Stepping Forward Support Limited

Stepping Forward Support LTD

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Stepping Forward Support LTD is a supported living service that provides personal care and support to people living with a learning disability in their own homes.

At the time of this inspection, the service was supporting four people living in three houses. The service provided staff 24 hours a day with sleeping-in facilities for staff to stay overnight. Only two of the four people supported were receiving personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People could not be assured they would receive safe care and support. Healthcare professionals had raised concerns that the service was failing to follow advice regarding the diet requirements needed to help manage one person's medical condition. We found that despite having information and guidance, the service had failed to ensure this advice was implemented. The service had also failed to seek medical advice when this person showed signs of being unwell. This placed the person at risk of receiving unsafe care.

Quality assurance processes, although improved since the previous inspection in August 2019, had been ineffective in assessing, mentoring and improving the safety and quality of the service. The service was receiving advice and support from the local authority's quality assurance and improvement team (QAIT) as well as the intensive assessment and treatment team for people living with a learning disability (IATT). The manager told us they found their guidance and advice very informative and useful. However, records showed the service did not always follow this advice and was slow to implement changes.

Recommendations for staff training had been made at the previous inspection. The provider told us they had not been able to access formal face to face training. However, they had not sought guidance from other sources, such as information available from professional organisations. This meant people's needs were not met by staff trained to meet those needs.

Staff recruitment practices remained safe, and there were sufficient staff on duty during the day. We have asked the service to review people's staffing needs at night when only sleeping-in staff were available.

The relative we spoke with said they felt the care and support their loved one received was safe. They said, "He is happy, and he's well looked after." They said, "He's been given a lifestyle I could never have dreamed of."

People received their medicines as prescribed. However, not all staff had been assessed as competent to administer medicines and some staff required an update in their training.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: The service was last inspected in July 2019 and was rated requires improvement (the report was published on 12 August 2019). There were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted due to concerns received about whether people's health care needs were being managed safely. Healthcare professionals were concerned about how the service was supporting one person with their diet to manage a health condition. Due to safety concerns this person had moved to alternative care provision for a period of assessment. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well-led key question sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stepping Forward Support Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection. We have also made a recommendation for the service to review people's staffing needs with the local authority.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Stepping Forward Support LTD

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector undertook this inspection.

Service and service type
This service provided care and support to four people living in three houses, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

One of the provider's directors held the position of registered manager with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. The service also had a manager who managed the service on a day to day basis on behalf of the provider.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure the provider would be available to speak with us.

Inspection activity started on 3 January 2020 and ended on 7 January 2020. We visited the office location on 3 January 2020 and visited one person in their own home on 6 January 2020. We spoke with staff and a

relative on 7 January 2020.

What we did before inspection
Prior to the inspection we reviewed the information we received from the local authority and professionals who work with the service. We also reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return before this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We met with one person who used the service, the second person who received support with personal care was in hospital at the time of the inspection. We spoke with one relative about their experience of the care provided. We spoke with six members of staff including the provider, manager and care workers.

We reviewed a range of records. This included the care and medicines records for the two people receiving support with personal care. We looked at the staff file for the member of staff recruited since the previous inspection. A variety of records relating to the management of the service, including quality audits, were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Prior to the previous inspection in July 2019 the service was working with the local authority's safeguarding and quality assurance and improvement teams (QAIT). Health care professionals were concerned people were not receiving safe care. The service was placed in to 'whole service safeguarding' process which meant the local authority would keep the service under review. The service had voluntarily suspended providing a service to any new people.

At this inspection in January 2020 the service remained in whole service safeguarding and the suspension on taking new people remained in place. The service continued to be supported by QAIT. As a result of professionals' concerns over one person's safety, they were removed from the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People could not be assured they would receive safe care and support.
• At the previous inspection in July 2019 we found improvements were required with how information was provided to staff about one person's healthcare condition. We made a recommendation for improvement.
• Prior to this inspection in January 2020, healthcare professionals shared their concerns about how this person's diet regime, required to manage their medical condition, was being managed. During this inspection we found the way in which this person was being supported did not mitigate risks to their health and safety.
• Records showed that although staff had information about the importance of supporting the person to follow a healthy diet, staff had failed to follow this advice. The information included what symptoms might indicate a decline in the person's health as well as a statement that if the person's medical condition was not well managed, "This could have a significant and detrimental effect on [name's] physical health and quality of life."
• Records also showed the person was exhibiting these symptoms of not being well, but staff failed to seek medical advice until requested to do so by a nurse visiting the person.
• Staff had received training in the care of people with this medical condition, but this had not been until November 2019, several months after safety concerns were raised about the service's practice.
• Prior to, and following the previous inspection in July 2019, QAIT was supporting the home to develop systems and processes to promote safe, person-centred care. Despite this support, the provider had not acted to address the safety concerns raised by healthcare professionals. They had failed to review people's support and people remained at risk of receiving unsafe care.

Using medicines safely
• At the previous inspection in 2019 we found improvements were required with how the service reviewed

staff's competence to administer medicines and whether people received their medicines as prescribed. The manager was being supported by QAIT to review medicine practices.
• At this inspection we found insufficient improvements had been made. Records showed not all staff had had their competence to administer medicines assessed by the manager, and five of the 14 staff had not received an update in their training in the safe administration of medicines for over one year. The manager confirmed this training had been arranged through the service's on-line training provider.

Failure to do all that is reasonably practicable to mitigate risks to people's health and safety and to ensure staff were trained an competent to administer medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other risks such as those associated with impaired mobility, when travelling in a car and eating and drinking were assessed and guidance was provided for staff about how to support people safely.
• Medicines administration records had been fully completed with no gaps in recordings. This indicated people had received their medicines as prescribed.

Systems and processes to safeguard people from the risk of abuse
• The person we visited was unable to share their views about whether they felt safe with the staff. Our observations showed they were happy and relaxed in staff's company. They greeted staff enthusiastically and was seen to laugh with staff and engage in conversation.
• The relative we spoke with said they felt the care and support their loved one received was safe. They said, "He is happy, and he's well looked after."
• Staff told us, and records showed, they had received training in safeguarding. Staff were aware of their responsibilities to protect people from abuse.

Staffing and recruitment
• Recruitment practices remained safe. We saw that appropriate pre-employment checks and references had been obtained for a member of staff recruited since the previous inspection.
• The two people whose care we reviewed continued to receive shared staff support 24 hours a day, as well as a number of one-to-one staff hours every week. Night support was provided by a member of staff sleeping in. However, one person's records showed their night-time needs had increased. They were awake during the night, often more than once, and required support with personal care. This meant staff had to wake and be with them. We asked the manager to review this person's night time staffing needs with the local authority and to review the staff rota to ensure staff did not work supporting people during the day when they had been awake during the night.

We recommend the service reviews it's staffing arrangements and consults with the local authority to re-assess people's staffing needs to ensure these remain safe at all times.

Preventing and controlling infection
• Infection control practices continued to be safe. Staff received training in food hygiene to enable them to support people to prepare meals safely.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The service has been registered with the CQC since January 2012 with the provider acting as the registered manager since that time. At the previous inspection in July 2019 we found improvements were required in a number of areas including risk management, the safety of medicine administration, staff training and supervision and working in accordance with the MCA. The provider and manager acknowledged this and said they were "starting from scratch" with reviewing and developing their systems.

• At this inspection in January 2020 we found some improvements had been made in relation to some management processes including the introduction of quality audits, staff supervision and medicine administration competency assessments. The manager had also recorded capacity assessments and best interest decisions for people receiving care and support.

• However, processes had not been effective in reviewing the safety of the support provided to people. For example, the service maintained records of the support each person received. This included what support staff had provided with personal care, what people had to eat and drink and a description of their well-being. From the review of one person's records it was clear staff had failed to support this person in line with the guidance provided by professionals. The processes in place for identifying quality and risk had not identified these significant shortfalls in the provision of safe care.

• The manager told us they worked alongside staff to support people. The duty rota showed the manager worked with people receiving support with personal care at least once a week. However, they had failed to address the dietary needs of one person. The failure of the provider and manager to seek advice or follow guidance had led to this person being removed from the service for welfare reasons.

Continuous learning and improving care; Working in partnership with others

• The service was receiving advice and support from QAIT and IATT. The manager told us they found their guidance and advice very informative and useful. However, records showed the service did not always follow this advice and was slow to implement changes.

• Recommendations for staff training had been made at the previous inspection in July 2019. The provider told us they had not been able to access formal face to face training. However, they had not sought guidance from other sources, such as information available from professional organisations. This meant staff had not received the training they needed to ensure they could meet people's needs.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• At the previous inspection in July 2019, the manager said they routinely observed staff interacting with people and asked people if they were happy but had not formally recorded these observations. The manager gave assurances these observations demonstrating people were happy with the staff would be recorded in future.
• At this inspection in January 2020, we found that although the manager continued to work alongside staff and monitor their interactions with people, they had not incorporated these observations into the quality assurance system.
• Staff told us that despite having regular contact with the provider and manager, they didn't feel listened to. Where concerns were raised, and suggestions made to improve the service and people's support, they said no action was taken. Staff said communication between themselves and the management team needed to be better. One member of staff said, "The office needs to be better organised. When you raise a concern, you don't know what is being done about it, better communication needed."
• We discussed this feedback with the manager, who acknowledged staff might feel they had not been paid enough attention, as they had been concentrating on improving the assessment and auditing systems. They had discussed this with staff and reiterated they were always available to them.

Failure to have effective systems in place to assess, monitor and improve the service as well as to mitigate risks to people's health and safety is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● The relative we spoke with told us their loved one received a good level of care and support. They said staff were dedicated to ensuring they were happy. They said, "He's been given a lifestyle I could never have dreamed of." They described their relationship with the provider, manager and staff as good and said they had "gone above and beyond" what would be expected of them in their care and support. They said, "They care for him, that's the important thing."
• Staff told us they worked well together as a team and did their best for people. One described the team work as "great". Staff felt their level of care was good and they were all dedicated to supporting people to have a happy lifestyle.

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 The provider failed to do all that is reasonably practicable to mitigate risks to people's health and safety. The provider failed to ensure the proper and safe management of medicines

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place to assess, monitor and improve the service as well as to mitigate risks to people's health and safety.