Turning Point

Turning Point - Derby

Inspection report

Suite 2.1, Southgate Business Centre
Normanton Road
Derby
Derbyshire
DE23 6UQ

Tel: 01332394483
Website: www.turning-point.co.uk

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14 April 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Turning Point – Derby supports adults to live as independently as possible who have a learning disability and/or autistic spectrum disorder and whose behaviour may challenge. At the time of our inspection, 11 people were receiving personal care and lived in their own properties or supported living accommodation.

People's experience of using this service and what we found
People were not always protected from harm, incidents and risks were not effectively reviewed to ensure that safe care could be provided in future.

At our last inspection staff had not received training, at our recent visit this had improved. Risk assessments and care plans had not always been effectively reviewed to ensure staff guidance was in place.

People in the main received their medicines safely. We identified that some improvements were needed to the written medicine guidance in place for staff.

There were sufficient staff employed and safe recruitment checks were completed, before staff commenced their employment at the service

Infection prevention and control best practice guidance had been implemented by the provider, including COVID-19 training being made available for staff.

The previous inspection identified concerns with the oversight of the service. This poor oversight had resulted in care not being provided in line with current standards. This inspection identified that required improvements had not been made. This was due to ineffective oversight at the service.

Rating at last inspection
The last rating for this service was requires improvement (published 23 October 2020).

Why we inspected
We inspected this service on 23 and 24 September 2020, we found breaches of regulation 12, 13 and 17. This resulted in a warning notice for the service. We returned to the service to follow up the breaches of regulation and see if sufficient improvement had been made.

We undertook a focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has

changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Turning Point- Derby on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified an ongoing breach in relation to governance at the service. Full information about CQC's regulatory response to the more serious concerns found during inspections, is added to reports after any representations and appeals have been concluded.

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 always safe. Details are in our safe findings below	**Requires Improvement** 
Is the service well-led? The service was not well-led. Details are in our well-led findings below	**Inadequate** 

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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
The inspection was undertaken by one inspector and an assistant inspector

Service and service type
This service provides care and support to people living in six 'supported living' settings, 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection, this registered manager had been away from the service for over a month.

Notice of inspection
This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the action plan provided by the service. We sought feedback from stakeholders who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
On 12 April 2021 we requested staff phone numbers were emailed to us. We then phoned six care staff to discuss their experiences of working for Turning Point- Derby.

On 13 April, we went to the Turning Point- Derby office. We spoke with the locality area manager and administrative assistant. We reviewed a range of records. This reviewed the relevant part of six people's care records. We looked at two staff files in relation to recruitment. We saw a variety of records relating to the management of the service, including policies and procedures, audits and staff training.

On 14 April we phoned two relatives for their feedback about the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess and support the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- At the last inspection, people's personal emergency evacuation plans (PEEPs) lacked guidance of individual support needs. At this inspection we found PEEPS were still not sufficiently detailed to provide a safe evacuation. PEEPS did not guide staff on how to manage people's specific behaviours in the event of an emergency. We also found PEEPS in people's care plans were different to the fire log-book folder. This puts people at risk of harm in the event of an emergency.
- Risk assessments and care plans were not always in place for people's specific care needs. For example, oral health care plans were not in place for people with swallowing difficulties (dysphagia) or people not tolerant of mouth care. This put people at risk of not having their oral health needs met.
- Dysphagia guidance did not reflect current recommendations from speech and language therapists. The service did not use consistent terminology when referring to modified diets. This put people at risk of receiving food that did not meet their dysphagia needs and increased the risk of choking.
- Positive behaviour support (PBS) plans were in place but did not provide adequate information to ensure people's safety. We identified PBS plans that did not highlight triggers for people and failed to identify any risks from other people using the service. This placed people at risk of harm.

Systems and processes to safeguard people from the risk of abuse
- Appropriate action was not always taken following incidents to prevent them happening again. For example, documentation suggested one person had skin damage. Professional advice had been sought, but not followed. This incident was reported to the local safeguarding team by the inspector, as an allegation of neglect.
- Care plans to keep people safe from potential abuse were not person centred. We found two people to have identical safeguarding care plans. This meant specific risks to people were not always directly addressed, putting people at risk of harm.
- At the last inspection, staff did not always record incidents. At this inspection we found staff knew how to report concerns. We found evidence that incidents were now recorded and matched with records such as daily notes and body maps.

Learning lessons when things go wrong

● At the last inspection staff did not clearly record incidents that occurred at the service. At this inspection incidents were now better recorded, however analysis of incidents and action taken following incidents remained poor. This impacted their ability to mitigate risk

● Relatives we spoke with were kept informed about any incidents and were satisfied about how they were handled.

Using medicines safely

● One person received complex medicine which required daily professional communication to administer. There was a lack of risk assessment and guidance for staff to follow. While staff were providing this medicine as prescribed, the lack of guidance risked unsafe care. We have been informed that since the inspection, this person is no longer receiving this medicine.

● There was a lack of guidance in place for topical medicines. There were no records of how much topical medication is used and where it was applied on people. This put people at risk of not receiving topical medication correctly.

● At the last inspection the service had not discussed giving people their medication covertly with the pharmacy. At this inspection we found covert medication was now discussed with the pharmacy. Further work was needed to ensure this was reflected in their medication policy. We have since been informed that this policy has been updated to ensure good practice in the future.

● People in the main received their prescribed medications safely. Robust medication stock checks were in place which did not raise any issues.

Staffing and recruitment

● Recruitment processes were robust. We found suitable staff were safely employed at the service.

● There were enough staff to support people to meet their care needs.

● Staff had completed training in relation to specific care needs of the people they support such as diabetes awareness and Pica disorder. Staff were positive about the training provided.

How well are people protected by the prevention and control of infection

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for staff.

● We were assured that the provider was promoting hygiene practices at people's homes

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to have effective oversight of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice which stated improvements in governance needed to be achieved by a set date. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. The warning notice had not been fully complied with.

- The last inspection found care plans did not always provide clear guidance for staff to follow. At this inspection, we found that some care plans remained poor quality. Where care plans had been reviewed by the senior team, the errors had not been identified and resolved. There had been a failure to respond to our concerns and improve care plans.
- The last inspection identified that incidents were not clearly recorded by staff. At this inspection, we identified that incidents were now recorded but poor governance meant that effective action was not taken to prevent reoccurrence.
- Personal evacuation plans did not detail people's needs. This is an ongoing concern from the last inspection, poor oversight had not addressed this risk
- There was no choking policy in place at the service. Care plans showed that specialist advice for this was not accurately recorded for staff to follow. This put people at risk of receiving the wrong nutrition support. For example, the care plan guided staff to provide a blended diet, which was more restrictive than the soft diet the specialist had advised. All service user's at Turning Point- Derby had some level of swallowing needs. The failure to have a policy for this, and provide clear guidance put people at risk of poor-quality care and potentially at risk of choking.
- Audits for the provider had not identified the risk that people's oral health care needs may not be effectively met. There were no oral health care plans, and staff did not routinely record when oral health was supported.

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 provider has a legal duty to notify us of events that occur at the service. We had been notified of

events. An incident had repeatedly occurred, and the provider had notified us that the care plan had been updated. We reviewed this care plan and found the review had been ineffective and poor staff guidance was still in place. This risked the incident reoccurring because staff still had unclear guidance.
● Where incidents had occurred at the service, records showed us that the provider had informed people's relatives. Relatives told us that their communication with the service was good.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had regular team meetings. Most staff told us that the communication with management was positive.
● Staff engaged with an annual anonymous survey sent out by the provider. This had just started at the time of our inspection, so the results had not been collated for us to review.
● Relatives were consulted for feedback. We saw that relative feedback was mostly positive – this reflected the verbal feedback we gathered during the inspection phone calls.

Continuous learning and improving care
● Care staff were keen to improve the quality of care provided. They spoke of previous inspection findings and what they had changed. For example, they were now recording incidents in a more thorough way.
● While the staff team were keen to provide good quality care, the management had not always effectively audited records to ensure other improvements were made. For example, at the last inspection we identified that thickener was left accessible. Thickener is used to alter the consistency of drinks to allow a person to swallow more easily. It can be a choking risk and should be locked away. While staff now locked thickener away, we identified that other choking risks had not been reviewed effectively at the service.

Working in partnership with others
● At the last inspection, we identified that injuries sustained by people had not always been referred for medical advice. At this inspection, we found that professional reviews were now occurring. However, further work was needed to ensure that the professional advice was followed and clearly recorded

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 had failed to robustly assess and support the risks relating to the health safety and welfare of people. This put people at risk of harm

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 17 HSCA RA Regulations 2014 Good governance There was insufficient governance to make required improvements to the service. This put people at risk of poor quality care

The enforcement action we took:

We have identified an ongoing breach in relation to governance at the service. Full information about CQC's regulatory response to the more serious concerns found during inspections, is added to reports after any representations and appeals have been concluded