Liberty Centre Limited

Liberty Centre

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**

Overall summary

This inspection took place on 19 and 20 January 2015. We gave the provider 48 hours' notice to make sure there would be someone in. We found the service was compliant with the regulations we inspected against when we last inspected in October 2013.

Liberty Centre is a service specialising in supporting people with autism and learning disabilities. It provided domiciliary care for one person and supported living for four people. The service has 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.

People were not always protected from abuse and harm. We saw there had been a number of incidents of violent behaviour that had resulted in injury. These had not been reported or effectively followed up.

Summary of findings

Medicines were not always managed safely. We saw that there were mistakes in the recording of people's medicines, there were stocks of medicines that could not be accounted for and some medicines were not being stored in accordance with their instructions.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, the provider had not made an application with the local authority to the court of protection, even though people's liberty may have been restricted.

The provider had not followed safe recruitment processes. Staff had been employed before their criminal records checks had been returned and the gaps in people's employment history had not been explored.

People's backgrounds were respected. We saw that people were provided with food that related to their cultural background and personal preferences, and they were supported to access religious services in the community.

Care did not meet people's individual needs. The provider did not keep accurate records about the needs of each person, with risk assessments and care plans not relating to the person's current needs.

People using the service and their families were encouraged to give their feedback about the service. We saw that family members were involved in people's care and had been consulted about decisions made about people's care.

The provider did not have effective systems for monitoring and auditing the quality of the service.

CQC registration requirements, including the submission of notifications in relation to safeguarding and applications to the court of protection and their outcomes had not been met.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to care and welfare of service users; assessing and monitoring the quality of service provision; safeguarding service users from abuse; management of medicines; consent to care and treatment; records; requirements relating to workers; and, supporting workers. You can see what action we told the provider to take at the back of the full version of this 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. People were not effectively protected from abuse or harm.

Incidents were not appropriately reported and were not investigated to prevent them from happening again.

Medicines were not managed safely, with mistakes in recording and medicines not stored in accordance with their instructions.

Safe recruitment practices had not always been followed and staff had been employed without appropriate checks.

Is the service effective?

Requires Improvement

The service was not always effective. Staff training was not up to date.

People had restrictions on their freedom but the provider had not made an application to the court of protection to deprive people of their liberty.

People's cultural and religious backgrounds were supported through provision of appropriate food and religious activities.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always supported to maintain their independence and do tasks they were capable of.

Care workers knew about people's backgrounds and life histories, although these were not detailed within their care plans.

People were supported to make choices about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans did not always show the most up to date information on people's needs, preferences and risks to care.

The provider did not keep adequate records on people using the service, with gaps in records relating to people's care.

The service had a feedback system in place and supported family members to give their feedback about the service and were able to make complaints.

Is the service well-led?

Inadequate

The service was not well-led. The provider did not have effective systems in place to monitor the quality of the service.

The provider had not made notifications to CQC of incidents as required by their registration.

Summary of findings

Staff members knew about whistleblowing and felt able to raise any concerns with the senior management team.	

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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.

The provider was given 48 hours' notice because the location provides a domiciliary care service and supported living for four people in two locations; we needed to be sure that someone would be in.

The inspection was carried out by one Inspector. We reviewed the information that we held prior to the inspection, which included a safeguarding notification and two previous inspection reports and additional information provided by the registered manager throughout the inspection process.

During the inspection we reviewed five people's care files, two people's medicines records, six staff files and a selection of policies and procedures. We also spoke to the registered manager, four members of staff and two family members of people using the service. We also observed care taking place within the supported living service.

Before the inspection we also spoke to the safeguarding teams at two local authorities who commission the service.

Inadequate

Is the service safe?

Our findings

We found that people were not protected from harm or effectively safeguarded from abuse. One relative told us, "[Person] isn't always safe and has had a few incidents since using the service. We need to have more input and information about what is happening." We saw that care files and risk assessments were not regularly reviewed and did not meet the needs of people using the service. In care files and accident records we saw examples where incidents had occurred between people using the service and both other people and staff, and these incidents were not appropriately investigated or reported. Where one person had been injured by another, the person's care file was not updated and the risk assessment was not reviewed to take into account recent behaviours that challenged the service. This meant that people were at risk of receiving inappropriate or unsafe care and were at risk of further harm. None of these had been reported to CQC as is required by the conditions of registration.

People's risk assessments and behaviour management plans were not kept up to date and did not reflect the complex needs and severe levels of behaviour that challenged the service. The plans did not have clear guidance for staff on how to recognise triggers or manage these behaviours effectively. This placed people at risk of harm through unsafe responses to manage behaviour.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We completed a comprehensive audit of the medicines procedure and checked the stock of medicines at the supported living service. We saw that medicines were not managed safely and that people were at risk of harm through receiving medicines at the wrong times, that some were not stored correctly and the stocks of medicines did not correspond with the records.

We looked at the Medicines Administration Records (MAR) for two people who used the service. We saw several gaps in the recording on the MAR sheets where there was no signature or marking down of whether medicines had been administered at these times or not. We checked the blister packs which showed the medicines were not in them, but could not tell when these had been administered.

We checked the stocks of medicines and found several examples where the medicines in the boxes did not correspond with the stocks that should be in the boxes according to the MAR charts. We saw an example with one person's medicines where tablets were unaccounted for. There were 14 tablets missing from the pack with no audit trail to explain whether these had been given to the person or not.

We saw two medicated creams that had been prescribed to one person. One of these creams had not been opened and there was no record of it being given to them. The instructions on the cream stated that it must be kept refrigerated. This had not happened and we saw that both creams were kept in the medicine cupboard, not the refrigerator. This meant the medicine would be less effective and placed the person at harm of not receiving effective medicine for their conditions.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not always follow safe recruitment practices. We reviewed five staff files and saw that people had been recruited who were not appropriate for providing care and support to people. This included people with convictions that would exclude them from working in care services. We also saw three examples where people had started working and providing care before their criminal records checks from the Disclosure and Barring Service (DBS) had been returned and did not have two references. This meant that people were employed and providing care who may have been barred from working with vulnerable people, placing people who used the service at risk of harm and abuse,

We saw examples in two staff files where applications showed significant gaps in their employment history. These were not investigated and the provider had not taken appropriate steps to ensure that these people could explain their previous employment and make sure that people had the skills and were fit and proper people to provide care.

This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

Our findings

We saw that staff were not appropriately trained and supported in order to carry out their caring responsibilities effectively. We reviewed staff files and saw that care workers were not fully trained in the core training they needed.

We reviewed the training records in four staff files, and in we saw that they did not have up to date training in areas such as medicines, physical intervention, managing challenging behaviour, first aid and autism awareness. We saw that people using the service were identified as having severe levels of challenging behaviours but staff did not have the relevant training in order to manage these behaviours. This meant that people were at risk of unsafe care as staff had not had recent training to keep their skills and knowledge up to date.

We also saw there were gaps in the supervision and appraisal of the staff team. We saw in one person's file they had received an appraisal in 2011 and then the next one was not until 2014, when it should have been completed annually.

This was a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider was not meeting the requirements in relation to the Mental Capacity Act 2005 and associated code of practice to help protect people's human rights in relation to their mental capacity and consent. We observed that people in the supported living services were unable to leave the house without staff escort and had staff supervision at all times. We spoke with the registered manager who stated that there was not anybody using the service who was deprived of their liberty. The registered manager did not have a clear understanding of their requirements under the Mental Capacity Act 2005 and associated Code of Practice and had not taken the appropriate steps to assess the capacity of people using the service or make applications to the court of protection.

There had been no assessment of people for deprivation of liberty and no applications to the local authority or court of protection had been made for these people. As a result, these people may have been deprived of their liberty unlawfully.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person's relative told us, "The food is good and they provide the food that [person] likes and is used to getting with us." We saw that people were provided with the food and drink they required and that their backgrounds and individual needs had been taken into account. We saw a menu for one person which detailed their food for the week, which included a range of cultural specific foods that reflected their ethnic background. A staff member told us how they had discussed this menu with the family of the person to make sure it was the type of food the person liked and was used to eating and we saw that people were able to choose their own food. One care worker told is, "I give them a choice of food - I get out a couple of options and [person] points at the one they want."

People's general health was monitored by staff and any changes in people's health was noted and reported to senior staff. One member of staff told us, "If there is any change to their health I immediately inform my manager who will investigate and make any referrals." We saw details of appointments that had been made in people's care files and that people were able to access the health services they required, including hospital appointments and specialist services.

Requires Improvement

Is the service caring?

Our findings

We observed that people were treated in a caring manner by staff, who addressed them by name and supported them to undertake tasks in order to get ready to leave the service for the day care centre. A relative told us, "I think they are caring and interested in what they do."

We spoke to staff who told us how they tried to put the person at the centre of their work and communicate with them as effectively as they could. One care worker told us, "I put [person's] interests first - I know what [person] does and does not like."

People's cultural backgrounds were respected. We saw that one person was supported to attend religious services and this was detailed within their care plan. They also received food that was appropriate for their ethnic background and responded to their family's wishes for their diet.

Care workers told us how they always offered choice to people and supported them to make decisions about their care, including what they wanted to ear and wear each day. Another care worker told us, "I make sure people feel valued - I respect them and give them choices and dignity when I care for them."

We saw that care workers knew about people using the service from talking to their families, but did not have the information they required within the care files.

We were told that people were able to access advocacy services through the local authority and that both general and statutory advocacy services were available if people wanted to use these services.

People were not always supported to be independent. We saw that people were constantly supervised by staff and that tasks were done for them, instead of supporting people to do what they could. One care worker told us, "If they want a drink we will make it for them. They can't use the kettle on their own" and "They never do cooking for themselves. There is always staff to do the cooking and one to supervise them." This meant that people's freedom was not always respected and that the service was not working to maintain people's independence.

Requires Improvement

Is the service responsive?

Our findings

People did not receive care and support that was personalised to meet their individual needs. A relative told us, "I haven't seen their care plan since our first meeting and it wasn't finished then. Some things needed to be modified. It didn't cover important points for their health." Staff had not always appropriately assessed people's care needs, and when assessed they were not accurately recorded within people's care files.

In the care files we reviewed, we noted that people's risk assessments and support plans were not up to date and did not reflect the changes in people's needs or any incidents that they had been involved in. We saw in one person's risk assessment that it was to be reviewed annually or sooner in case of any incidents. The plan was more than one year old and had not been reviewed, and also in this time we saw t his person had been involved in incidents that required first aid and had been noted as having severe levels of behaviour that challenged the service. The risk assessment was not appropriately detailed or informed by recent incidents for staff to be able to provide safe and appropriate care for this person.

We saw the risk assessment and management plan for one person with a health condition that had not been updated since they started using the service in early 2014, and the plan was not appropriate for the service that was being provided. The risk assessment also did not reflect the recent health problems from this condition the person had and the increased support needs that related to this.

Care plans did not include the details of people's life histories and preferences and did not provide enough detail for care workers to be able to provide appropriate support. Risk assessments had identified severe levels of challenging behaviour but did not have detail about how to manage these behaviours or respond safely to violent or aggressive behaviour.

We saw there were frequent gaps in record keeping in care files and daily reporting that would impact upon people's care and support needs. We saw that sleep monitoring charts that were supposed to be kept daily were not always completed. This meant that behaviours related to sleep could not be effectively monitored and inappropriate support could have been given.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service and their families were able to give feedback about their care to care workers and the registered manager. We saw examples where family members had written to the manager about their relative's care, giving suggestions for what should be provided for them. We spoke to staff who confirmed that they knew about these suggestions and had implemented them in the care they provided. However, these changes had not been updated within people's care plans.

We were told by staff they would regularly meet with family members to discuss their relative's care and address any concerns that they had about the care provided. We saw details of how they met with one family on a monthly basis to monitor the care being provided and that changes were made based on these meetings. Relatives told us they knew how to complain and had been able to raise their concerns with the registered manager

Inadequate

Is the service well-led?

Our findings

We spoke to a relative who told us, "Communication is key and it doesn't always work. They aren't very efficient in how they run." The provider had not gathered data about the service in order to effectively monitor the quality and safety of the service. There were no audits completed routinely and we saw that care plans, medicine charts and risk assessments had not been reviewed and audited by the dates that had been set for them.

Risks to people were not always identified, monitored or effectively managed and there was no evidence of any learning or change to care provided in response to any incidents. One relative told us, "I'm concerned that there have been several incidents and that their care is managed properly and any problems are reported and investigated properly." We saw that risk assessments and care plans were not updated or reviewed in response to nay incidents and there had been no audits of medications to identify any errors in how medicines were being given to people.

We saw examples of recurring incidents involving the same people and staff, but there had been no changes to the way that care was delivered to this person and no evidence of learning from these incidents.

The incident report forms were all kept within people's care files with no central accident and incident log for any incidents to be reported in. This meant that there was no easy way for staff to monitor any patterns in accidents and incidents and they were not able to learn from any incidents that had occurred.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider has not submitted any safeguarding notifications to CQC as they were required to do as a condition of their registration. We saw examples of incidents that had resulted in injuries to people that had not been notified to CQC.

This was a breach of Regulation 18 Care Quality Commission (Registration) 2009.

Staff told us that the registered manager and senior team were open and they were able to speak to them about any concerns or issues they had. One staff member told us, "They [the registered manager] would listen to any suggestions. I've given them ideas and they have done some of them."

Family members of people using the service were able to make suggestions about the service and have been involved in the development of the service. We saw that one parent had been involved on the interview panel for new care workers to make sure that people working in the service could relate well to people using the service their families.

We spoke to staff members about their experience of working at the service. They told us that they felt well supported by the management and could ask for support. They all knew about whistleblowing and felt confident that they could raise a concern and that it would be listened to and investigated.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 10(1)(a)(b)**

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People did not have up to date and adequate care plans, risk assessments and records of their care. Regulation 20(1)(a)**

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff did not have adequate or up to date training necessary to support vulnerable adults and staff appraisals were not up to date. Regulation 23 (1)(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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services and others were not protected against the risks associated with unsafe or unsuitable care as risk assessments, care plans and support plans did not meet their needs. Regulation 9 (1)(a)(b)(i)(ii)

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 29 May 2015

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with unsafe use and management of medicines. Regulation 13.

The enforcement action we took:
We served a warning notice and the provider was told they must become compliant with the Regulation by 29 May 2015

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 29 May 2015

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures in order to ensure that no persons are employed for the purposes of carrying on a regulated activity unless that person is of good character, and ensure that information specified in schedule 3 is available in respect of a person employed and such other information as appropriate.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 29 May 2015.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The service had a high number of incidents that have not been notified to CQC and have not been reflected in people's care plans or risk assessments. Regulation 11(1)(a)(b)

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 29 May 2015.