Manchester City Council

# MLDP North Network

## Inspection report

Heathfield Resource Centre
Heathfield St, Newton Heath
Manchester
Greater Manchester
M40 1LF

Tel: 01616825463
Website: www.mldp.org.uk

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This was an unannounced inspection which took place on the 22 and 23 March 2016. We had previously inspected this service in July 2014 when we identified four breaches of the regulations we reviewed; these related to assessing and monitoring people's nutritional needs, administration of medicines, acting in accordance with the Mental Capacity Act (2005) (MCA) and having effective quality audit systems in place for the service.

Following the inspection in October 2014 the provider wrote to us to tell us the action they intended to take to ensure they met all the relevant regulations. Part of this inspection was undertaken to check whether the required improvements had been made. We found that people's nutritional needs were assessed and monitored and medicines were safely administered. However we found that the service was not acting in accordance with the MCA and did not have robust quality monitoring systems in place.

MLDP North provides support for 55 people living in their own homes. Some people lived in their own bungalow in a complex of several bungalows together. People received a range of support each day. Other people lived in shared houses with staff support 24 hours per day. Each house or group of bungalows had a designated staff team. The staff teams were managed by a care co-ordinator, who managed two teams. There were seven care co-ordinators in total.

The service had a registered manager in place. 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. The registered manager was not working at the time of our inspection and so the service was being managed by the Nominated Individual (NI). A Nominated Individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity.

People we spoke with, and their relatives, said that they felt safe being supported by MLDP North. Staff told us that they had completed safeguarding training and could describe the action they would take if they witnessed or suspected abuse. We saw that referrals were made to other professionals by the care co-ordinators if relevant when concerns were raised. However these had not been followed up to ensure a prompt response from the other agencies. We were told that a new policy had been introduced to make sure any new referrals were followed up in a timely manner.

We found some risk assessments were in place to identify and mitigate risks people may face. However not all risks had been identified and they were not always up to date. Behavioural support plans were in place for people with complex needs. These gave guidance for staff to manage people's behaviour; however they did not identify what the actual risks were.

We found agency staff were employed on temporary contracts to provide consistent support for people.

However we saw that the number of incident reports increased when agency staff were used. Staff told us that some of the people they supported could not access their usual activities with agency staff due to the risk of an incident occurring when people were supported by unfamiliar staff. We were told agency staff did not always complete the necessary incident forms, meaning that a complete record of the incidents which had occurred was not kept.

We were shown the information provided to two new agency staff to support people with complex needs. The information was not sufficient to enable the agency staff to safely support the people who used the service.

We found a safe system for administering medicines was in place. Staff had received training in the administration of medicines. People we spoke with told us that they received the medicines as prescribed.

A safe system for recruiting staff suitable for working with vulnerable adults was in place.

Staff we spoke with demonstrated a limited understanding of the MCA and how this legislation was relevant to their practice. The registered manager had failed to take the necessary action to ensure the rights of people were upheld when they were unable to consent to their support.
Staff we spoke with said that they had completed training courses but we were unable to check this as training records were incomplete.

We found that people were supported to maintain their health and systems were in place to monitor people's nutritional intake where required.

All the people we spoke with, and their relatives, were complimentary about the regular staff supporting them. We observed positive interactions between staff and people who used the service during our inspection. Staff we spoke with had a good understanding of people's needs.

We saw care plans included people's likes and dislikes and were written in a person centred way. However care plans had not been reviewed and updated and information was not always easily accessible.

We saw a survey was used to ask for relatives views about the service. However we did not see any evidence that these were analysed and actions taken about any points raised.

Staff said they enjoyed working at the service. However we found staff supervisions and team meetings were inconsistent across the different staff teams.

There was not a robust system of quality audits in place. Spot checks were inconsistently completed, incidents were not reviewed, training records were not complete and MCA best interest assessments had not been completed.

During this inspection we found twelve breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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, it 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?

**Requires Improvement**

The service was not always safe.

Not all risks had been assessed. Other assessments had not been reviewed in a timely manner.

Staff had been safely recruited. Staff had received training in how to protect people who used the service from the risk of abuse.

Records of medicine administered were complete and there were clear instructions to guide staff in the safe administration of 'as needed' (PRN) medicine.

### Is the service effective?

**Inadequate**

The service was not always effective

Staff did not clearly understand the principles of the MCA. No records of best interest meetings applications to deprive a person of their liberty were seen.

Agency staff who did not know the people they were supporting were being used. They were not provided with the information they required to support people with complex needs.

Staff told us they had received an induction and training for their role. However training records were unclear and supervisions were not regularly held.

People were supported to meet their health and nutritional needs.

### Is the service caring?

**Requires Improvement**

The service was not always caring

People's support had been changed without them or their families being informed or consulted.

We observed positive interactions between staff and the people who used the service.

People's privacy and dignity was respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care records were written in a person centred way but had not been regularly reviewed and were not up to date. The information was not always easy to access. Guidelines to promote people's independence were not up to date

People with complex care needs could access the community with staff who knew them well. Some more independent people were at risk of social isolation.

A complaints policy was in place and relatives said that staff were approachable.

## Is the service well-led?

**Inadequate**

The service was not well-led.

Quality audit systems were not sufficiently robust.

Staff were inconsistently supported by their line managers.

The service had a registered manager; however they were not in work at the time of our inspection. The service was being managed by the Nominated Individual.

# MLDP North Network

**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 the 22 and 23 March 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors on both days of the inspection. A third adult social care inspector contacted families of people who used the service by telephone on the second day of the inspection.

Before our visit we asked the provider to complete a Provider Inspection Return (PIR) form and this was returned to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service including notifications the provider had made to us. We used this information to inform our inspection.

During our inspection we spoke with six people who used the service and seven relatives. We spoke with 17 members of staff, the Nominated Individual (NI), three care co-ordinators and a registered learning disability nurse. We also visited people in their own homes to carry out further observations and to speak with staff.

We were unable to speak with the registered manager as they were not in work during our inspection. The registered manager from MLDP Central was present on the second day of our inspection as they work with the same policies and procedures as MLDP North.

We looked at the care records, including care plans and risk assessments, of 12 people who used the service and observed how people were being supported and their interactions with staff. We also looked at a range of records relating to how the service was managed, including five staff personnel files, staff training records, quality audits, policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

The people we spoke with told us they felt safe supported by MLDP North staff. One person said, "I feel safe here; I like that the bungalows have a gate and so no one can just come in." Another told us, "Yes I feel safe; this is a good place." However another person said that they did not feel safe at night as the night staff had been replaced by an on call response service. They told us that the care co-ordinator was aware of this and was trying to arrange for the person to move to a property that had staff available at night.

People's relatives we spoke with said they felt that their relatives were safe. One said, "Yes, we have no concerns there" and another told us, "We have a lot of input with the carers, he feels very safe with them."

We looked at the risk assessments in place for 12 people who used the service. We found some risk assessments in place, for example manual handling and choking. However the risk assessments did not cover all the aspects of a person's support. For example one person had a risk assessment in place for a visitor who tried to take advantage of them and for transfers to and from their wheelchair. We did not see any other risk assessments for this person in relation to independent living or achieving goals identified in their care plan. We saw a falls risk assessment for one person dated October 2014. Another person had guidelines for going out on their own dated January 2014. There was no evidence that they had been reviewed.

We found some people had a positive behaviour support plan in place and we looked at seven behaviour support plans. These gave guidelines for staff to manage potential behaviours. However the assessments did not always clearly define what the actual risk was or who it was a risk for. In some instances the risk to staff and the public had been assessed but we did not see supporting evidence to promote the health and well-being of the people being supported through positive risk taking.

Staff members told us that they had received training in physical intervention. This was refreshed annually, however we were told that a recent course had been cancelled and needed to be re-arranged. A relative confirmed that staff did use physical restraint when required. They told us, "Staff will explain to me what had happened and how [Name] was restrained."

We looked at the services' incident reports completed following an occasion of challenging behaviour. We found that the number of these had increased recently. We reviewed nine incident reports covering a six week period from one property and found that eight had occurred when agency staff was on duty. A staff member at another property told us, "We had nine ABC (antecedent, behaviour, consequence) forms from last weekend; all with agency staff." Another staff member said, "We use ABC forms to try to identify the triggers to behaviour. The agency staff don't use the forms which means things are difficult to monitor properly." ABC forms are used to record what was happening before the incident (antecedent), what the behaviour was (behaviour) and what occurred after the incident (consequence). These are particularly important when supporting people who have difficulty communicating in conventional ways. This is because people with complex needs can become frustrated and behave in a way which challenges the service. ABC forms can help identify triggers to a particular behaviour and therefore enable staff to better

understand how to support the people they work with in a positive way.

We asked the care co-ordinators and the MLDP Learning Disability Nurse about the number of incidents being reported. One acknowledged that the number of incidents had increased and there were more incidents when agency staff were working. Another said, "I'm concerned about the risk to people in small shared homes at weekends with staff who are not familiar to them."

We looked at eight 'violent incident reports.' A violent incident is reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) to the Health and Safety Executive and to the Care Quality Commission (CQC). We found that none of the incidents met the threshold of a 'violent incident' under the RIDDOR regulations. However all of the reports were incidents involving unfamiliar staff.

Staff members told us that they had received training in safeguarding vulnerable adults. They were able to explain what action they would take if they witnessed or suspected any abuse. We were told that the care co-ordinators would act on their concerns and make referrals to other agencies such as the social work teams as needed. We saw that safeguarding was an agenda item for formal staff supervisions.

We were aware of a recent safeguarding issue where staff had raised concerns and the care co-ordinator had raised referrals with other professionals and services. However there was not a robust policy of following up the referral to ensure that it was acted upon in a timely manner. The person did not receive prompt support from the other agencies resulting in harm to the person concerned. This meant that the service had not kept the person who used the service safe from harm. A care co-ordinator told us a policy had now been introduced to escalate and follow up all referrals to other agencies if a response was not forthcoming in a timely manner.

We found that not all risks were assessed and managed appropriately and the provider did not take reasonable steps to mitigate risks to people who used the service. We found this to be a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

At our last inspection of this service in July 2014 we found that the Medicine Administration Record (MAR) did not include the time a medicine had been administered. We asked the provider to send an action plan outlining how they would make improvements. At this inspection we found that a safe and effective system of administering medicines was in place. Medicines were stored securely in each person's home we visited. The MAR sheets were fully completed. Records were kept of medicines received and disposed of. Clear written guidelines were in place for any 'as required' medication to inform staff of when they should be administered. The time medicines had been administered was recorded. One person told us, "They're on the ball with my medicines; I always get them." We therefore found significant improvements had been made in relation to medicines management.

We looked at the recruitment process for five staff members. All the information was held electronically by the central Manchester City Council Human Resources department. We saw an application form with a full employment history and two written references that had been verified as being correct. A criminal records check from the Disclosure and Barring Service (DBS) had been obtained. The DBS identifies people barred from working with vulnerable people and informs the service provider of any criminal convictions noted against the applicant. This meant that the service had a system in place for recruiting staff who were suitable to work with vulnerable people.

We saw people's homes were clean and personalised. We saw personal protective equipment (PPE) such as gloves were available for staff to use as required.

We saw Personal Emergency Evacuation Plans (PEEPS) had been written for people in the bungalows without 24 hour staff support. These gave guidelines on how a person could be evacuated from the building in an emergency.

We were told that the Housing Association who owned the properties completed all the annual gas, electricity and fire alarm safety checks. All documentation was held by the housing association so we could not evidence that all checks had been completed and were up to date. We recommend that copies of all safety checks made are requested. We saw evidence of weekly tests being made for the fire alarm and monthly safety checks being completed by staff.

We saw that the service had a business continuity plan in place in case of an emergency that would affect the running of the service. The plan had been written in 2013 and had been due to be reviewed in April 2015. This meant that the plan may not contain up to date information for staff to use in an emergency, which could affect the running of the service following an emergency.

Inadequate

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DoLSiDS) We checked whether the service was working within the principles of the MCA.

We found that staff had a limited understanding of the requirements of the MCA. We found that people who used the service had restrictions in place, such as doors being locked, fridges being locked, cigarettes being held by staff and gates at the entrance to the bungalow complex being locked so people had to ask staff if they wanted to leave.

We asked staff why the restrictions were in place for one person. They told us, "We have always done it." We were told one person at a property was not allowed to enter the kitchen due to the presence of knives. We could not find any evidence to support this or a risk assessment to support them to manage this risk. For another person we saw written on an incident form, "Historically the door has been kept locked."

We found no evidence of corresponding best interest meetings being held or applications for DoLSiDS being made in people's files. One staff told us that the information was kept at the office. We asked to see the best interest and DoLS information at the office. This could not be provided and we were told by a care co-ordinator that it was not in place for people.

We were told by the MLDP Central registered manager that people who may be subject to a DoLSiDS were being identified and prioritised. We were also told that when people were reviewed by the adult social care team the least restrictive options were considered. However we could find no evidence of this in the care files we saw.

We found the lack of capacity assessments, best interest meetings and DoLSiDS was a breach of Regulation 11 (3) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We asked about the staffing levels at the service. Members of staff we spoke with told us more agency staff were currently being used as there had been a block on overtime by regular staff since January 2016. We were told that fourteen agency staff had been given two month contracts to work at specific houses. This was done to try to provide consistency for the people who used the service. We were also told other regular agency staff were requested if additional cover was required. However we saw that new agency staff were also used to cover the shifts required. In one property we visited there were two agency staff on duty and no

regular staff. One had worked one shift previously at the property and the other was on their first shift. They were supporting three people with complex needs. One person living at the property was becoming anxious about which staff would be working the next day. The agency staff were unable to provide re-assurance to reduce their anxiety.

We found the information provided for agency staff who were new to the property was not sufficient for them to meet the needs of the people they were supporting. We were shown a written handover sheet given to the agency staff. This did not include information about the people they were supporting or any emergency information. This meant that the new agency staff were not able to effectively and safely support people.

A staff member told us, "We worked the other day with three agency staff who were not familiar to the guys (people who used the service). We had to do all the routines with people in order to prevent any incidents. It is hard for us to do this and keep people safe." Another told us, "[Name] won't be going for a walk because it's agency staff; we have to keep people safe."

This meant that people who used the service were not supported by regular staff who knew them well and had the information to meet their needs. This was having an impact on people's levels of anxiety and the activities they were able to undertake. We found this was a breach of Regulation 12 (2) (c) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014

During the inspection we looked at whether the staff received the training they needed in order to carry out their roles. Staff members we spoke with told us that they had completed courses including manual handling, first aid, safeguarding, physical intervention and medicines administration.

We were given a file containing staff training certificates. However this was not up to date and not all certificates were included. A care co-ordinator showed us a new computer based system for recording training that had been completed and booked. This included an overall training matrix for all training courses provided. This had been introduced in mid-2015 and did not contain historical data of courses staff had completed. Therefore the care co-ordinators could not see if a staff member had previously completed a course and when they required a refresher course to be arranged. We were shown a second computer system that held courses completed by staff. This information was held for each individual staff member and so it was not possible to see which staff needed what training without going into each individual staff file. We were also shown handwritten lists currently being compiled by each care co-ordinator for their staff teams. From these different records it was not possible to see whether staff were current with their training requirements or not.

We also saw that all training courses had been cancelled since January 2016. We were told that this was for budgetary reasons. Courses were booked for the new financial year from April 2016 and included courses in the safe handling of medicines, epilepsy awareness, autism awareness and supporting healthy lifestyles.

We were told that the new training data base was updated by the Manchester City Council central administration team. The care co-ordinators would receive a list of which staff required refresher courses so that they could be booked on to them.

Staff told us that when they started their employment they shadowed experienced staff so they could get to know the people they were supporting and their routines. They also completed mandatory training courses.

We saw evidence that regular team meetings were held for some staff teams. However this was not

consistent for all teams, with other teams telling us that they did not have any team meetings.

We asked staff whether they received regular supervisions with their care co-ordinator. We received conflicting information. One staff said that they had regular supervisions. However other staff said that the care co-ordinator would visit the property once or twice a week but they did not have formal supervisions. This was confirmed by one care co-ordinator we spoke with. This meant that staff may not meet their care co-ordinator regularly depending on when they were working and when the care co-ordinator visited the property. In one property we visited we were told that the care co-ordinator rarely visited the home.

The care co-ordinators told us that they had regular supervisions with the registered manager. We were told that the NI was also starting to carry out supervisions with the care co-ordinators in the absence of the registered manager.

The lack of clear training records to ensure staff training and development needs were met and the lack of formal supervision processes for staff means that the service is not able to ensure that people using the service are supported by suitably qualified, competent skilled staff. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found risk assessments were not in place for people who had swallowing difficulties and people's weight had not been monitored where they were at risk of too much weight loss. At this inspection we saw from the care records referrals to the Speech and Language Team (SALT) had been made. Swallowing guidelines had been written by the SALT team and eating or choking risk assessments and guidelines were in place. We were told the staff would inform the SALT team if there were any changes in a person's needs, the SALT team would not routinely visit to review the guidelines. Therefore staff continued to follow the guidelines given to them. These meant systems were in place to meet people's nutritional needs.

We saw people were supported to attend relevant health appointments. We were told how staff supported one person who becomes anxious in new situations to attend hospital. They arranged to go in the early hours of the morning when it would be quieter and re-arranged the hospital environment to look like a café to reduce the person's anxieties. Relatives also told us that staff supported their loved one to GP, dentist and hospital appointments and kept them informed of the outcomes. Records were kept of any healthcare professional visits and appointments which meant staff could monitor and plan for people's welfare. This meant that people received support and treatment to maintain their health.

Requires Improvement

# Is the service caring?

## Our findings

All the people we spoke with were complimentary about the staff who supported them. One said, "The staff are dead good," and another said, "I get on well with all the staff." Relatives we spoke with were also complimentary about the staff. One told us, "I have never seen a bad one; they are lovely people," and another said, "Yes the usual staff are very caring; a couple of times when agency staff have been on duty they don't seem as caring."

Throughout our inspection we observed warm and friendly interactions between staff members and the people who used the service. Staff we spoke with knew the people they supported well. We observed how one staff member de-escalated a potentially challenging situation quickly and efficiently.

We saw that staff were well motivated and worked together as a team. Some staff could clearly explain the meaning of person centred care. However other staff did not know why some restrictions such as locking the kitchen door were in place; it had become custom and practice rather than assessed and person centred.

Staff explained how they maintained people's privacy and dignity when providing personal care. We noted that staff knocked and waited for an answer before entering people's bungalows. This helped to ensure people's privacy and dignity were respected.

Our discussions with the regular staff showed they had a good understanding of the needs of the people they were supporting. Staff also demonstrated a commitment to providing high quality care.

Care records we reviewed included information regarding people's likes, dislikes, interests and background. This should help staff form meaningful and caring relationships with the people they supported.

We were told that some shifts during the day had been removed from some of the properties supported by MLDP North. These are due to be re-instated on the 1 April 2016. We were told this was because the people using the service had not been formally assessed as needing this support. Where people had an existing assessment for this support the shifts were not removed. The MLDP Central registered manager informed us that risk assessments were not needed for this change 'as there was not expected to be any increase in adverse behaviours as a consequence.' However staff told us that people who used the service had not been able to access the community as much as they usually did and this had been a problem, with people becoming agitated because their routines had changed.

A staff member said, "Nobody sat down with [people who used the service] to tell them; we were instructed not to tell their families." This meant that the management of the service was not being open and transparent with people who used the service or their families. Nor did they involve people or provide them with information and an explanation about changes to their support plan.

We saw that some people had access to a mobility car that they paid for through their benefits. This enabled them to go out into the local community and on trips with staff. However a relative told us that there often

was not a qualified driver available to use the car as much as they would like. This meant that people were not able access their local community on a regular basis.

We saw in some people's care files a person centred end of life plan was in place. This detailed the wishes of the person at the end of their life. However we did not see similar plans in the more independent bungalows.

We saw that care records were held securely in the staff office at each property. We were also told that two people chose to keep their care plan files in their own bungalow. This helped to ensure that the confidentiality of people who used the service was maintained.

Requires Improvement

# Is the service responsive?

## Our findings

The care records we reviewed showed information was gathered about people's care needs and daily routines. Records were written in a person centred way. However we found that person centred records were embedded in the middle of the files and the person's negative behaviours were the most prominent information held. This meant there was a risk staff would concentrate on a person's behaviours rather than their needs and routines.

In some properties the information was difficult to find in amongst other information held in the file. In one property the care plan was found in a drawer by the adult social care inspector and the information contained was out of date. We saw one care plan dated October 2015, however another person had an assessment from 2011 in their file and no evidence of having a review of their needs. This person had set goals to achieve in 2015 and risk assessments had been updated, but no formal review of their care was recorded.

We saw one person had a care plan dated 2012, however they had a behavioural support plan dated December 2015. This meant that an up to date person centred plan was not available for staff, but information about how to manage their behaviours had been updated.

We saw that one person had a social services support plan dated January 2014, with no evidence of a review having taken place since. A care co-ordinator told us, "Reviews were not completed each year. If a person's needs changed a request was made to their social worker for a review to be arranged." However we saw that this had not been done for those people who had had shifts removed from them due to the shifts not being part of their assessed need. Good practice would be for the service to conduct its own internal review if social services were not able to undertake a formal review. We saw evidence of people setting and achieving goals in 2015, however we saw that people had not identified any goals for 2016.

In one property we saw that the records held for all three people who lived there needed updating.
In another person's file we found three versions of a behavioural support plan. This meant that staff may not know the current guidance for supporting people or responding to their needs.

An agency staff told us that a person who used the service required support whenever they went out of the house. The care plan for this person stated they were able to go out unsupported.

We found that the paperwork used differed between the properties. We were told that this was because two services had been combined in 2015 and they were in the process of standardising the paperwork used by the service.

At the bungalows where more independent people lived we saw that independent living skills assessments had been completed for two people in 2013. We did not see evidence that they had been reviewed and updated. For two other people we saw that logs were maintained of tasks people had completed for themselves or with staff support. However we did not see any corresponding assessments or guidance for

staff. This meant that people may not be consistently supported to maintain their independence.

We saw weekly activity planners for some of the people who used the service. We saw in the more independent bungalows a person's assessed support did not include staff support for social activities. We saw that some people attended day centres once or twice a week. Staff told us that some people purchased additional support from a personal assistant for social activities. However records for people accessing the community showed that for some people this was limited. On the day of our inspection one person had not left their bungalow complex for five days. We saw that for another person the activity log had only five entries for February 2016 and none for March. This meant that some people were at risk of social isolation.

We found the lack of clear care plans and goals which had not been regularly reviewed with the people who used the service and their families to be a breach of Regulation 9 (3) (a), (b) and (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that a complaints policy was in place. This detailed who to contact with a complaint and the process and timescales that would be followed to assess the complaint. A central complaints team ensured that complaints were dealt with in a timely manner. We were told relatives of people who used the service were given a copy of the complaints procedure and they were also available in the properties. One relative told us that they had previously made a complaint and were happy with the way that it was dealt with and resolved. Other relatives told us they had not needed to make a formal complaint. They told us they contacted the staff or care co-ordinator in the property concerned and discussed any issues with them. They said the issues were resolved at this stage. One person who used the service we spoke with said, "If I'm not happy about something I will talk to my link worker or another staff member."

We saw evidence in one of the more independent bungalow properties that regular tenants meetings were held. We saw that people were able to raise any issues or concerns they had at these meetings and actions were put in place to address them.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection we found that the quality assurance systems in place were not sufficiently robust. At this inspection we found improvements had not been made to the quality assurance systems and they were still not sufficiently robust.

We found some audits were in place, for example spot checks by the care co-ordinators were due to be completed every three months, surveys had been sent to relatives of people who used the service and observations of medicines administration. However these were not consistently completed. We were told that a more comprehensive three monthly house audit was not completed as the care co-ordinators did not have time to do them. They undertook the shorter spot checks instead when they were able to.

Throughout the inspection we found a number of examples which demonstrated a lack of clear leadership and management. For example, in some properties we saw evidence of team meetings being held. However in other properties we were told that team meetings did not take place. We were told that some care co-ordinators visited their properties once or twice a week; however other staff teams told us that the care co-ordinator rarely visited but was supportive via the phone.

This meant that staff were not consistently supported by their line managers and the care co-ordinators may not have been fully aware of the details of the challenging incidents staff were supporting people with.

We found the care files were not up to date, audits of incidents were not robustly completed by the manager to identify trends, training records were incomplete and it was therefore difficult to have an overview of what training had been undertaken and what was required. We were told that the returned surveys had been looked at by the care co-ordinators and passed on to the registered manager. The care co-ordinators we spoke with were unaware of any analysis of the results or actions being taken in response to the survey.

Support staff told us that the information for best interest meetings and DoLS assessments were held at the office, but the information was not there. Staff also told us that incident forms were kept at the office; however one care co-ordinator told us that they were stored in people's files. A staff member told us that they completed incident forms when there had been some challenging behaviour but not when 'as required' medication was administered as part of the person's behaviour plan to de-escalate a situation. They said they did not know if this was the correct procedure or not but it is what they thought they needed to do. This meant that there was no clear guidance for staff to follow in relation to how to report and monitor incidents which occurred at the service.

We were told that agency staff often did not complete incident forms. One staff said, "Agency staff don't complete incident forms unless the regular staff have time to sit down with them to go through the form." This meant that not all incidents were recorded and therefore a complete analysis of them was not possible.

We found information kept about people was not easily accessible, up to date or accurate. We found this to be a breach of Regulation 17 (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

2014

We also found the lack of robust quality assurance systems was a breach of Regulation 17 (2) (a) (e) (f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were positive about their role and said that they knew their care co-ordinator. We asked staff how they were supported following an incident of challenging behaviour. We were told by one team that they could have formal debriefs with their care co-ordinator but they just used other members of the team for support. Staff told us that they raised concerns with the MLDP North Learning Disability Nurse who would review the behaviour support plans.

Relatives we spoke with said that they would contact the staff in the property where their loved one lived if they had a complaint or issue. They said that the staff were helpful and would usually resolve things with them. The relatives did not know the registered manager; however they were not concerned by this as they would deal with the staff or care co-ordinator at the property.

We were told a survey was sent to all relatives in October 2015. Four relatives told us they had not been asked to provide any feedback on the service and two people said they had. All the relatives we spoke with said that staff kept them informed about any changes or medical appointments for their loved one.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

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<br><br>Lack of clear up to date care plans with agreed goals. Regulation 9 (3) (a) (b) (c). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Lack of training records and consistent staff supervision. Regulation 18 (2) (a) |

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Best interest meetings and DoLSiDS assessments and application had not been made. Regulation 11 (3) |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risk assessments were not completed or were not reviewed. Regulation 12 (2) (a).<br><br>The provider did not take reasonable steps to mitigate the risks to people who used the service. Regulation 12 (2) (b).<br><br>People were not supported by regular staff who knew them well and had the information to meet their needs. Regulation 12 (2) (c) |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Information kept about people was not easily accessible, up to date or accurate. Regulation 17 (2) (c).<br><br>Lack of robust systems to monitor and review the service. Regulation 17 (2) (a) (e) (f) |

**The enforcement action we took:**

Warning Notice