands) Ltd

Detailed findings

Background to this inspection

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

The inspection took place on 15 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a small domiciliary care service and we wanted to make sure people were available.

The inspection team included one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of caring for someone who had a learning disability.

Before the inspection we looked at all the information we had about the provider including notifications of significant events. We spoke with representatives of the London Borough of Hillingdon who commissioned the service. We received copies of reports from the London Borough of Hillingdon regarding their own audits of the service.

People who used the service were not able to tell us about their experience of the service because of the degree of their learning disability. We spoke with the relatives and representatives for six of the people who were using the service over the telephone. We also spoke with six members of staff on the telephone.

During the inspection visit we met two people who were using the service, three support workers, a team leader and the manager. We looked at the records relating to the care and support of two people, the records of staff recruitment and support for six members of staff, record of the provider's checks on the service, staff communication, records of incidents and accidents and how medicines were being managed for two people.

Requires improvement

Is the service safe?

Our findings

The manager told us that some of the recruitment checks on new staff were made by the provider's head office. He told us that he interviewed staff. We looked at the recruitment records for six members of staff. There was no record of a Disclosure and Barring Service (DBS) check, (which includes a check on the person's criminal record), for two members of staff. There was only one reference check from a previous employer for two members of staff and no reference checks for one member of staff. Therefore people using the service may have been at risk because the provider had not checked their suitability to work with vulnerable people before they started work at the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of relatives and representatives told us they did not feel confident that their relatives were safely cared for by the service. Some of their concerns were around the lack of permanent staff. They said that they were unhappy with the number of temporary staff who worked at the homes. They were also concerned about the hours the staff worked, saying that some staff worked excessively long hours, putting people at risk. The manager told us that these issues had been resolved and that more recently people had been supported by a team of permanent support workers. They also said that staff did not work long hours. We looked at the staff rota for one of the homes. This indicated that there was a team of permanent staff who provided the majority of support. However, we noted that the majority of staff regularly worked 11 and a half hour shifts, sometimes on consecutive days. This could mean that people they were supporting may be at risk because the staff were tired or not able to concentrate towards the end of these shifts. One relative told us, '' (the staff) working those hours are going to be pretty dead on their feet.''

Other concerns from relatives included one relatives concern that belongings had gone missing. The manager told us this had been investigated and the police had been told, but the investigation was inconclusive. The relative of this person said that they were concerned about other things going missing in the future. The majority of representatives told us they were concerned about safety issues because they felt the management support at the home was not good enough, therefore if something went wrong it was not dealt with in an appropriate way.

The provider had a procedure regarding safeguarding vulnerable adults and the staff had read and signed this. The staff were able to describe the procedure and what they would do if they suspected someone was being abused or at risk of abuse. Some of the things the staff told us were, "Yes I have had training. I've had to deal with issues, for example a service user hitting another service user I will report it and deal with the issue", '' It's about looking after service users, protecting them from harm'' and ''I mostly understand about neglect, financial abuse, educational abuse. Our duty is if we see a member of staff abuse a service user, to raise the alarm and report what is going on.''

The provider had followed local authority safeguarding procedures and had worked with the local authority to investigate allegations of abuse. They had also notified the Care Quality Commission and other relevant parties.

The care records for people included risk assessments and risk management plans. These described areas of risk and how staff should support people. In particular some people were at risk of challenging others. The plans described how the staff should support people to minimise the risks of this happening and what they should do to support people if this did happen. Risk assessments also described the risks people experienced in the community, such as road safety awareness. We saw that support plans included information on how the staff should support people when they were outside of the home. The staff were able to describe how they would support people and the action they took to minimise risks and to keep people safe. We saw that risk assessments and support plans were regularly reviewed and updated. The information for the staff was clear and easy to understand. Support plans incorporated the guidelines from the healthcare professionals who worked with people, such as therapists and psychologists.

Some people's representatives felt that the service did not manage risk appropriately and they were meeting with the provider and other professionals to discuss this.

We saw that incidents where people had been physically challenging to others were recorded. The team leader told us she discussed these with the staff, her manager and the

Requires improvement

Is the service safe?

other professionals involved in caring for people. The records included an analysis of what had happened and whether there were any lessons the staff could learn to prevent the incidents reoccurring.

The provider had procedures for managing people's medicines. The staff told us they had received training in this and had been assessed before they were permitted to administer medicines. Records relating to medicines were clear, accurate and up to date. There was evidence of administration and people had received their medicines as prescribed. Medicines were stored securely. The staff carried out checks and audits of the medicine records and medicines held at the home. These were accurate. One member of staff was responsible for checking medicine records and supplies each day and these checks were recorded.

Requires improvement

Is the service effective?

Our findings

Relatives and representatives told us they were concerned that that staff did not have the training and skills to meet people's needs. Some of them said the staff did not understand about food and nutrition, others told us they were concerned that the staff did not understand or know how to meet specific health care needs. Some representatives told us the staff were not trained and did not know how to support people when they were physically challenging.

The staff files contained evidence of training in medicines management, safeguarding adults and autism for some members of staff. There was no central record of staff training and the manager did not have a system to audit when staff training was due and what the staff training needs there were. The manager told us there had been a problem with the training provider and they were attempting to purchase services from another trainer. He also told us they had set up a system for on line training, although the staff had not started using this at the time of our inspection.

We looked at six staff files, there was a record of one formal supervision meeting for two members of staff. There were no records of individual supervisions or appraisals for the other four members of staff. The team leader told us they held staff meetings with a group of staff, however there were no records of these.

The staff told us they had shadowed experienced staff and read policies and procedures as part of their induction when they started work at the service. However, there was no record of staff induction and no records to show they had been assessed as competent or that they had understood their role and responsibilities.

The staff told us they did not feel supported by the organisation. For example, one member of staff told us they had been injured whilst at work. They told us the provider had not contacted them to find out about their injury and recovery. They said they were not offered any paid time off following the injury or any support when they returned to work. Other staff told us they had not received a written contract despite requesting this. Some of the staff said they were not always paid the correct amount following overtime.

The staff told us they did not have regular formal supervision and had not received appraisals. They also said that they had not been trained to undertake some of the duties they performed. For example, some of the staff had not received training about epilepsy or how to administer emergency medicines to someone who was having a seizure. One member of staff described an incident where a person had a seizure when they were being supported by untrained staff. The staff also told us they had not been trained in supporting people whose behaviour was physically challenging. They said that some people regularly hit, kicked and were physically aggressive towards other people who used the service and staff. They said they had not had any training to explain how they should support the person or what to expect when this happened. The staff told us they had received medicines management training, and some staff had received training in autism and safeguarding adults. However, they said the provider had not organised for other training and they did not feel equipped to carry out all aspects of their role. Some of the things the staff told us were, ''Unfortunately I could request training but it would fall on deaf ears, however they have offered to put me on an NVQ", "I have asked for epilepsy training but it has not been provided", "I've sorted training out myself. They (Enable) don't have a training program. They used to when I first started but not now" and "I think there is training due. Hopefully it will happen soon but there has been no letter about training yet."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The staff told us they worked well as a team and supported each other. They said that the team leader was very supportive and they could speak with her at any time. They told us they had good systems to communicate with each other and we saw they used a communication book and a diary for this. The staff told us the team leader was very dedicated and they felt she supported them when they had a problem. The staff planned each shift to make sure people received the care and support they needed from allocated members of staff. They told us this system worked well.

The Care Quality Commission (CQC) monitors compliance with the Mental Capacity Act 2005. The provider had carried out capacity assessments for people who used the service. These included information on how people communicated

Requires improvement

Is the service effective?

their choices and understood information. People using the service had the capacity to make decisions about their day to day lives, for example what they ate, how they spent their time and what they wore. However, they had been assessed as lacking capacity to understand more complex decisions and to understand their support plans. There was evidence that the provider worked with relatives, representatives and other professionals to plan people's care and to make decisions about their health and wellbeing.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager told us there were no restrictions at the service and people were not being deprived of their liberty.

The staff had not received training in the Mental Capacity Act 2005 organised by the provider however some of them had been trained by previous employers. They demonstrated an understanding of the legal requirements of the Act.

People's nutritional needs were recorded. They were involved in choosing their own meals, planning and shopping for these. People used their own money to purchase their food and their menus were planned according to their preferences and needs. The staff told us that some people could make their preferences known and that they knew the likes and needs of others so they could plan meals for them. Some of the relatives and representatives felt the staff did not always know people's needs, for example they gave them food they did not like or eat. They also told us the staff did not always have the skills to prepare fresh meals and just heated ready-made food up. Relatives felt that people would benefit from more fresh fruit and vegetables in their diet.

People's health care needs had been assessed and were recorded in the support plans. There was evidence the staff monitored people's health each day. We saw records to show people saw health care professionals when needed and that the advice from these professionals had been included in the support plans. Each person had an up to date health action plan and information about their health needs which could be used if they attended hospital, so that unfamiliar health care workers could see what these needs were.

Good

Is the service caring?

Our findings

The relatives of people who used the service told us they thought the staff were kind and caring. They said the staff were calm and considerate. They thought their relatives had good relationships with the staff. They told us people's privacy was respected and they were able to spend time alone in their bedrooms. Relatives told us people were always well dressed and clean, although one relative was concerned that the staff did not always clean their relative's teeth well enough. One representative said that they thought the staff did not always understand or meet their relative's cultural needs, for example around their diet.

We observed the staff being kind, polite and caring. They had positive interactions with the people who they were caring for. They spoke fondly about them. The staff offered people choices, respected their answers and responded to them when they had a need. The staff told us they always worked at the same home, supporting people they knew well. Some of the things the staff told us were, "I like the staff I work with. I get on with the parents and love working with the service users" and ''It's quite rewarding if I teach a service user something new or help them access what they want to do.''

The staff understood about the importance of treating people with respect and dignity. One member of staff told us, "It's treating someone how you would like to be treated. When washing someone you don't make silly comments. You look after them and cover them up. If anything happens you don't make a big deal about it. You deal with it as calmly as possible."

Requires improvement

Is the service responsive?

Our findings

The relatives and representatives told us they felt the provider did not respond to their concerns or complaints. Some of the things relatives told us were, ‘’We have raised issues and these have not been sorted out’’, "I've made a bit of a complaint but no one gets back to me. You don't know who to speak to, to be honest’’, ‘’nothing ever changes, we have raised concerns but we do not hear anything back’’ and ‘’I have complained and I am still waiting for a response.’’

There was no record of complaints, how these had been responded to and any actions taken to prevent problems reoccurring. The team leader told us that she had some emails of complaints on her laptop, but there was no central record of these. There was no evidence that the provider had acted on some of the concerns relatives told us they had raised.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and representatives told us they did not feel people’s needs were always met. Some told us their relatives were not learning new skills and did not take part in planned activities. One representative told us they had seen their relative learning new skills and they were pleased with this. People told us that their relatives were not always supported to use the community and to take part in activities because there were not always the staff available to support them. The manager told us that this had improved and people were supported to take part in a variety of activities. We saw evidence that people did use the community, attended college, clubs and leisure pursuits outside the home. However, some relatives felt this did not happen enough.

Some relatives felt that people were involved in making decisions about their own care and that their choices were respected. Some of the relatives felt this depended on which staff were supporting people. The representatives told us they had been involved in planning relatives care to some extent but that they were not consulted about changes and that it was difficult to contact the manager so they could discuss any changes they wanted. They said that the staff did not always identify and meet people’s needs, for example when they needed new clothing or equipment, and that they had to remind the staff to attend to these needs.

The team leader had designed and created support plans for each person. These were clearly laid out and identified people’s needs, abilities and the support they required from the staff. The staff told us the support plans were clear and useful. These were regularly reviewed and updated. The staff recorded the care and support they had given each day and these reflected the needs identified in the support plans.

Inadequate

Is the service well-led?

Our findings

The provider did not have systems to assess or monitor the service. The manager told us that he did not carry out audits of the service. He said that he visited the homes where people were being supported and he received feedback from the team leader. There were no recorded audits of checks relating to the way in which the service was managed, people were supported or the records relating to this.

The relatives of people who used the service told us they did not think the service was well managed. Some of the things they said were, "They do have some very good staff but as a company I can't say anything good about them'', ''Enable as a company are not doing a good job'', ''The staff are doing things but are not supported by management'', ''the managers keep coming and going'', ''There needs to be better management from the top", ''the manager is managing Reading and Hillingdon. He's hard to get hold of and won't answer his phone. I can't get hold of him'' and "If the person at the top is rotten, there is no hope for the company. In my opinion I don't think the management of Enable should be in the caring profession. The company is pretty awful. They need more managers and more staff." The relatives also told us that they were not well informed about changes that affected the service. For example, one person said, ''I had been trying to call the manager and someone else answered and told me that manager had left and that they were the new manager. I then had to contact the manager again and again the manager had changed." Another person told us, ''I only find out what is happening through my relative (a person who used the service.''

The staff told us they did not feel supported by the manager or the organisation. Some of the things they told us were, "We need more support from the top management. If they would come in and see what is happening and what they could do to help'', "The manager I've seen as a one off. I don't really have meetings. The team leader is helpful", "The whole service could do better. We haven't had any petty cash in a few months. They need to be more organised'', ''I've never been thanked for the work I do" and "We don't see much of the manager. There are issues regarding pay. Sometimes it's wrong or we have trouble reclaiming money we've spent. There is a lack of communication between the house and management.'' A senior member of staff told us, ''There is only so much support I can give staff. I was on annual leave and on call. Technically I didn't have a break."

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

The manager had been in post for approximately two months before the inspection. They were the registered manager for another branch of the organisation. They had applied to add the Hillingdon location to their registration so that they would continue to manage the two branches. Before they took up their post there had been a number of different managers who had worked for short periods of time at the location.

At the time of our inspection the Hillingdon branch offered personal care and support to eight people living in three different homes. The London Borough of Hillingdon were commissioning and monitoring this service. The London Borough of Hillingdon and the families of four people living in two of the homes had decided to commission care from another provider. The manager told us that the branch would continue to provide support in one of the homes, where four people lived. They told us they hoped to build up their reputation within the borough to expand the service.

The manager told us the organisation had recently employed a person whose role would include quality monitoring. However, he said that they had not yet visited or audited this location.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had not obtained satisfactory evidence of the conduct in previous employment or information relating to the criminal record of persons employed.** **Regulation 19(3)** **Schedule 3(2) and (4)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not provide appropriate support, training or supervision to persons employed at the service.** **Regulation 18(2)(a)**

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had not established and operated an effective and accessible system for identifying, receiving, recording, handling and responding to complaints.** **Regulation16(2)**

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not established and operated an effective system to assess, monitor and improve the quality and safety of the service and did not seek and act on the feedback from the relevant person and other persons for the purposes of continually evaluating and improving the service.

Regulation 17(2)(a), (e) and (f)