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Affinia Healthcare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The announced inspection took place on 24 and 31 October 2017. At the last inspection on 21 October 2016 the services met the regulations we inspected.

This inspection was completed on 24 October and 31 October 2017. Affinia Healthcare is a domiciliary care agency that provides personal care to people living in their own homes and some living in supported living in the London borough of Havering. At the time of our service there were 55 people using the service nine of which were receiving personal care in a supported living set up.

At the time of our visit there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

At our last inspection in October 2016 the service met the regulations we inspected. However at this inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. 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.

People we spoke with told us they felt safe and that they were treated with dignity and respect. However we found risks were not always effectively assessed reviewed or managed in order to protect people from harm. Safeguarding processes in place were not always followed. This resulted in delayed safeguarding investigations and demonstrated staff knowledge gaps as to what and where to report different types of abuse. The updated electronic policy did not have any local authority contact details.

Medicines were not always administered as prescribed. We found several instances where medicine administration records had not been completed in order to evidence that people had received their medicines as prescribed. We also saw medicine record transcribing errors which resulted in people receiving less that their prescribed medicines.

People were not always supported by staff that had undergone the necessary training to enable them to deliver support effectively. There were shortfalls in the systems in place to monitor and ensure staff attended all relevant training and were kept up to date with practice.

There were inadequate care planning systems in place which did not ensure people's needs were accurately documented.

Staff demonstrated limited understanding of the Mental Capacity Act 2005 beyond considering consent before care was provided. Capacity assessments were not always completed properly and did not always reflect how specific decisions of people who may lack capacity had been made.

This resulted in decisions being made by people who had no legal delegation to do so.
We found several failings in the current governance systems in place which had failed to identify and address issues we found at our inspection. These included breaches of information governance as staff could still access the service's records whilst no longer actively requiring access to people's personal information. People's records were not reviewed in a timely manner and were not completed to reflect a complete an accurate account of care delivered. The provider had failed to ensure an open and transparent culture.

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, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Safeguarding processes in place were not robust enough to protect people from harm.

Medicines were not managed safely in order to ensure people received their medicines as prescribed. This left people at risk of further deterioration of their health and wellbeing.

Risk assessments were not reviewed and updated to show current risks and guidance regarding mitigating risks. This included the risks associated with behaviours that challenged the service.

There were safe staff recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective. There were shortfalls in the completion of accurate mental capacity assessments and ensuring decisions were made in people's best interest.

Staff did not always demonstrate full understanding of the Mental Capacity Act 2005 and how they applied this within their role.

Staff training was not comprehensive and did not include key areas staff needed to enable them to support people effectively. Similarly induction was not always consistently documented and delivered to ensure all staff understood their roles and responsibilities.

People told us they were supported to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring. Peoples information was not always protected.

People told us staff were caring and supported them.

People were supported to maintain their independence where

possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always accurate or reviewed when people's needs changed. Pictorial care plans were in place, however the information within was not always person centred.

Where social inclusion was part of the care plan this was clearly assessed although all attempts to encourage this were not always documented or known by staff.

People and their relatives told us they were able to make a complaint and told us they were listened to.

Is the service well-led?

Inadequate

The service was not well-led. There were ineffective monitoring systems in place which had resulted in several breaches of legislation.

The inconsistent leadership in place meant policies and procedures were not always followed in order to ensure people were protected from harm.

There were ineffective record keeping systems in place. People's records did not reflect their current needs and left them at risk of receiving inconsistent care that did not meet their needs.

The culture was not always open and transparent.

The governance systems in place had failed to protect people's information and had breached data protection requirements.

Affinia Healthcare

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 24 and 31 October 2017 and was announced. The provider was given 48 hours' notice on the first day and 2 hours' notice on the second day because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was completed by an adult social care inspector 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.

Prior to the inspection we gathered feedback from previous reports and notifications. We attended a safeguarding meeting and were in contact with the local authority commissioning team. We also received two whistle blowing concerns relating to safeguarding incidents.

We spoke with ten people who used the service and two relatives over the telephone in relation to the domiciliary care part of the service. We spoke with three people and two relatives at the supported living service. We spoke with the registered manager, the deputy manager, an administrator and five care staff.

We looked at 13 care plans including risk assessments, six medicine administration records,12 satisfaction surveys feedback forms and 11 staff records including training appraisals and supervision. We looked at staff meeting minutes held in April and July 2017, three safeguarding records and 10 accident and incidents logs. We reviewed 12 policies including complaints, safeguarding and whistleblowing.

Inadequate

Is the service safe?

Our findings

There were ineffective safeguarding processes at the service which were not robust enough to protect people from abuse. The safeguarding policy did not contain information about the local safeguarding authority contact details. This would not enable staff to contact the appropriate authority promptly in the event of an allegation of abuse. Safeguarding strategy meetings (meetings to discuss safeguarding concerns) and information we received confirmed that suspended staff had continued to work and access the supported living service whilst on suspension with the registered person's knowledge. This demonstrated a lack of understanding of the risk management responsibility to protect people and the staff member concerned whilst safeguarding investigations were still in progress, and exposed people to potential risks of further abuse.

We found systems in place to report safeguarding were not always followed or effective. Staff were not able to explain the current safeguarding process beyond reporting to the manager. They were unsure of the procedure to follow in the absence of the manager or where the allegations involved the registered manager. This meant that potential abuse would not be reported promptly and effectively, therefore people were at risk of potential harm.

Safeguarding incidents had not been reported to the local authority and the Care Quality Commission (CQC) in a timely manner. For example, we found that an ongoing safeguarding incident had only been reported to us three months after it had occurred and had been reported to the registered manager. Another safeguarding incident had showed the current systems in place had failed to protect people from financial abuse. This showed that the safeguarding procedures at the service were ineffective and failed to ensure that action was taken in a timely manner. The provider had not put robust systems and checks in place to reduce the risk financial abuse leaving people at risk of financial abuse.

The service demonstrated a lack of understanding of essential safeguarding processes, which needed to be followed to keep people safe. This placed people at risk because there were no assurances that safeguarding incidents would be reported to the appropriate authorities in order to ensure appropriate protection plans were in place to protect people from harm.

The service failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider was failing to provide proper and safe management of medicines and people did not always receive their medicines as prescribed. People told us they received their medicines, and we saw procedures in place for storing and ordering medicines at the supported living site. However, we looked at Medicines Administration Records (MAR) and saw evidence that four people had unexplained gaps in their records. For example, we found gaps in one person's records for a topical cream between 25 September 2017 and 22 October 2017 where the MAR had not been signed to indicate the cream had been applied. We also found a gap for another person on 28 and 29 October 2017 for their night medicine haloperidol. The risk to this person for missing their haloperidol could include increased agitation and deterioration of their

mental well-being. Another person had an important medicine for a chronic condition missed on 2 and 20 September 2017. We asked the registered manager about this and they told us they had just moved to a different medicine administration recording system and that they audited the records. The audits in place had identified shortfalls but there were no action plans in place to address the recording issues identified.

Staff members had not had their competency to administer medicines assessed. Staff told us that competency assessments had not been carried out and records supported this. This meant that the service had failed to take steps to ensure that staff had sufficient knowledge and competency to give people their medicines safely.

We reviewed risk assessments in place relating to people and their environment. These included mobility falls and self neglect. However the risk assessments were not reviewed in a timely manner and did not outline how to effectively manage risks. For example a risk assessment talked about a person being disorientated but did not outline actions staff would take to reduce the risk. Although people told us staff knew them well, any new or agency staff would not have this information. This placed people at risk of not being supported in a safe way at all times. A person had behaviours that challenged the service including assaulting others and damage to property. We found the risk assessments related to the above behaviours were not updated in a timely manner. The current risk assessment for behaviours that challenged was to be reviewed by May 2017. This had not been reviewed or updated to reflect current strategies in place to enable staff to manage the risk. One staff member told us the person's behaviour was getting worse and that they sometimes went out at night to the shop next door thinking it was morning. This risk was not documented in the current risk assessment. This failing to accurately assess and document such risks placed people at risk of harm to themselves or others.

These failures to ensure medicines and risks were managed safely were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff to support them, however; they did comment that staff were sometimes late. One person told us, "The staff are good. Someone always comes although sometimes late." Another person commented, "There are enough staff to help me." Relatives also told us people received their visit although not always at the agreed time. We asked the office staff if there had been any missed or late visits and were told there were none. However; when we reviewed rotas dated 9 to 15 October 2017 we found that there were 44 late visits outside the one hour either side of the visit times flexibility allowed by the commissioners. Care staff confirmed that visits were sometimes outside the one hour either side but told us that they would always call to let people know. When asked staff said there had been staffing issues that weekend. We recommend more work is done to ensure visits are scheduled on time to enable people to plan their day.

People told us they felt safe. Comments from people included. "I am very happy with care and I feel safe when they are here", "I like the one I have in the morning, [staff] is very kind and helpful and I feel very safe when [staff] is here". However we found shortfalls in the systems in place to keep people safe.

There were safe recruitment practices in place. These included checks carried out with the Disclosure and Baring Service (DBS) to ensure that staff did not have criminal convictions or cautions to be considered. Staff told us and records confirmed staff had attended an interview and supplied two verifiable references before they started to work at the service. One staff member said, "I was not allowed to start until my references and DBS came back." Another administration staff told us, "I am responsible for ensuring there are two verifiable references and checking and getting copies of their ID." We saw right to work checks for staff who required VISA's to work and proof of identify in all the staff files we reviewed.

There were procedures in place to deal with foreseeable medical emergencies. Staff were aware of the procedure to take in an emergency and, if necessary, would wait with people for the arrival of emergency services. They also told us they would call the office if they arrived for a visit and the person did not respond. We observed this in practice on the day of our visit when we heard the office staff calling people to double check if they were at home and requiring their visit. This meant that staff took appropriate action to ensure people were safe.

Requires Improvement

Is the service effective?

Our findings

People told us consent was sought before care was delivered. However documents reviewed showed consent to make decisions was not always sought and decisions were not always made in their best interests. The service failed to ensure that consent to care was sought in line with the Mental Capacity Act 2005 (MCA). Staff told us that eight people did not have capacity to make specific decisions such as managing their finances. We checked all eight records and found capacity assessments for specific decisions were either incomplete or undated. Similarly the consent to care documents were also not completed properly.

Where people lacked capacity there was no documented evidence of Power of Attorney or best interest decisions in place. This showed shortfalls in staff's understanding and evidencing consent especially for people who lacked capacity to make specific decisions. This left people at risk of decisions being made without their consent infringing on their basic right to choice. This left people at risk of decisions not being made to directly benefit them or in consideration of their views or opinions.

The 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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. When spoken with staff members were not able to explain beyond consent to care and treatment in relation to the MCA. They all worked with people who had fluctuating capacity to make different day to day decisions. However they could not explain capacity in relation to the people they worked with. The registered manager told us they had recently implemented the capacity assessments and that it would take time for staff to get used to completing them properly.

Where people were 16 or over and unable to give consent because they lack capacity to do so, the registered person did not always evidence that they had acted in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not always supported by staff that had received appropriate training. People told us they thought staff supported them well. One person told us, "They help me with all my chores and to wash. No complaints." We reviewed staff training records and could not find up to date training on aspects of care such as mental capacity, medicine administration and food hygiene. We spoke to staff about this and they could not remember if they had up to date training in the above areas. Four staff members told us they had not had any recent medicine administration training. Two staff members had not received up to date food hygiene training, although they told us they assisted people to prepare lunch and we saw them do this on the day of inspection. This showed staff were not always supported to have training in order to ensure they delivered safe care based on current best practice. This left people at risk of unsafe care that did not meet their specific needs.

The service provided support to people with complex needs such as behaviours that could challenge the service, and learning disabilities. However staff and records showed that they had not received specialist training to enable them to support people effectively. Staff confirmed when asked that they had not attended specialist training. This meant people were supported by staff who had not received the specific training and support they needed to meet people's needs.

Staff told us they had received an induction including shadowing. Staff told us they could not recall how many visits they had shadowed but had found shadowing beneficial. We looked at staff records and found the induction process was not documented by the service. We spoke to both the registered manager one staff member about this and they showed us a blank induction form. The form itself was ineffective in recording and demonstrating when shadowing took place and what types of support staff had shadowed. This showed us the current induction process was not always followed consistently to ensure all staff were inducted to the same level of knowledge and competency. Although the registered manager was aware of the Care Certificate, this was not yet fully incorporated into the current induction process. This meant we could not always verify the content of the induction staff in order to check and ensure consistent support was offered to ensure safe care delivery.

After the inspection the provider sent us information that additional medicine management training was carried out by the deputy manager. However; the information was not specific about when this was completed, which staff had attended and if any competency checks were completed. Another email submitted after the inspection stated, 'MCA DoLS Awareness training' was offered by the local authority and held on 16 March 2017 but did not outline if and how many of the staff had attended. None of the records submitted outlined which staff had attended Mental Capacity training and Food Hygiene training. This demonstrated that the provider did not have adequate systems in place to ensure staff received sufficient training to enable them to support people effectively. This left people at risk of receiving care in an unsafe manner from staff who did not fully understand the theory behind the support they were giving.

Staff did not receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform. There were shortfalls in the current induction, training in place and gaps for medicine management, Mental Capacity Act and food hygiene. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us and records confirmed that there was regular supervision and annual appraisals offered to all staff. We saw supervisions occurred at least four times a year. These consisted of objectives set by staff and their manager which were reviewed at variable times. Staff told us they were happy with the supervision. One staff member said, "Supervisions are very helpful and spot checks as we as we discuss what is going well and what could be improved." The registered manager told us there were opportunities to continue development if staff wished. Staff we spoke with and records reviewed showed, where possible, staff were enabled to develop by pursuing health and social care qualifications.

People were supported to maintain a healthy diet when it was part of their care pan to do so. People told us they got help were needed to warm their meals. One person said, "They help with my breakfast, lunch and supper." Staff were able to tell us of people's diverse food preferences. They gave examples of where they had prepared culturally specific food at people's requests. For example one staff told us of how they sometimes prepared cultural specific food for a person of West African origin. Special diets such as diabetic or soft diets were documented in people's care plans and included their food and drink likes and dislikes.

People told us they were supported to access health care services. One person told us "They come early when I have a hospital appointment." Another person told us, "They help me call the GP or the nurse when I

need them." Staff told us they supported people to go to hospital appointments where necessary and to collect prescriptions in order to enable people to maintain their health. This was confirmed within the care records we reviewed.

Requires Improvement

Is the service caring?

Our findings

People told us they were kept informed and had access to information. One person told us, "I just have to ask or check my booklet or ask [relative]." We saw that information was available for people in a format they could comprehend. This was in an easy to read format to ensure people with communication difficulties could understand. Although the support contracts were inaccurate, they were pictorial so that people who used the service could understand. The service user guide and how to make a complaint section were also pictorial to ensure people could understand the information. Management were aware of the current advocacy services available and cited shortfalls in getting appropriate advocacy service for people. However; staff were not always clear when and how people were signposted to access these. This could result in people not accessing the right independent support when required. We recommend further action and support for staff on available advocacy services.

People's information was not always protected. We found at times people's information had been accessed by staff who had no authority to do so via an electronic system. This did not always ensure the privacy of people using the service. The registered person was initially unaware. We spoke to administrative staff about this and they showed us a new system the provider had just purchased which enabled them to have control over staff access to the system.

People and their relatives told us staff were kind and caring. One person told us, "I am happy here. [Staff] is good to me." Another person said, "It's very good here." A third person commented about staff stating, "They are very kind and do what I ask them to do." A fourth person was very complimentary about staff and said, "The way they treat me tells me they are caring. Nothing is too much for them and I don't feel afraid to ask, I call them my little angel." Staff spoke fondly of people they looked after and addressed them by their preferred names. We observed staff speaking to people in appropriate tones and responding to them promptly when they called for assistance.

We observed people being treated with dignity and respect. One person told us, "Yes they treat me with respect, I will ask them to move my position and massage my side and they don't complain." Another person said, "They always make sure I am covered when they support with washing." People told us their privacy was respected. Staff told us they had received training on how to respect people's wishes. They told us they always explained to people in a way they could understand. We saw staff and the registered manager distract and persuade a person whose clothes were dirty to go to different areas within the supported living accommodation and to have their lunch. Staff told us they would keep trying to persuade the person to change their clothes and were eventually successful. One staff told us, "Once you get to know people and they also get used to you it becomes a lot easier to try and help them. However no two days are the same so what works one day might not work another."

People and their relatives told us they had been involved in care planning. Care plans had a section where people's involvement could be recorded. One person told us they had discussed and agreed to what was in their care plan including visit time preferences. Another person said, "They discuss with my relative as [relative] is able to give more information." We saw evidence of this in care plan reviews that were

completed by keyworkers together with people and their relatives where possible.

People were encouraged to maintain relationships with those that mattered to them. One person told us, "I go to my [relative's] house at the weekend." Another told us, "My aunt comes to visit everyday and is very helpful with all my requirements. [Relative] sorts everything out." On the day of our visit to the supported living service we met two relatives who told us they visited when they could. We also overheard a phone call where a relative had rang to inform the registered person that they wanted to take a person out overnight. We saw staff help this person pack and ensure they had money before they left. Another person had been supported to attend a reunion and told us staff had helped with personal care and make-up. Their care records showed staff had facilitated and supported this person to attend the reunion.

People were encouraged to maintain their independence. One person told us, "They leave all I need within reach. That really helps me get on when they are not about." Another person commented that staff had been helpful in ensuring they were pain free. This had helped them do more for themselves. Staff told us and care plans confirmed that people were supported to be as independent as possible and encouraged to do as much as they could for themselves. For example one care plan read "prompt [person] to wash their face."

Requires Improvement

Is the service responsive?

Our findings

We reviewed care records and found assessments were completed when people began to use the service. These included peoples past medical history, likes and dislikes and support needs. Support plans were then developed. We found support plans entitled, 'Individualised support plans'. Although on a pictorial template, they said the same thing about people's preferences and triggers word for word for each person. For example the section entitled, 'helping take control of my life' in four people's care plans all said, 'I would best speak up for myself if I was around people I know' and, 'Not too many people around me.' We spoke with two people, observed their interactions and spoke with staff about their requirements. We confirmed that the recorded information did not match their needs. This showed they had not been completed to show individual preferences and were therefore not person centred.

Care records were not always accurate and did not always reflect people's current complex support needs which included mental health issues, substance misuse and severe learning disabilities. People's support contracts had their own name as well as that of other people receiving care from the service on subsequent pages. This showed that documents were not always completed on an individual basis for each person, to reflect their specific needs. One person's care plan had their details on one page and went on to describe another person's details on the next page despite this person having complex behaviour support needs. This meant care plans were not always completed accurately to reflect people's current needs. The registered manager told us that the contracts and pictorial care plans had been recently implemented and that they would check to ensure they were completed properly.

The service had failed to ensure care plans were reflective of people's preferences. This meant that staff could not rely on the information in the care plans to enable them to support people in accordance with their needs and wishes. This left people at risk of receiving care that did not fully meet their needs in instances where new staff were allocated to assist them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to make a complaint if they had any issues. One person told us, "If there was a problem I would speak to my [relative] who would contact the office." Another person when asked if they were aware of the complaint process responded by stating, "If I have any complaints I would call them." Relatives also told us they would talk to the registered manager if they had any complaints and felt their issues would be resolved.

Staff told us complaints would be reported to the registered manager. We asked for a complaints log and were told there had been no complaints in the last year. We reviewed the complaints policy and found it was up to date and accessible to people and their relatives. During the visit we saw people come in to ask the manager to resolve any issues one of which was heating that had stopped working at the supported living site. However we did not see these recorded as complaints.

People told us they were asked for their feedback. One person told us, "Someone calls to check how things are going." We saw completed satisfaction surveys, however they were not always dated to enable us to

know when they were completed. Staff told us these were completed every summer.

People and their relatives told us they were involved in planning their care. Most were happy and thought staff responded to their needs. One person told us "My [relative] found them for me and he discussed care plan with them. I can call and cancel a visit if I am going out." The same person and another two confirmed their request for same gender care staff was honoured in order to make people more comfortable during personal care. We confirmed this within the daily records log we reviewed.

Inadequate

Is the service well-led?

Our findings

We found significant shortfalls in the way the service was being led. The current systems included audit of records, satisfaction surveys, clocking in and clocking out system and regular spot-checks on staff. These systems had failed to pick up and address shortfalls we found in training, assessing risk and care planning and reviewing processes in place. Furthermore whistle-blowers reported a closed culture where challenging bad practices was not addressed and incidents were not always taken seriously.

Prior to the inspection we had received information of concern relating to safeguarding issues at the service. There was an allegation that staff who raised concerns, including whistle-blowers, were not supported and issues they raised were not always taken seriously. The safeguarding concerns were confirmed by the documents we reviewed during to our visit. We found notifications were not always submitted in a timely manner as required by law. We had not been notified of some safeguarding events until two months after the event occurred and we were notified only after we had received and shared information of concern received with the local authority. This meant safeguarding matters were not always dealt with in an open, transparent manner. The lack of transparency had resulted in delays in safeguarding investigations and meant the CQC and the local authority had not been informed of safeguarding events as required by law.

There were ineffective systems in place to ensure peoples information was protected and only accessed by staff who had authority to do so. The local authority's investigation and CQC inspection found that staff had access to people's information through the organisation's software and emails. Staff could change passwords and still access the service's software containing people's details even when they were no longer actively employed by the organisation. This meant that staff no longer employed by the service continued to have unauthorised access to people's information. The systems in place had failed to ensure people's information was protected and put them at risk of receiving further contact and support from staff who no longer worked for the service.

The provider did not always maintain accurate records of people's care. The systems in place to check record keeping had failed to pick up discrepancies we found on the day of inspection. We found consent forms were either incomplete or had date discrepancies. One printed electronic consent form was dated as printed October 2017 but had been signed in July 2017. Five out of six health action plans at the supported living scheme were incomplete or not dated and four did not have the person's name. These issues demonstrate ineffective systems which did not always accurately enable the registered manager to assess monitor and improve the quality and safety of the services provided. This meant we could not rely on the records we reviewed as a contemporaneous record of care delivered. Furthermore these records did not give staff a clear guide as to the comprehensive support needs of people using the service.

We found some information within care documentation was out of date and had not been picked by the governance systems in place. The manager told us they had an audit system in place. However this had not picked up that some documents still in use were out of date. We looked at communication consent forms. They all had out of date information which referred to the 'Primary Care Trust' and 'Commission for Social Care Inspections' organisations which were no longer in existence. This did not ensure people were sign

posted to the correct organisations when they needed help and meant people may not be able to get the support they required. We spoke with the registered manager about this at the time of inspection and they said they would update the forms to reflect the correct organisations. The above reflected failures in the governance systems in place and demonstrated a lack of understanding of developments in regard to regulations and essential external organisations.

We reviewed 12 satisfaction survey feedback forms completed by people and their relatives. Two satisfaction surveys had no date, and four had no name. There was no summary of the survey with key feedback and any actions identified. This meant the current systems in place were not robust enough to effectively monitor the quality of care delivered. They did not always ensure feedback given by people and their relatives was taken into account in order to improve the service.

The inadequate systems in place to manage record keeping, quality assurance, training and training and information governance were governance were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they were happy with management with the exception of visit timings. One person told us, "I find they are listening people and communicate with me well." Another person said, "I find them very supportive, open and they communicate well with me." One relative told us, "Timing has always been an issue. We were told there has to be a 30 minute to1 hour window. The service is short of staff at the weekend and it appears that the same few staff covers all the shifts." This was confirmed by staff logging in and logging out records we reviewed. This meant that people did not always receive care in a timely manner.

People, their relatives and staff told us that some monitoring checks had been completed within the last six months. One person told us, "The management do spot check and would call and ask if I would be in today, and ask can we pop round and see how things are going". Staff told us spot checks to monitor how they delivered care were completed and we saw evidence of these in records we reviewed. Staff told us they were supported by management. One staff said, "I call the office if I need anything." Another staff told us, "There is always someone available even at weekends."

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not designed care or treatment with a view to achieving service users' preferences and ensuring their needs are met. They were not always reflective of service users preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where service users were 16 or over and unable to give consent because they lack capacity to do so, the registered person did not always evidence that they had acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform. There were shortfalls in the current training in place and gaps for medicine management, Mental Capacity Act and food hygiene.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure risks to the health and safety of service users of receiving the care or treatment were assessed and reviewed in a timely manner so to do all that is reasonably practicable to mitigate any such risks. The registered person did not always ensure the proper and safe management of medicines.

The enforcement action we took:

NOD to restrict admission in light of reg13,12,17,9,18,9 breaches.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. Systems and processes were not always operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:

Issued NOD to impose conditions.