Turning Point

Turning Point - Wiltshire

Inspection report

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Ratings

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

Overall summary

Turning Point Wiltshire is registered to provide personal care. The service provides 24 hour support to adults with learning disabilities and complex needs. The service operates from office premises in Salisbury.

This announced inspection took place on 25 and 27 August 2015 and 1 September 2015.

People were placed at risk from unsafe care and treatment because risks were not reduced. Risk assessments were not reviewed following incidents and accidents to ensure that action plans were in place to lower the risk to people. Some people were at risk from poor moving and handling techniques. For example, one person was moved out of the bath by three staff following a seizure when this person was not able to bear their own weight.

People were placed at risk from unsafe medicine systems. Some repeat prescriptions were not requested in a timely manner and some people were not having their medicines at the prescribed times. Arrangements were not in place for staff to administer medicines at locations where lone working staff were not competent to

Summary of findings

administer medicines unsupervised. Staff were not signing medicine administration records (MAR) charts or food and fluid monitoring charts when prescribed thickeners were used in fluids.

The members of staff and relatives we spoke with raised concerns about the changes in staffing. Relatives were concerned the staff changes were having significant impact on their family members as changes in behaviours may not be recognised or activities that mattered to people were discontinued. Healthcare professional raised concerns about the lack of routine and changes in staff which meant appropriate guidance was not always followed on how to support people. For example, supporting people with eating and drinking.

Some people were placed at risk from the processes followed by staff when people's capacity to make decisions was assessed. Some people were assessed as lacking capacity although they had fluctuating capacity to make decisions. Best interest decisions did not accompany mental capacity assessments.

People benefit from ongoing healthcare. People told us they were accompanied by the staff on healthcare appointments. Health action plans and hospital passports were developed to ensure important information was available to medical staff in the event of an admission. One epilepsy profile, we looked at, was not reviewed following epilepsy seizures and healthcare professional's advice was not sought following an episode. This meant people may not be receiving the most appropriate care and treatment needed when they experienced an epilepsy seizure.

Members of staff attended training but one to one meetings were not always regular. This meant staff did not benefit from meetings with their line manager where they discussed training needs, concerns and their performance.

People were not supported with their preferences and the staff were not always respectful of people's rights. For example, one person had to drink only decaffeinated coffee because they became "hyper." We saw at one location only staff were able to lock the bathroom door. At another location we saw listening devices were left on in a communal area where people and visitors in the vicinity could hear.

Information recorded about people's preferences was not always up to date. Support plans were not monitored or reviewed to assess the progress or effectiveness. Some staff said they read the most appropriate section of the support plans. They said when they arrived on duty they had "handovers" during which they were told about people's daily health and wellbeing. On the first day of our inspection visit the registered manager said that we were "currently updating support plans, and that training on support plans had been completed by all staff."

The culture of the service was described by a visiting professional as 'transient' [lasting a short time] as staff were constantly changing. Staff said the culture was improving but more improvements were needed to enable them to have trust in the organisation. Members of staff said the morale was low as they were often moved to different locations and people were not receiving consistent care by staff who knew them. They said there was a lack of leadership as team leaders were not designated to all locations. They said team leaders were shared in some locations. The registered manager said staff were moved to locations were their strengths were needed and their preference of location was considered.

Staff helped people to understand the options available for example by using pictures and easy read formats. Day to day care was delivered with compassion. People were supported to maintain links with friends and relatives. Relatives said the staff were caring and their family members liked the staff. People had access to voluntary organisations to help them with the bereavements process and advocacy support.

People experienced a variety of activities mainly provided by their day care service. People knew who to approach with their concerns. Relatives said they felt confident to complain and their concerns were investigated. People were given easy read information on how to raise complaints.

People said they felt safe with the staff. Relatives said the staff reported allegations of abuse and statutory organisations had investigated the allegations. Members of staff knew the signs of abuse and the procedure for reporting abuse.

People's views about the service were gathered through house meetings and surveys. Relatives said their views

Summary of findings

were gathered through forums and surveys. The agency received 10 surveys responses from people and their relatives. We saw from the responses that people were happy with the support they received from the staff.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not managed appropriately. People were placed at risk from unsafe moving and handling techniques. Risk assessments were not reviewed following an incident or accident.

People were not protected from unsafe medicine systems. Repeat prescriptions were not ordered in a timely manner for people to have their medicines at the prescribed times. Staff were not signing the medicine administration records or food and fluid charts when they administered medicines such as thickeners in fluids.

People were not receiving consistent care and treatment. Staff told us there were staff changes. Relatives and healthcare professionals raised concerns about the changes of staff and the impact this had on people.

People felt safe living in the home and staff knew the procedures they must follow if there were any allegations of abuse.

Staff said where risks were identified risk assessments were developed.

Is the service effective?

Requires improvement

The service was not effective.

People were able to make day to day decisions and about their meals and activities. Mental Capacity Act (MCA) assessments were completed for people with cognitive impairments. However people were placed at risk of harm when staff were assessing their capacity to make decisions. For example road safety. Where people lacked capacity MCA assessments in place for specific decisions were not accompanied by best interest decisions.

Members of staff did not benefit from regular one to one meetings with their line manager. They were not given the opportunity to discuss their performance, concerns and training needs.

People received ongoing healthcare support. Health action plans and hospital passports were devised to ensure medical staff had important information about the person in the event of an admission to hospital.

Is the service caring?

Requires improvement

The service was not caring.

People were not always respected as adults. Members of staff did not always use an appropriate manner to address people or to describe the support to be provided. Their dignity and privacy was not always respected.

Summary of findings

People going through bereavements were cared for with compassion and support from voluntary organisations was sought. Where people needed support with communication independent advocacy was provided.

Staff used a calm approach and used distraction techniques to support situations when people were feeling frustrated.

Is the service responsive?

Requires improvement

The service was not responsive.

People may not have been receiving care and treatment which met their current needs. Support plans were not evaluated or monitored to assess their effectiveness.

People experienced a variety of activities provided mainly by the day support services.

People were provided with easy read copies of the complaints procedures. Relatives said their complaints were investigated and action was taken to resolve their concerns.

Is the service well-led?

Requires improvement

The service was not well led.

There had been a period of instability with changes of managers. The staff did not feel well supported by the registered provider. They said morale was low and the culture needed improving before the staff could trust the organisation.

Relatives and healthcare professionals expressed concerns about the changes in staffing. The registered manager told us of the improvements to be made but these needed to be embedded into practice.

The views of people about the quality of care were gathered through individual and group meetings and by surveys.

Turning Point - Wiltshire

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 25 and 27 August 2015 and 1 September 2015. We gave the registered manager 48 hours notice of the inspection because we needed to be sure that the registered manager would available during the inspection.

The inspection was completed by two inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all of the information we hoeld about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with three people who used the service, eight relatives, nine staff including an agency worker, the registered manager and the head of operations. We spent time observing the way staff interacted with people who use the service. We looked at the records relating to support and decision making for five people and the management of the service. Following the inspection we spoke with staff from the community learning disabilities team and social workers.

Inadequate

Is the service safe?

Our findings

Risks were not managed appropriately. A member of staff said risk assessments needed to be more detailed and specific. We saw from the records that guidance given in the risk assessments was not always followed. The risks assessments were not reviewed to ensure people's safety. For example, the guidance for one person at risk of malnutrition was to have their weight monitored monthly and for staff to monitor their food and fluid intake. However, the person's weight was not monitored monthly. We saw from 13 January 2015 to 25 August 2015 the person weight was recorded four times. A member of staff said when they went to weigh this person they were told the (weighing) chair was broken but when they tested the battery, it needed charging and the scales had not been working from August 2015. Food and fluid intake monitoring charts were not completed according to guidance and where people refused meals and fluid, the action taken by staff to encourage food and fluid intake was not recorded. This meant staff may not have been able to identify the signs of deterioration in people's health.

Staff said where risks were identified they assessed the risk and developed action plans to reduce the risk to people or to enable the person to take risk safely. Risk assessments were developed for people at risk of choking, for the potential of people developing malnutrition and for people with mobility needs. Staff said specialists such as Speech and Language Therapist (SALT), Occupational Therapists (OT) and specialist nurses provided guidance on how to reduce the risk. However, risks were not managed appropriately in line with the guidance.

Some people were placed at risk from unsafe moving and handling procedures. An incident report dated 9 July 2015 showed three staff moved a person from the bath when they were recovering from a seizure and were not able to support their weight. We noted the person had two seizures but the risk assessment was not reviewed to ensure the actions remained appropriate. The registered manager said the incident was incorrectly recorded by the staff and the person was able to hold their weight. We consulted healthcare professional about managing incidents when people experienced seizures in the bath. This professional said the person was placed at risk as the staff may have dropped the person when they were moved from the bath and not able to hold their weight. This meant some staff were not able to follow plans of actions on how to lower the risk to people.

This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A record of accidents and incidents was maintained. A member of staff said there was a culture of learning from events. An incident reporting management system was used by staff to record the nature of incidents and accidents. For example, medicine errors, accidents and aggressive incidents. The action taken along with the level of risk was included in the system. The agency manager said it was the responsibility of the location manager to assess the incident and identify patterns and trends.

Medicines systems were unsafe and placed people at risk. People told us the staff administered their medicines. A relative told us the staff had missed his relative's medication on two occasions, in March and June this year. They said the staff had taken appropriate action by seeking guidance from the GP when the errors were identified.

Some people were not having their medicines regularly because adequate stocks of medicines were not ordered. We saw recorded in the communication book where one person was not having their medicines regularly because repeat prescriptions were not requested in a timely manner. The head of operations told us staff acted promptly and had requested replacement medicines from the pharmacist. We saw there were gaps between the person receiving the replacement medicines and the person having the medicine at the prescribed times. This medicine was prescribed to relieve symptoms associated with inflammation, ulcers and sores in the bowel causing bleeding, stomach pain, and diarrhoea.

The medicine administration records (MAR) charts or food and fluid intake chart for one person at risk of choking had not been signed by staff on each occasion when prescribed thickeners were used in fluids. A member of staff told us when they were lone working it was their responsibility to arrange for staff from other locations to visit and administer medicines at 8am and 8pm. This meant there was a potential for people to not have their medicines

Is the service safe?

administered as prescribed in a timely manner. The team leader agreed to develop a plan of staff who were to visit and administer medicines until the members of staff were competent to administer medicines unsupervised.

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

A member of staff told us medicine errors had occurred but the number of errors had reduced with the introduction of checks. They said staff had attended medicine training and their competency was assessed before they administered medicines unsupervised. Another member of staff said more recently staff were suspended from administering medicines when they made three consecutive errors. These staff had to attend refresher training and their competency was re-assessed before they administered medicines unsupervised.

People were placed at risk from unsafe care because staffing levels did not support people adequately and did not offer continuity of care. A member of staff said activities had been cancelled because there were insufficient staff for people to have adequate support in the community. Another member of staff said currently the staff on annual leave and absent staff were having an impact on the care people received. Three relatives expressed concern about the changes of staff. For example, that the new staff could not recognise the small changes in their family member's behaviour that may indicate something is "not quite right." A relative said "the staff changes had been unsettling for him [family member]. The team leader of the house has changed. There's a new manager. It takes him [family member] a long time to get to know someone, and their name. He's been saying 'that man' instead of being able to name a member of staff.'

Staff told us they were frequently moved between locations. One member of staff said they were moved three times in as many months and another said they were moved five times in 18 months. They said there was no consultation and staff liked to work at the same locations. Another member of staff said "most staff work across services. It doesn't work, there is a lack of continuity and involvement because the hours in services are not the same each week." This meant staff were not having regular contact with people. A visiting healthcare professional said "there is a lack of routine. Changes with the staff were having an impact on the care people were receiving. We spend time with staff on how to support people and on our next visit they have been moved which means there is little opportunity to move things on." The registered manager said the staff were consulted about their move to other locations and the staff's preferences was taken into account. They went on to say staff were moved to locations were their strengths were needed.

This was a breach of Regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A manager of locations said the staffing structure was better but recruitment and retention was a challenge. Staff said there were vacant hours which were covered by bank and agency staff. A member of staff said the same agency staff were used to maintain consistency for people. The head of operations told us the agency needed to cover 149.4 vacant hours across all supported living services. They said "we have active campaigns with our recruitment agent and one new staff member will be starting shortly for 37 hours. It is something we have to work actively on."

Suitable arrangements were in place to ensure people were safeguarded from abuse. People said they felt safe with the staff and when we observed people they were comfortable with the staff. A relative said "I have no instances of concern. The staff haven't upset him [person] and he hasn't said he doesn't like anyone." Another relative said "he's definitely safe. He's always happy. You can tell if he likes someone and the staff are very good." Two other relatives were concerned about the safety of their family members. They said incidents had occurred which the local authority safeguarding lead had investigated. The staff knew the signs of abuse and the actions they had to take to report their suspicions of abuse.

Staff knew it was their duty to report any poor practice they may witness from other staff. They said the whistleblowing procedure was discussed during staff meetings. An internal protocol was developed by the agency manager to encourage staff to report concerns. Another member of staff said they had confidence that their concerns would be taken seriously.

Requires improvement

Is the service effective?

Our findings

Arrangements were in place to assess people's capacity to make decisions. A member of staff said the people using the service lacked capacity to make decisions. Another member of staff told us they assessed people's capacity to make decisions about their personal intimate care, finance, administration of their medicines, community access and continuous supervision. However, MCA assessments were not always completed adequately. For example, best interest processes were not followed for one person assessed as lacking capacity to make decisions about their personal care.

Some people were placed at risk of harm by the process followed to assess people's capacity to make decisions. Staff had not considered a person's level of cognitive impairment and their understanding of road safety before asking them to cross the road. Another person showed a good understanding of maintaining their health and wellbeing needs. As this person was not aware of possible infections should they neglect their nail care or the importance of health appointments, they were assessed as lacking capacity to make decisions about their care. The registered manager said there were issues with the form used to record people's capacity and staff's recording which did not allow for a judgement of fluctuating capacity.

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

Staff said people were enabled to make choices. They said people made decisions. For example, what they wear, daily menus. Staff told us they used the person preferred means of communication to gain their consent. For example, visual choices, pictures and objects of reference. Two people told us they made decisions about refreshments, activities and holiday venues.

A member of staff told us positive behaviour plans were developed with the appropriate professionals. They said the plans were developed in the best interest of people who lacked capacity and for those people whose behaviour challenged others. Another member of staff explained the distraction and techniques used to respond to people who at times used aggression and violence to communicate their frustrations.

Staff transferring locations said they received an induction to the new service. They shadowed existing staff for three days and went through procedures and routines. They said the induction prepared them to work at the location. Two staff at Meadow View said they had recently transferred but knew the people living at the location which "made their role easier." One member of staff said "I know they like me."

A training programme was introduced to develop staff's skills and knowledge to meet people's needs. A manager of locations said the staff were encouraged to attend the training provided. Another manager of a location said where regular agency staff were used they were able to attend specific training to meet people's needs. For example positive behaviour training. Staff told us they had recently attended person centred training to help them develop support plans.

Systems which included appraisal and one to one meetings were in place to support staff with their roles and responsibilities. However, one to one meetings were not taking place regularly for all staff. A location manager said there was an expectation for staff to meet their line manager monthly to discuss issues, performance and training need, however this was not taking place The supervision and appraisal matrix included the names of 44 support workers and 38 staff were currently working for the agency. We saw from the matrix that six staff had met with their line manager once to have a one to one meeting and two had not met with their line manager.

Staff said one to one meetings had a set agenda which included personal development, training needs and performance monitoring. However, some staff said their one to one meetings with their line manager was irregular. Another member of staff said there were annual ongoing personal reviews (OPR). They said at OPR goals and targets were set which were reviewed six monthly.

This meant staff were not benefitting from one to one support from their line manager. The head of operations told us the frequency of one to one meeting with support workers was being addressed with the appropriate line manager.

People benefit from on-going health and social care support. People told us the staff accompanied them on healthcare appointments. Relatives told us their family members healthcare was managed by the staff and they were kept informed of their relative's health. Staff said

Requires improvement

Is the service effective?

people were registered with a local GP and had access to facilities such as chiropody, dentists and opticians. A locations manager said part of the team leader's role was to ensure people had access to healthcare. They developed health action plans and hospital passports which included important information for medical staff in the event of a hospital admission.

Profiles were developed for people who experienced seizures. However, the profile for one person was incomplete. The epilepsy profile did not give staff guidance on the actions they must take should subsequent seizures occur. Staff did not maintain a record of seizures experienced by this person. The accident reports for this person showed they had experienced two seizures in July but the specialist nurse was not contacted to review the epilepsy profile. A healthcare professional explained the expectations was for staff to contact them for advice following seizure episodes. They said the profile was not up to date and required reviewing by the community learning disability team. The registered manager said profiles were reviewed two yearly by the organisations specialist nurse.

Requires improvement

Is the service caring?

Our findings

People were not respected as adults by the staff. Support plans were written in the first person. We also noted the language used did not consider people as adults. For example, a risk assessment was developed for “Causing disruption" for one person who became bored, entered the kitchen and helped themselves to other people’s food. Their personal care plan stated “I like to be given a little cream or body lotion in my hands to "play" with when you are supporting me.” An agency worker inappropriately described one person as "sneaky" because they were using the staff’s coffee instead of their own decaffeinated coffee. They told us the person had to drink decaffeinated coffee because it made the person “hyper.” A relative gave us an example of staff's inappropriate response on the actions staff needed to take to ensure people were appropriately dressed in the community.

People’s rights were not respected by the staff. A member of staff said the induction for new staff covered respecting people’s rights. Staff gave us examples on how people were respected. They said people had access to the community and services and that their bedroom doors were lockable. A member of staff said people were offered choice and staff were able to interpret behaviours and respond appropriately. However, listening devices used to remotely listen to sounds in bedrooms were left on in the lounge. This meant people in the lounge and vicinity were able to hear the activity in specific people’s room. A member of staff said they were used at night and may have been left on in error. At another location only the staff had keys to lock to the bathroom door. This meant people and visitors were not able to lock the bathroom door.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Six relatives told us the staff were caring and their family member was well cared for. One relative told us their family member was supported by the staff during an admission to hospital. Another relative said her family member was supported by the staff on a hospital appointment and the staff had explained what the treatment involved.

Staff said spending one to one time with people ensured relationships were developed. A member of staff told us relationships were built with people by getting to know the person as an individual and by ensuring they knew people’s preferences. However, another member of staff said there were challenges with some staff who were reluctant to change and develop more person centred ways of working. They said there was “resistance to change and reluctant to embrace new working practices". For example, staff were reluctant to help people develop independent living skills by promoting the preparation of group meals.

People’s day to day care was delivered with compassion. A location manager said where people experienced bereavement support from external voluntary organisations was sought to help the person with their loss. A member of staff said an independent advocacy service was used for people who used non-verbal forms of communication

Staff responded to people in a way they were able to understand for example, by the use of photographs and pictures. They said independence was promoted which increased the opportunities people were given. A member of staff said at house meetings people were able to sit and discuss issues about group living.

A member of staff told us people were helped to maintain contact with friends and relatives. We observed staff supporting people to visit family. One person told us the staff helped them to visit family weekly which they enjoyed.

Requires improvement

Is the service responsive?

Our findings

People's background histories, likes and preferences were included in their support plans. However, the information was not always accurate or updated. When we asked a member of staff about one person's habits as recorded in the care plan they told us the information was not accurate.

People were not protected from unsafe care. Support plans for the delivery of care were not monitored and did not reflect people's current needs. A manager of locations said support plans were developed with the person, their family and support workers. They said support plans were active documents which followed a specific format. For example, what I can do for myself, what I need support with and how I would like to be more involved.

Staff told us the support plans were developed by location managers with input from the team leaders of the location. They said there were plans for support workers to have more input into the development of the support plans and they had attended training in person centred care to enable them to do this. The staff we asked told us they did not always read the care plans. One member of staff said they read what was appropriate to the task they were about to perform. Another member of staff said "to read support plans is difficult when people need attention. On the first day of the inspection the manager told us they were currently updating support plans, and that training on support plans has been completed by all staff.

Support plans showed some people had strict regimes imposed for repetitive behaviours. For the section of the support plan titled "How I like you to support me with drinking fluid" staff had recorded "Before I go to fetch a drink in the kitchen. I must go to my chart and see which drink I have put on chart for the morning then take the drink picture off the chart and only then I precede to the cupboard to get my drink. Staff need to stop me if I try and push past them." The language in some support plans had been modified, there were parts crossed out, but no date was recorded of when this modification took place. For example, the communication plan for one person described the actions staff must take for inappropriate behaviour. Staff had modified the language and documented "ask me to go to my room." The date of the change or the name of the staff making the change was not included.

Support plans and risk assessments were not evaluated or monitored to assess their effectiveness. This meant an overview of the progress made on the action plan was not provided. A member of staff said a communication book and checklists kept staff informed of daily events and activities.

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

Opportunities were available for people to experience community activities. Two people told us they attended day care services in the community. We observed staff supporting people to participate in community activities such as horse riding, swimming and sailing. Relatives we asked were able to describe how their family member spent their time. They said there was a range of activities, many of which were delivered through attendance at day services.

People and their relatives were made aware of the complaints procedure. Some relatives said they had made complaints and the service had always responded. A manager of locations said families were provided with copies of the complaints procedure. We saw the agency's easy read complaints procedure was on display in people's homes. A member of staff said complaints were discussed during staff meetings. People's feedback was encouraged and their relatives during family forums. The agency maintained a log of complaints which described the nature of the complaint, the investigation and the actions taken to resolve the complaint.

Requires improvement

Is the service well-led?

Our findings

People were placed at risk from a management team that did not provide stability. A healthcare professional told us the organisation was “creating a transient [lasting a short time] culture as staff are always being moved around.” Staff told us the culture was improving but morale was low with the changes in managers and the constant transferring of staff.

A member of staff said “it’s a developing culture. Changes in senior staff have not been good. Morale is low and staff are moving around a lot.” Another member of staff said the staff above the registered manager “was heavy handed." Staff tend not to approach them. I would go to the manager or HR and then I would leave. The manager does listen but does not reconsider decisions.” A third member of staff said the team was new and communication was an issue as staff were not always kept informed of the changes. The managers of locations said the culture had changed in the last six months. They said there was an open and honest culture there was learning from events, their suggestions were sought and their views were valued. Although morale was improving more improvement was needed for staff to have confidence in the organisation.

There was a lack of leadership in locations. A member of staff said there was a lack of monitoring in locations because a team leader was not designated to every location. They said “ideally every service should have a team leader” working in each location as some locations share a team leader. A member of staff said the manager was new and “things were moving forward.” They said recruitment had been a problem and was a challenge to the manager. However, motivation was difficult when there were shortages of staff. Although morale was improving more improvement was needed for staff to have confidence in the organisation.

Relatives expressed concerns about the lack of communication and the changes of staff. One relative said "my brother is sad when staff leave. Families need to be told about changes. They don’t say why people [staff] are leaving. I don’t know if it’s internal issues, but I’m getting uneasy as a family member because I don’t know why.’ Another relative said "you get settled and then suddenly it all changes round again. I find it a bit frustrating. They sometimes move managers around internally. There are staff shortages and relief staff. It’s not the same with relief staff if they don’t know the people."

A registered manager was in post. The registered manager said there had been a lack of support and there were weakness but practices were changing. They said the focus was to break down poor practice, and improve communication. One to one meetings with the line manager were happening regularly and people are being informed of new legislation. Staff had received online training which was to be supplemented by face to face training. A member of staff said “the changes of managers had created instability and lack of support [to staff]. The last two years have not been good. A regional manager started, they made changes but left soon after.”

People’s views about the service were gathered through house meetings and surveys. Relatives said their views were gathered through forums and surveys. The agency received 10 survey responses from people and their relatives. We saw from the responses that people were happy with the support they received from the staff.

The provider had systems in place to monitor the quality of the service. There were regular audits carried out at locations by local teams. We looked at the audits for three locations which had identified that improvements were needed. Where required actions had been identified an action plan was developed to address the issues. For example updating support plans, ensuring Mental Capacity Act (MCA) 2005 were completed and medicine management. The audit had a traffic light colour coded system to identify when things had been completed (green), partially completed (amber) or needed completing (red).Where concerns arose additional audit visits were conducted. For example, one location had an additional visit to audit medicine systems following repeated medicine errors. We saw records of a recently completed audit by the local authority who fund services for some people and an action plan of improvement needed was devised. The agency manager had produced checklists to better collate information which will sit alongside staff’s one to one meetings. For example end of month reports which cover risk management, support plans and staffing issues.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were placed at risk because action was not taken to mitigate or reduce the risk the risk.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were placed at risk from unsafe care and treatment because regular staff were not used to deliver care and treatment to people with complex care needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from unsafe medicine systems.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The staff lacked an understanding of the principles of the Mental Capacity Act 2005 and the processed followed to assess people's capacity placed them at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

People's rights were not respected. People were not empowered or given the autonomy to live more independent lives.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The progress made on the support plans was not monitored or updated to meet people's changing needs. Information about people's preferences were not always accurate.