Pharos Care Limited

Pharos Supported Services

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 7 January 2016. This was an announced inspection and we telephoned the provider the day before our inspection to ensure we had an opportunity to speak with people who used the service.

The service was registered to provide personal care for people and we visited people who received support within their own flats; this was part of a complex which included a residential service managed by the provider.

The service did not have a registered manager, although we have received an application we are currently reviewing. 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.

People chose how to spend their time and staff sought people's consent before they provided care and support. However, some people were unable to make some decisions and it was not always clear how decisions had been made in their best interests. Some people had restrictions placed upon them as they were not able to go out alone as they needed support to remain safe in the community. Applications had been made to review if these restrictions were lawful; although the provider had not considered how all aspects of support may be restricting people.

People were provided with opportunities to develop their interests and join in social activities and be independent. However, some people were not sure if they needed support for all activities and how this should be provided, as their care records did not include this information. Other people needed support as their behaviour may harm themselves or others. Support plans to guide the staff had not been developed to ensure care was given consistently.

People knew how to report concerns and staff knew how to keep people safe and helped people to understand risks. Checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service.

People were supported to be responsible for their medicines. Staff knew why people needed their medicines to keep well.

People received an agreed level of staff support at a time they wanted it. People were happy with how the staff supported them.

People were helped to prepare and cook their own meals and people were responsible for shopping and planning their meals. People could choose their own food and drink and were supported to eat healthily.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always supported to manage their behaviour to ensure their safety. People and staff were unclear how to support some people as the care records had not been completed to ensure people received consistent care. There were sufficient staff to meet people's agreed support needs and recruitment procedures meant checks were carried out to ensure staff were suitable to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent when providing support although where people may lack capacity; decisions were not always made to ensure people were supported to be safe in the least restrictive way. Staff received an induction into the service and were given opportunities to develop their skills to support people. People were helped to prepare their meals and eat a varied diet.

Pharos Supported 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.

This inspection took place on 7 January 2016 and was announced. We carried out this inspection because we had received concerns about how people were supported. We contacted the provider before our inspection because the location provides a domiciliary care service for younger adults who are often out during the day, and we needed to be sure that someone would be in. Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with two people who used the service, six members of care staff and three health and social care professionals. We did this to gain people's views about the care and to check that standards of care were being met.

We observed how the staff interacted with people who used the service.

We looked at three people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

People were supported to remain independent although their care records did not always reflect their support and associated risks. We looked at one care record with one person and they were unclear if they were able to go out alone or with support; the care records did not include how it had been agreed staff would support them. They told us, "I'm not able to go out on my own I think. I need to ask the staff." We spoke with two members of staff who told us they were able to go out alone but they were concerned about them going to some local places because this may put them at risk of harm. There was no information about this agreement or what the risks to the person was when out alone. This meant clear guidance was not available for the person to ensure they kept safe.

One person presented with complex behaviour which may harm themselves and others; there was limited information about how they should be supported to keep safe in the home and when out. When we spoke with staff, we were given different information. One member of staff told us, "I'd ask them to stop and explain." Another member of staff told us, "If they don't want to listen, they won't. We have to use our judgement at the time depending on what happening." Information was recorded about each incident of complex behaviour but the analysis had not been used to review the support plan with them. The person went out independently but staff advised them to avoid certain places for their safety and that they should return by an agreed time. There was no clear information about what the person wanted or agreements in place for if they did not return home and we saw the police had been contacted on occasions, as staff were concerned about their safety.

One person may cause harm to other people and staff were unclear how to assist to help manage their behaviour and keep other people safe. Staff received training to support people with complex needs and manage potential or actual behaviour, however, one member of staff told us, "There are a team of staff who respond to urgent situations and I am one of them. We have all received the same training and know what we should do, but we are not consistent and we respond to some behaviour and do different things." For example, when supporting one person who may become agitated, one member of staff told us, "I'd move away and let the person have some space if they were agitated." Another member of staff told us, "If they grabbed you, you'd have to remove their hand." Where incidents of behaviour occurred the staff recorded what had happened before, during and after the incident and this confirmed there was not a consistent response. This meant these people were not receiving consistent care to support them to manage their behaviour and keep them safe.

The above evidence shows that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were helped to understand what potential abuse was and how to report it. One person told us, "I know the staff look after me and do what they need to. If they thought someone was being mean they'd help me to sort this out." Staff explained how they would recognise and report abuse. Procedures were in place that ensured concerns about people's safety were reported to the registered manager and local safeguarding team and we saw concerns had been investigated.

People received an agreed level of staff support at a time they wanted it and this took into account the activities people wanted to do in their home and when out. The level of support was reviewed with the person and people who commissioned the service to ensure it continued to meet their needs; we saw the agreed support was provided. Some people had a chart in their home with photographs of which staff were supporting them and at which time. Other people were informed verbally of who was providing their support. One person told us, "I can't always remember who is helping me, so I like to just ask." People told us they were satisfied with the frequency of staff support. One person told us, "I like doing all my own things like cleaning and cooking. I do it by myself and its better this way." We checked the records for two people which demonstrated that they received the agreed level of staffing that the provider had been commissioned to deliver. We saw where people had complex needs or were unwell the provider had provided additional staff cover to ensure they remained safe.

People were supported to retain responsibility for their own medicines and medicines were kept in their home. One person told us they knew what tablets they took and had a timed dispensing device so they could be independent in this area. Other people were prompted to take their medicines and there was a record of when people received their medicines. The staff told us they had received training for medication and had been re-assessed to ensure they were competent. The staff demonstrated a good knowledge of what medicines people needed and why they were required.

When new staff started working in the service, the staff told us that that recruitment checks were in place to ensure they were suitable to work with people. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. The recruitment records confirmed these checks had been completed prior to new staff starting to work in the service.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw consent was sought before any care was delivered and staff recognised where people refused support. One member of staff told us, "We know people have the right to make their own decisions. If they can't, other people can help them but we must always speak to the person first." However, some people did not have capacity to make certain decisions and there was no evidence that capacity assessments had been completed to demonstrate how decisions had been made in their best interests.

We saw some people had restrictions placed on them as they could not leave their home without support. The staff told us that these people would not be safe and needed support and may not have the capacity to make a decision about how safe they were. The staff told us that where people wanted to go out or approached the front door to be opened, they would speak to the person and explain they could go out later with a member of staff, but these people could not go out unsupported. Applications to legally restrict people through the Court of Protection had been made but had only considered how some equipment used in the service may be restrictive, for example the use of bed rails. Some people used assistive technology and had bed sensors fitted to alert staff if they moved or left their room. We were not able to speak with people about the use of this equipment although the staff told us that if the alarm was activated they would check on the person and support them back to bed. Staff told us that some people may lack the capacity to make a decision about the use of this equipment. This meant that this practice may also restrict people.

The above evidence shows that there was a breach of Regulation 11 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We heard staff helping people to arrange how to spend their time and people deciding how to spend their time. One person wanted to go shopping and they researched products on the internet before going out. The person was prompted to consider their finances and on-going expenses to ensure their purchases were a good option. They told us they enjoyed swimming and were going later today but the support was flexible and when the person changed their mind, alternative arrangements were made to ensure they were able to do what they wanted to do. This demonstrated they were able to make everyday decisions about their care and support.

Staff told us they had received an induction when they started working in the service and worked alongside

experienced members of staff to enable them to develop a relationship with people. One member of staff told us, "You are not expected to know everything straight away and are given time to get to know people so you can support them. Another member of staff told us they knew how to support people and recognised where they needed further assistance. They told us, "I am very clear on what my role is. I have only had behaviour training up to level two, so I can't assist if there are any incidents; I support other people to make sure they are safe."

People were supported to eat the food and drink they liked. One person told us, "I have to do my own washing and cooking. I make a plan and we go shopping for the food." Where people needed support with food preparation and meal times, a record was made of the support they received and any concerns.

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 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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not designed to meet service users' preferences and to ensure their needs were met.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not being provided with the consent of people.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users liberty of movement was being restricted.