Voyage 1 Limited

Voyage (DCA) (North East)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Voyage (DCA) (North East) offers a supported living service to people within their own homes or shared houses. It offers personal care to people within the North East area. People who use the service have learning disabilities, autism and/or physical disabilities. They are supported with personal care, medicines, cooking, shopping, activities and other day to day tasks. At the time of this inspection 30 people were using the service.

The last inspection of this service was carried out on 4 November 2013. The service met the regulations we inspected against at that time.

The previous registered manager had left the organisation in September 2015. The service did not have a registered manager at the time of this inspection. 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.

This inspection had been brought forward due to several safeguarding incidents raised by the provider and serious concerns of the local authority which had led to the reassessment of people and relocation of some people. The provider had identified that many incidents of physical and verbal aggression had occurred between people who used the service, but these had not been reported or investigated by the agency staff. This meant vulnerable people had not been protected by the agency and safeguarding adults protocols had not been followed until new management staff visited the service in October 2015.

Risk assessments of people's safety and individual needs were either inaccurate or not in place, for example the risk of falls for some people. The agency had not supported the people in one shared house to keep their house clean which could have affected their health, and waste bins were spilling out at the side of the premises which had attracted vermin.

People did not have information about the service they should expect. There were no records to show people agreed or consented to the support they received. People were supported with their medicines but guidance plans about 'as and when required' medicines were incomplete or missing so staff may have been giving these inconsistently.

The records about how staff had been recruited did not always include satisfactory checks such as references and disclosure and barring checks (these are checks about criminal convictions and whether applicants are barred from working with vulnerable adults). This meant the provider had not always made sure that staff were suitable to work with the people who used the service.

Staff did not know how to make sure people's rights under the Mental Capacity Act 2005 were upheld. (MCA is a law that protects and supports people who do not have the ability to make their own decisions and to

ensure decisions are made in their 'best interests'). Staff felt people did not have capacity but this had not always been effectively assessed and people were expected to make some complex decisions, for example about finances regardless of their capacity.

The provider had not made sure people received personalised care. People's individual care records did not accurately reflect their needs or were incomplete. This meant that it was not always possible to be clear if a person was supported in the right way or in the way they preferred.

The provider's quality monitoring processes were not effective in managing risk or making sure people received a safe or quality service. Shortfalls had been identified earlier in the year but no remedial action had been taken. Staff had computer-based training in appropriate areas of care, but the provider had arranged to renew the training for all staff following the identified concerns at this agency. Staff said they had not felt well supported over the past year but felt things were "getting back on track".

People who could express a view, and their relatives, felt the staff were caring and helpful. People described the support workers as "nice" and "lovely". Visiting health and social care professionals told us the staff were knowledgeable about individual people and were aware of their individual preferences. People were supported to do shopping and encouraged to make their own daily decisions for example about meal choices.

During this inspection we identified six breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Staff could tell us how to recognise and respond to abuse. However we found people were not protected as the provider had not followed appropriate procedures to safeguard people.

Risks to people's safety were not always assessed or were not kept under review.

It was not possible to ascertain that there were enough staff because the provider did not have a record of how many support hours each person had been assessed for.

Is the service effective?

Requires Improvement

The service was not always effective. There was no demonstration that people agreed with their care package or that they consented to the support they received. Staff did not understand mental capacity assessments or how these applied to people who used the service.

Staff had access to training in care and health and safety, and this was to be renewed. Staff had received some supervision sessions but had not always felt supported in their roles until recently.

People were supported to access health care services when this was required.

Is the service caring?

Good

The service was caring. There were friendly relations between people and the staff who supported them.

People's privacy was promoted. They were encouraged to make their own choices about their day.

Staff took time with people and supported them in an unhurried way.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care records and support plans did not always reflect their specific needs and some did not appear to have been reviewed or updated in three years. This meant staff did not have guidance about people's needs or how to support them in the right way.

People did not have information about how to make a complaint, but said they would tell staff if they were unhappy.

People felt there were recent improvements to the support to go out for social activities. Staff were knowledgeable about people's individual preferences.

Is the service well-led?

Inadequate

The service was not well led. The provider's quality assurance system had not been effective in making sure that people were safe.

The provider's monitoring arrangements had identified several shortfalls to the service earlier this year but no review or actions had been carried out so the shortfalls remained.

People had not had opportunities to comment on the service either in questionnaires or at meetings. This meant people's views had not been sought or acted upon.

Voyage (DCA) (North East)

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 began on 3 November 2015 and was unannounced. Other visits to the agency were carried out on 4 and 18 November 2015 which were announced. The inspection team consisted of four adult social care inspectors.

Before our inspection, we reviewed information about any incidents we held about the agency. We contacted the commissioners of the relevant local authorities before the inspection visit to gain their views of the service provided by this supported living scheme.

During the inspection we spoke to 15 people who used the service, some of whom had limited communication, and a relative. We spoke with five support workers, two team leaders, an administrator, a service manager, an operations manager and a managing director for community services. We spoke with four visiting health and social care professionals including social workers and an occupational therapist. We observed care and support in two shared houses. We viewed a range of records about people's care and how the service was managed. These included the care records of 11 people, the recruitment records of 10 staff members, training records and quality monitoring reports.

Inadequate

Is the service safe?

Our findings

Over the past few months several safeguarding incidents had occurred at one of the shared houses which had not been reported in a timely way. The incidents related to some service users hitting out at other service users. There was no evidence that there had been any investigation or action taken about these incidents. This meant people had been at risk of sustained abuse by others, and that protocols to protect those people were not put in place. In discussions support workers described how they had provided verbal and written reports about incidents where people had been hit or kicked by other service users. Staff told us they had assumed that the incident reports would then be passed to the relevant agencies. However the incidents continued to occur and the safeguarding reports were not made to the organisation or other agencies, so no investigation or action had taken place.

The people we spoke with at one shared house told us the situation had been difficult and they had spent much of their time in their own bedroom. Some incident reports included reference to people being "afraid of the situation". Some staff told us they felt "intimidated" and "scared" of one of the people who had behaviours that included hitting out at people and staff members.

In September 2015 the failure to report safeguarding incidents was identified by a new operations manager. The provider then made retrospective referrals about safeguarding incidents to the local authority, as required by local safeguarding arrangements. The referrals included 38 incidents of physical incidents by service users at one shared house. As a result some people were relocated from the service to ensure the safety of the other people who lived there. Prior to this, there was no evidence the provider had investigated safeguarding incidents or made any checks of the safety of the service for the people who lived there which could have identified the safeguarding matters earlier.

Staff said they had training in safeguarding and training records confirmed that 95% of the staff group had completed on-line training in safeguarding vulnerable adults. In discussion they were able to describe how they would report concerns within the locations they supported. However, they were not clear of the process beyond that point. As a consequence, incidents between service users had not always been reported to the appropriate authorities for investigation. This meant the provider had not ensured that its safeguarding processes were operated effectively by staff.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

There were no recorded risk assessments for some people's individual and specific risks, such as cooking, going out alone or going on trips. One person was prone to falls without warning. There were guidelines about their use of protective headgear and how to support the person when standing, but no risk assessment about how to minimise the risk of falls. There was no evidence that staff had been trained on falls or how to manage this.

Risk assessments were not in place for some people whose behaviour could be challenging for themselves

or others. There were no strategies for supporting some people to manage behaviours.

In one shared house people had not been supported with the cleanliness of their accommodation. For example waste bins, including clinical waste, were overflowing. Waste bags had been stacked up by staff on the ground at the side of one shared house. The overspill of bags and food from a pet hutch had led to vermin. Staff had not been sure of the contractual arrangements to remove the waste so it had lain on the ground for several weeks. One person's bedroom had been left in an unhygienic state of dust and debris. Although staff stated that this was the tenant's own accommodation so they were not in a position to interfere, the agency had a responsibility to make sure risks to people's health and safety were recognised. Since the inspection both these matters had been addressed, but until that time the agency had not done all that was reasonably practicable to prevent potential risks to the people who used the service.

The agency supported people with their medicines. Some people's care files included medicines guidance about using invasive epilepsy medicines but no staff were trained in this medication method so they did not administer this. However there were no other protocols in place to guide staff about what to do in the event of epileptic episodes. This meant people's health and wellbeing may not have been supported effectively during these episodes. This could have potentially resulted in serious consequences.

In one shared house there were no protocols about how to manage controlled drugs, even though one person was prescribed a controlled drug. Some people did not have protocols about when they might need their 'as and when' required (PRN) medicines. There were a small number of gaps where medicines had not been recorded on the medicines administration records (MAR). Where people might have a variable dose of a medicine, for example either one or two pain relief tablets, the number was not always recorded on the MAR.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

The provider had a recruitment and selection process. However this had not always been followed by the agency. As a result the recruitment records of staff members were inadequate and incomplete. For example on one staff file there was no evidence of a disclosure and barring service (DBS) check to see whether the applicant had a criminal record. Another staff member had part of DBS clearance relating to children but no check of the adults' barred list to show whether they were barred from working with vulnerable people. There were no references in four out of ten staff files that were checked. It was found that 39 out of 67 staff members had not been subject to an updated DBS check within the last three years and one staff had not had an updated criminal records check since 2003. This was contrary to the provider's own recruitment protocols. Following this inspection the provider began an audit of all staff files.

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

The service was unable to demonstrate how staff support was determined. In one shared house the staff ratio had recently improved as two people had moved out but staffing had remained the same. This meant there were now opportunities for people to receive one-to-one support at times. Some people had been identified as needing periods of two staff to support them, for example with moving and assisting or showering. These hours were now identified on individual timetables and staff were allocated time for each person at the start of their shift.

However, at another shared house staff were not allocated calls of a set duration for individuals and were

"on the floor" permanently. The staff rotas showed that there were variably three or four support staff on duty for 11 people. There was no breakdown about how many hours of support each person was allocated or entitled to. As a result it was not clear whether there were right number of staff to support people at this house. The operations manager acknowledged that there should be precise allocations of each person's support hours in order to calculate adequate staffing levels for each person. At the time of this inspection the service had begun to have discussions with the local authority to identify each person's required support hours.

We spoke with 15 people who used the service. Some people had limited communication. In one shared house people told us they had not felt safe when two other people had lived in the same property. However they said they now felt "safe" and "more relaxed" since those people had moved.

Staff also commented that the service was now a safe place for people and staff members at one house since a change in the tenants. A relative commented, "Whenever I have visited the [people] always seem well supported by the staff on duty." A social worker told us, "My client says they are happy to stay here now that two people have moved out."

Requires Improvement

Is the service effective?

Our findings

Staff did not have a sound understanding of the Mental Capacity Act 2005 (MCA). MCA is a law that protects and supports people who do not have the ability to make decisions for themselves and to ensure that decisions are made in their 'best interests'. Staff told us that some people did not have capacity to make some of their own decisions, for example in relation to finances. However there were no mental capacity assessments in place for those people about how this had been decided and no clear records about what arrangements were in place to support them other than a reference to an 'appointee'. Some people deemed by staff as lacking capacity were expected to make complex decisions about their lives such as managing their finances.

Records about people's consent to care were variable. For example, there were medicines consent forms for some people which had been signed by them to say they agreed with staff managing their medicines. For other people there were no medicine consent forms even though staff supported those people with their medicines. As a result there was no evidence that some people had been consulted or agreed with the way their medicines would be managed.

There was no information within the two locations we visited about what people could expect from the service. There was no service user guide (information booklet) and no care agreement about the support people should receive. This meant people did not have information about the service they should receive and there was no demonstration that some people consented to their care.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Following the inspection the provider had begun to work with local authorities to re-assess the needs of people using the service including, where appropriate, an assessment of their mental capacity to manage finances. Where necessary safeguards were being arranged for people whose finances were to be supported by the Court of Protection.

Some people had behaviours that could challenge the service and other people. Their support plans indicated that staff should use 'talk-down techniques' and several daily records reported that staff used 'talk-down techniques' when people were agitated. However there was no indication of what this meant, nor any personalised ways of supporting people with their behaviours.

One relative felt that the staff were not effective in supporting people to manage their behaviours. They commented, "There is one particular [person] who regularly antagonises the other [people]. The staff are sometimes slow to anticipate an altercation and tend to let it happen and then deal with the consequences after everyone is upset. I would suggest knowing this individual they would keep monitoring [their] behaviour in anticipation of any aggression."

Training records indicated that all staff had completed training in management of actual or potential

aggression (MAPA). However discussions with staff indicated that this had not been effective or sufficient to support them to deal with the behaviours of some people who had previously used the service. The operations manager acknowledged that staff had lost confidence in this area and there were plans for a further two day MAPA training course for staff.

The service had training records which set out the mandatory and optional training that staff completed. Staff had completed computer-based training in essential subjects such as first aid, nutrition, safeguarding adults and infection control. Most staff members (85%) had also completed face to face training in moving and assisting. New members of staff had to commence the Care Certificate training and could not undertake any task until they had finished the appropriate module. At the time of this inspection the provider had arranged for all staff to receive updated classroom-based training in the next month which would include personalised records, supporting lives ethos, values and attitudes and the Mental Capacity Act.

There were records of individual staff supervisions in April and May 2015 but no records of any recent supervisions. The supervision notes lacked detail and recorded only basic questions such as 'have you got any issues with the rota, staff or tenants?'. In discussions support staff confirmed that there had been few opportunities for formal supervision sessions with a senior member of staff. One staff commented, "I didn't get regular supervision sessions over the past year, but was told I could ask for one if I wanted." This was contrary to the organisation's own supervision procedures. The provider had now included future staff supervision arrangements as an action on its improvement plan, which stated, 'A formal process for informing staff of forthcoming supervision sessions to be implemented in addition to effective monitoring of content of discussion and agreed actions'. Staff told us they now felt "things are getting back on track". One staff member told us, "I feel more supported in the last two weeks than I have for the last year."

People who were able to express a view told us they were satisfied with the support they received with meals. People in one shared house told us the arrangements for grocery shopping had improved recently. One person told us, "We now go out a couple of times a week with staff for the shopping. We all put our money in together and choose what we're going to get." In one shared house people used a picture menu book to decide together what they would have for their meals the following week, and used this for their shopping list.

In the shared houses people could either dine in their own rooms or in the communal dining rooms if they wanted. There were communal kitchens for people to make their own drinks and snacks, with staff guidance where necessary. People had a choice of what they wanted. In one shared house most people tended to decide on a meal choice each day then everyone dined together in the communal dining room. Staff sat and ate at the table with people after everyone had been attended to. People who needed support to eat were given this straight away.

Staff knew people's likes and dislikes well. Some people had special dietary needs such as gluten-free. The long-term staff we spoke with were knowledgeable about those needs. For some people there were specific guidelines about how to support them with their nutrition and hydration needs. For example, one person's support plans advised they needed thickened drinks and 'fork mashable foods but not mixed together'. For other people the dietary support plans were not always sufficiently detailed. For example, one person had a fibre intolerance. The support plan about this did not set out guidance for staff about what the symptoms would be if the person was to have fibre, and there had been no review of this plan. The provider and placing local authorities were reviewing each person's needs and all their support plans.

People were supported where necessary to access community health service such as GPs and dentists. It was clear from discussions with health and social care professionals that people had been supported to

access specialist health care services where appropriate. For example some people had input from speech and language therapists and occupational therapists (OT). A visiting OT commented that staff were well informed about the person's needs and shared verbal and written information with them in order to analyse what was needed to support the person.

However the records of people's health care needs were not fully complete, and some recent guidance provided by healthcare professionals was not always present in people's files. The provider was liaising with health and social care professionals to ensure further copies of such guidance was obtained for people's files.
Staff did not have a sound understanding of the Mental Capacity Act 2005 (MCA). MCA is a law that protects and supports people who do not have the ability to make decisions for themselves and to ensure that decisions are made in their 'best interests'. Staff told us that some people did not have capacity to make some of their own decisions, for example in relation to finances. However there were no mental capacity assessments in place for those people about how this had been decided and no clear records about what arrangements were in place to support them other than a reference to an 'appointee'. Some people deemed by staff as lacking capacity were expected to make complex decisions about their lives such as managing their finances.

Records about people's consent to care were variable. For example, there were medicines consent forms for some people which had been signed by them to say they agreed with staff managing their medicines. For other people there were no medicine consent forms even though staff supported those people with their medicines. As a result there was no evidence that some people had been consulted or agreed with the way their medicines would be managed.

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This was a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Following the inspection the provider had begun to work with local authorities to re-assess the needs of people using the service including, where appropriate, an assessment of their mental capacity to manage finances. Where necessary safeguards were being arranged for people whose finances were to be supported by the Court of Protection.

Some people had behaviours that could challenge the service and other people. Their support plans indicated that staff should use 'talk-down techniques' and several daily records reported that staff used 'talk-down techniques' when people were agitated. However there was no indication of what this meant, nor any personalised ways of supporting people with their behaviours.

One relative felt that the staff were not effective in supporting people to manage their behaviours. They commented, "There is one particular [person] who regularly antagonises the other [people]. The staff are sometimes slow to anticipate an altercation and tend to let it happen and then deal with the consequences after everyone is upset. I would suggest knowing this individual they would keep monitoring [their] behaviour in anticipation of any aggression."

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aggression (MAPA). However discussions with staff indicated that this had not been effective or sufficient to support them to deal with the behaviours of some people who had previously used the service. The operations manager acknowledged that staff had lost confidence in this area and there were plans for a further two day MAPA training course for staff.

The service had training records which set out the mandatory and optional training that staff completed. Staff had completed computer-based training in essential subjects such as first aid, nutrition, safeguarding adults and infection control. Most staff members (85%) had also completed face to face training in moving and assisting. New members of staff had to commence the Care Certificate training and could not undertake any task until they had finished the appropriate module. At the time of this inspection the provider had arranged for all staff to receive updated classroom-based training in the next month which would include personalised records, supporting lives ethos, values and attitudes and the Mental Capacity Act.

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Staff knew people's likes and dislikes well. Some people had special dietary needs such as gluten-free. The long-term staff we spoke with were knowledgeable about those needs. For some people there were specific guidelines about how to support them with their nutrition and hydration needs. For example, one person's support plans advised they needed thickened drinks and 'fork mashable foods but not mixed together'. For other people the dietary support plans were not always sufficiently detailed. For example, one person had a fibre intolerance. The support plan about this did not set out guidance for staff about what the symptoms would be if the person was to have fibre, and there had been no review of this plan. The provider and placing local authorities were reviewing each person's needs and all their support plans.

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access specialist health care services where appropriate. For example some people had input from speech and language therapists and occupational therapists (OT). A visiting OT commented that staff were well informed about the person's needs and shared verbal and written information with them in order to analyse what was needed to support the person.

However the records of people's health care needs were not fully complete, and some recent guidance provided by healthcare professionals was not always present in people's files. The provider was liaising with health and social care professionals to ensure further copies of such guidance was obtained for people's files.

Good

Is the service caring?

Our findings

People who used this service were tenants of shared or individual houses. They received support from the agency with personal care, medicines, cooking, shopping, activities and other day to day tasks. One person who used the service told us, "It's great here. It's my house and I love it. I can go to the corner shop on my own and get the bus into town, it's great."

There were some good interactions between staff and people who used the service. People told us they "liked" the support staff. Staff were caring and knew people well. One staff member commented, "We have lovely tenants." A relative told us, "Sometimes [my family member] needs some additional emotional support and when he verbalises this, the staff are always there for him."

Staff were clear about respecting people and promoting their right to privacy and dignity. They were able to give examples of this, for example by knocking on people's doors before entering, speaking to people how they would like to be addressed, taking time with people and supporting them in an unhurried way. During the visit we saw one person who used the service enter another person's apartment without knocking. Staff spoke to them discreetly to remind them to respect other people's privacy.

The organisation had written protocols for staff about treating people with respect and dignity called 'Having the right approach'. This included acceptable and expected practices for staff such as 'consult with service users, regardless of their abilities/inabilities, and use every opportunity to get them involved in any decision making processes which affect them'.

Staff referred to people as 'tenants' to indicate that people were living an independent lifestyle. Some people went out independently in the local community and one person had a voluntary work placement. A relative commented, "My [family member] likes his independence, so that has been catered for." One person described how they had a key to their own room but did not have a key to their own front door even though they had asked for one. We told the service manager about this so it could be addressed.

During the inspection we spoke with four visiting health and care professionals. One professional described how the person had been well-informed by support staff about the visit before she arrived. They commented that staff were informative and friendly. They said that staff offered to stay with the person while they visited them. The person had chosen for the staff member to stay and the healthcare professional was very clear that this had been the person's own choice.

A relative commented, "Whenever I have visited, [people] always seem well-supported by the staff on duty."

People who were able to express a view told us they made their own decisions. Staff were aware of people's rights to make their own choices. Staff were also aware of people's rights to have an advocate and they were able to describe the advocacy arrangement for one person who had used this support. There were details of the advocacy services in the agency main office.

Staff had a good understanding of people's individual needs and gave us examples of how they supported each person according to their abilities and needs. Staff felt that the service was really improving in the past few weeks and commented, "It's really nice to work here now."

Requires Improvement

Is the service responsive?

Our findings

We looked at the support plans for 11 people to see how their individual needs and abilities were supported. The quality of people's support plans was variable. Some people's support guidelines were not written in a personalised way. Several people's documents were not signed or dated. It was difficult to ascertain when reviews took place, if at all. There was no evidence that one person's support plans had been reviewed since they were put into place in 2012 and another person's support plans were dated April 2013. As a result it was unclear whether the plans were still effective or appropriate.

The support files of two people had been recently updated and included guidance for staff about how to assist them with their individual needs. In these cases the two people had signed their support plans to show they had been included and agreed with them. However for the other nine people there was no evidence they had been included in their own support planning. Their support plans all included a generic statement at the top of the plan which stated 'I went through the guidelines with my support team and agreed to the contents adding any I felt needed to be added and omitting anything I didn't agree with'. Those support plans were not individualised and were not signed by people. There was no reference to how people had been involved and what communication methods had supported their understanding of their own support plans.

Some people's support plans were contradictory. For example one person's financial support plans stated that they understood the value of money whilst another support plan about safeguarding stated that the same person did not understand money.

Some people's significant needs had not been recorded within a support plans. For example one person had behaviours that could challenge the service, but there was no record of how they should be supported to help them manage their behaviours. For another person with epilepsy there was no support plans about the protocols to follow in the event of a seizure.

The support staff we spoke with agreed that support plan records were incomplete. One staff member told us, "We used to have care plans with everything in them but in August we were told they had to go to head office and when they came back they had no information in them."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

People who were able to express a view told us they felt staff understood their needs and provided the right support for them. One person told us, "Staff are nice and we're getting more help with things."

In discussion long-standing support workers were very knowledgeable about each person's preferences and skills, as well as their support needs. Staff were able to describe the things that were important to each person and how they supported them to achieve those things.

People were supported to access the local community for shopping and social activities, such as walks, going to a local pub or trips out. Some people had planned day time placements at day centres; other people were independently able to spend their day as they wished.
In discussion people said if they had a complaint they would "probably tell a member of staff" or "tell the manager", but had no knowledge of what would happen after that. There was a copy of the provider's complaints policy in the agency office which was dated March 2014. However there was no information in the shared houses for people about making a complaint. There were no information leaflets in writing or in other formats for people about how to complain and what they could expect if they did raise a concern.

The agency also had a 'help card' system which contained the phone number for the provider's whistleblowing hotline. However some of the people who used the service would not be able to use this. There had been no 'house' meetings for several months so people's comments and views had not been sought and they had not been reminded of their rights to make a complaint. The operations manager acknowledged this and stated she would send the complaints policy out again and would discuss it in staff and 'house' meetings.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection there was not a registered manager at the agency. The previous registered manager had left in September 2015. A service manager and team leaders were covering the management of the agency until a new manager was appointed.
The provider had systems in place to assess and monitor the quality of services provided but these had not been effective, and had not been undertaken on a regular basis. We saw a copy of a 'quality audit' report of the agency that had been carried out in February 2015 by the organisation's quality compliance manager. The audit score achieved by the agency was 39.6% and the audit report included 201 areas of shortfall identified by the quality compliance manager. Actions were recorded as completed on or by 27 February 2015 by the former registered manager. However there was no evidence that the provider had checked that the actions had been completed or whether the actions reportedly taken had effectively resolved the 201 shortfalls found.
Some of the shortfalls recorded in the audit of February 2015 were still outstanding at the inspection carried out in November 2015. For example, one shortfall identified in the audit of February 2015 included lack of mental capacity assessments for people who were deemed to be unable to make some informed decisions (for example about finances). During this inspection there was no evidence of mental capacity assessments or best interest meetings in respect of people who used the service. This meant there had been no monitoring by the provider to ensure that improvements had been made to the safety and quality of the service for the people who used it.

In July 2015 the agency had carried out a self-audit relating to each of the shared houses and the registered office. The outcomes were based on the CQC domains of Safe, Effective, Caring, Responsive and Well-Led. All the outcomes were scored highly (between 76 to 100%) but this self-audit contained no meaningful information and did not match with what we found during this inspection.

The provider's own quality procedures stated the organisation would "regularly review" the support, care and/or treatment plans and analyse the success or failure of these plans. This had not been carried out and some support plans were dated 2012 and 2013 without any indication of a review. The procedures also stated a monthly service review would be carried out to check whether the service was being provided in accordance with stated requirements. There was no evidence of monthly reviews of the service.

Senior managers told us that each location was expected to provide a weekly report of accidents and incidents and a monthly report of medicines records, finance records and each person's daily reports. This was to enable senior managers to analyse the reports for issues or concerns. However they acknowledged that reporting before October 2015 was sporadic, and accident and incident forms had not always contained details of any actions or decisions taken by management. Senior managers were now guiding support staff to complete records about each reportable incident. We saw that although incidents were now being recorded these were not being completed correctly with gaps in the documents. Some accidents reports did not show what action was taken. For example, one person had fallen and sustained a cut to their head. There was no record of any first aid provided or how the accident had been managed. Incidents reports were also incomplete and did not show actions taken. As a result it was unclear how these reports

could be audited in any meaningful way to identify any emerging trends.

Audits were now being carried out of staff recruitment files and a list of the missing documentation was attached to those files that had been checked. These audits were not yet complete at the time of this inspection and we identified several gaps in recruitment records.

We saw one 'tenants' meeting' had been held in November 2015 at one shared house, and there were plans to re-introduce these at another shared house. Prior to this there was no evidence that people's views had been sought about the service they received. The organisation's own procedures stated it would conduct "an annual service review that allows service users and their family, friends, advocates and other agencies to have their say". However there was no record of the last time people had been asked for the views and no analysis of their responses. We saw one annual service review record had been completed but it was not dated and staff could not remember when it was done.

Staff meetings had been held at one shared house in October 2015. Staff stated that prior to this they felt their views, suggestions and concerns were not listened to or acted upon. One staff member said, "I don't remember us having any other staff meetings this year." Another staff member commented that, until recently, "There were no monitoring visits that I know of by an operations manager – I never met them." In this way staff had not been included in providing feedback about the service and the provider had not continually reviewed or improved the service for the people who used it.

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

Senior managers had designed a comprehensive action plan to address the many shortfalls found from their own investigations and concerns raised by the commissioning authorities. It was clear from the actions already taken that the provider had acted quickly to address the immediate safety concerns. Further improvements were planned to resolve all other, longer-term issues. The provider was working with the local authorities and CQC to ensure the welfare of people using the service. The provider was committed to implementing improvements and to continually monitoring these to ensure that progress was both effective and appropriate.

The provider had a clear whistleblowing policy. The organisation operated a confidential whistleblowing hotline which was available to employees, people, relatives and visitors. There were posters entitled 'see something, say something' in areas used by staff with a flowchart for potential alerters, which was a good prompt for staff. Information about staff responsibilities and right in respect of whistleblowing were also outlined in the staff handbook.

People in one shared house told us the service had improved and was a "much nicer" place to be in the last few weeks. They told us that their accommodation was being redecorated and there were more staff to support them so there were more outings. Staff also told us they had seen a number of improvements to the service in the last few weeks. Staff members told us, "There was no communication between manager and staff before" and "I feel happy to come to work now. Things are much better even after only a few weeks".

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 People were not protected from the risks of unsafe or inappropriate care because care records were not always accurate or complete to ensure their needs were met. Regulation 9 (3)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff were not always acting in accordance with the Mental Capacity Act 2005 and were unclear about people's capacity to consent to care. Regulation 11(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks because the provider had not assessed or acted upon risks to the health and safety of people receiving care. People were not always protected from unsafe medicines management because there was not always guidance about their medication needs. Regulation 12(2)(a)(g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust recruitment and selection processes had not always been used to ensure that suitable staff were employed. Regulation 19 (3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not follow safeguarding procedures by reporting or investigating allegations of abuse so people were not protected from avoidable harm. Regulation 13(2)(3)

The enforcement action we took:

We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to regularly assess and monitor the quality of services provided were not effective, and were not undertaken on a regular basis. They did not effectively assess and monitor quality, nor did they identify, assess and manage risks relating to the health, welfare and safety of users. Regulation 17(2)(a)(b)

The enforcement action we took:

We are taking enforcement action and will publish this when the inspection process is complete.