Inshore Support Limited

Inshore Support LTD - Supported Living

Inspection report

Lynwood House
Dudley Road
Stourbridge
DY9 8DU

Tel: 01384421460
Website: www.inshoresupportltd.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The overall rating for this service is requires improvement

About the service:
Inshore Support LTD - Supported Living is a supported living service providing personal care to 21 people with learning disabilities, and physical disabilities. All people receive a minimum of one-to-one support throughout the day and night

People's experience of using this service:
There was a high use of agency staff and staff turnover meaning consistent care and support was not always delivered. Relatives, staff and professionals told us that there was a lack of activities and this effected people's quality of life and behaviours.

Quality assurance processes were not effective and did not pick up all the issues we identified. This included care plans and risk assessment not being accurate and up to date.

Systems and processes were not being used effectively to ensure people received good quality care. We saw monitoring charts that were not effective in relation to fluids and medicines.

The provider had not assessed people's capacity in relation to day to day decisions and there were restrictions written into people's care plans with no supporting evidence. It was not evident whether people had agreed or consented to some areas of their care and treatment or had contributed to the development of their care plans.

People were supported to access health care services when they needed, and we saw referrals had been made to the local community teams.

Relatives said they could talk to staff. People and relatives were confident if they raised a complaint, it would be dealt with appropriately.

Rating at last inspection
At the last inspection the service was rated good (report published 04 June 2016). The overall rating of this service has dropped since the last inspection.

Why we inspected
This was a planned inspection based on the ratings at the last inspection. The inspection took place on 03 and 04 April 2019

Enforcement
Full information about The Care Quality Commission's (CQC) regulatory response to more serious concerns

found in inspections and appeals is added to reports after any representation and appeals have been concluded.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Inshore Support LTD - Supported Living

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector and an assistant inspector.

Service and service type:
This service provides care and support to people living in their own homes, known as a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is small, and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
We sent the provider a provider information return (PIR). 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. Before our inspection, we reviewed the information included in the PIR along with information we held about the

home. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We contacted the local authority who commissioned services from this provider, they had concerns similar to what was found on inspection.

During the inspection five people shared their views about the support they received, not everyone was able to do this, so we also spoke with four relatives. Fourteen staff members were spoken with along with the registered manager who was available throughout the inspection.

We looked at the care and review records, for five people who used the service. We also reviewed management records for how people were administered medicines as well as a range of records relating to the running of the service were also looked at. These included incident and accident monitoring as well as complaints. We viewed three staff files and training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Staffing and recruitment
• The correct number of staff were on shift each day however, there was a high staff turnover and agency use which impacted on people's day to day lives. All people received a minimum of one-to-one support throughout the day and night.
• Staff told us that people could not always complete the activities they wanted to, because both permanent and agency staff did not always have the skills or ability to support people effectively. A relative told us "It's a real concern for us, [person] doesn't often get the chance to go out" and "When we ask why [person doesn't go out] we are told it's because of insufficient staff or no driver on duty"
• One person asked to go out for a drive in the morning, but staff told them they had to wait until the afternoon shift because there was no one who could drive their car. Staff told us the person was not able to use public transport because of risk.
• A professional who commissions services for people told us "All people funded should have sufficient funding levels to support activities relevant to their needs".
• Not all people had consistent staff teams, and this impacted on their wellbeing. A staff member told us "[Person] has a lot of consistency and that has helped with their behaviours, there has been a lot of improvement. It's a shame everyone can't have that"
• Relatives and professionals expressed concerns that relationships were not built with people because of the high staff turnover and agency use. A relative told us, "Staff turnover is very high. Staff who [person] gets to know tend to leave or get moved", a professional told us "When the staff are consistent and know the people well, the support is fantastic unfortunately this is changeable" and "I am concerned with the people who have left and the loss of consistency"
• The provider could not always demonstrate suitable people were deployed to cover shifts. One staff member told us in a 34-hour period, they had worked 27 hours, we also observed an agency staff member who was sat on a person's sofa with their eyes closed.
• The provider was recruiting new staff to fill vacancies. Recruitment checks took place however the provider had not explored all aspects to demonstrate new staff's working history was positive and that there were no concerns about their practice with other employers. We saw gaps in employment history that did not have an explanation.
• Rotas reflected the correct number of staff were on duty each day.

Using medicines safely
• Peoples medicines were administered as per the prescriber's instructions however, documents relating to medicines were not always filled out correctly and did not always identify issues that we found during inspection.
•One person had been administered an 'as and when required' medicine but it had not been signed for on

the medication administration record.
• One person's medicine record stated the time the medicine was given however the person's daily log contradicted this and stated the medicine had been administered one and a half hours later. We discussed this with the team leader who assured us the medicines were given at the correct time and it was a recording error.
• Staff told us they underwent medicines training and were assessed as competent before they could give medicines.
• People had regular medicines reviews with appropriate professionals.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People's care plans contained duplicate information and different versions of documents therefore, staff did not always have the most up to date information to follow. This included medicine care plans that did not match medicine records and multiple versions of behaviour management plans.
• Risk assessments were in place and staff said they had been updated, however the information was not always accurate. For example, we found someone else's name in a risk assessment and information that was conflicting in relation to times a person smoked.
• Staff told us they knew where to access care plans and risk assessments and had time to read them. Staff we spoke with could tell us what people liked and disliked and people's routines.

Systems and processes to safeguard people from the risk of abuse;
• Staff knew the correct procedure to protect people from risk of abuse. One staff member told us, "If you suspect or have evidence of abuse, or are uncomfortable with what you have seen then you report it. We encourage staff to refresh themselves on the policies".

Preventing and controlling infection
• A daily check system was in place to ensure a person's food was stored safely. The check had been completed by staff to say refrigerated food was in date, however we found out of date food in the person's fridge.
• Staff told us they had received training in infection control and we saw evidence of this. Staff told us personal protective equipment was available to them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• We saw people's choice were not always listened to. We observed one person asking to go for a walk and staff saying no because it was raining, there was no documented evidence in the person's care plan to state they could not go out if it rained.
• Where decisions had been made for people to receive treatment, for example dental work, the provider could demonstrate good practice in relation to The (MCA) however, the provider could not always demonstrate they had involved people in making day to day decisions and ensuring the appropriate consent had been gained
•There were decisions made for people in relation to day to day care with no evidence of capacity assessments or best interest decisions being undertaken. Relatives were signing records to consent on people's behalf without the legal right to do so. For example, one relative had signed to consent to a person's care and treatment and other relatives had signed to consent to photos being taken of people.
• Staff could not always tell us how people decided what they did each day and care pans did not identify why certain restrictions were in place around people's diets.
• The provider had followed the correct process of notifying the local authority so that appropriate applications could be made to the Court of Protection

Staff support: induction, training, skills and experience
• Staff told us, and records confirmed, they were supported through training. One staff member told us, "I have done my NVQ level 2 and am going to do my NVQ level 3, our training covers everything, it is really good." (An NVQ is a work-based qualification which recognises the skills and knowledge a person needs to do a job)
• Staff said they were well supported in their roles. Staff told us they had regular supervision and team meetings.

Supporting people to eat and drink enough to maintain a balanced diet
• One person required that their fluid intake was accurately monitored. Their care plan stated that jugs of fluid should be stored in the fridge and offered throughout the day with the amount of fluid being recorded. Staff were recording on a chart; however, this did not record the amount of fluid the person had consumed

to monitor this accurately.
• People had varied diets, one relative told us, "[Relative] has a varied diet, they like salads but will have a curry or the occasional take away from the chip shop, it is a good variety"
• Staff supported people to do their own food shopping and decide what they wanted to eat and drink.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access healthcare services including their GP and the dentist, however the outcome of health visits were not always recorded. A senior staff member told us that moving forward they would make sure that all appointments were recorded as soon as the appointment had finished.
• Where required, people had input from local community teams such as behaviour support and speech and language.

Adapting service, design, decoration to meet people's needs
• Staff supported people to keep their homes how they wanted them, one person told us how staff had helped them move their furniture so they could see their television more easily.
• One relative told us that the provider had helped the person to make a quiet room, they said, "[Person] has a quiet room and it has sensory lights, [person] like to sit in there for quiet time.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect..

Supporting people to express their views and be involved in making decisions about their care
• Care plans and risk assessments did not demonstrate how people had been involved in making decisions made about their care or how they were supported to express their views.
• One person required the use of a visual board to plan their day, staff told us it is usually in the kitchen, but it was not in use on the day of inspection and staff did not know where it was.
• Records reflected peoples likes and dislikes; a relative told us, "[Person] is happy with what they do, [person] has things in their home they enjoy".
• One staff member told us, "[person] said they did not want to go on holiday they wanted day trips instead, so we did this".

Respecting and promoting people's privacy, dignity and independence
• Staff did not always treat people with dignity and respect. We observed a person use the bathroom and leave the door open; the staff member had to be prompted by a senior worker to close the door. Another staff member talked about a person's behaviour that challenged, in front of the person.
• Staff told us they encouraged people to do things for themselves, one staff member said "[Person] can need lots of support but we encourage them to make drinks and breakfast and to do their own washing".
• A relative told us, "Staff encourage [person] to take their cups into the kitchen and wash up where they can"

Ensuring people are well treated and supported; respecting equality and diversity
• Whilst we observed positive interactions with staff and people, we saw two occasions where staff interactions did not have positive outcomes for people. For example, we observed a staff member talking abruptly to a person when the person came out of the bathroom asking for support.
• One person's care plan encouraged a diet that met cultural needs and we saw religious needs were offered to people where applicable.
• Relatives told us they liked the staff and staff were friendly. One relative said, "I could not wish for my [relative] to be in a better place, staff are pleasant and chatty".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff could not always demonstrate they gave people choice and control and responded to their needs
• We spoke to a professional that had been involved with a person for several years. They told us "I have suggested things that should be happening [for the person] but they [staff] aren't implementing them"
• Staff signed to say they reviewed care plans but there was no evidence of how this process involved or was communicated to people. Care plans did not always reflect people's current needs.
• One person had no toilet seat, they were unable to ask for a replacement so relied on staff to do this for them. Staff told us they break the seat regularly, we saw no plan in place to ensure the person had access to a new toilet seat whenever they needed one.
• A person's front door was unlocked and open when we visited them. Staff said they did this in case other staff needed to enter in an emergency. This response did not take into consideration the person's autonomy or choice.
• We saw some preferences being met, for example a person who smoked, had cigarettes with them and staff supported them to follow their tenancy agreement in relation to smoking outdoors.
• People had good links with family and staff supported people to maintain this. A relative told us, "I visit every couple of weeks and staff always ask [person] if they want to see me, it's their choice".

Improving care quality in response to complaints or concerns
• A complaints procedure was available, and we could see complaints had been logged and actioned.
• People could not tell us if they knew how to complain but a relative said "[Person] can make choice in their own way. [Person] will show you if they do not like something" a professional said "You will know if [person] is unhappy, they will tell you.
• Staff and relatives could tell us the correct procedure for making a complaint. A staff member told us, "I would raise concerns to my manger onsite or would inform the on-call. I would feel confident to raise a concern in this organisation"

End of life care and support
• There was no information provided about end of life care. We discussed this with the registered manager and they have since provided us with a document that they plan to implement. No one was receiving end of life care at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires improvement: The service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Care records did not accurately reflect people's current needs and the provider's audit systems and processes were not effective in identifying this.

• Systems and processes to assess if information was up to date, accurate and properly analysed were in place but were not working effectively. Audits undertaken had failed to identify the issues we found at inspection. These included concerns with care plan, risk management, consent and medicines.

• A medicine count sheet showed too much medicine in stock meaning the person may not have received their medicine as prescribed. We asked staff to count the medicine when we were present, the amount of medicine was correct but the recording of how much was present did not match. We saw 32 gaps on the same person's medicine count sheet for one month. This practice puts people at risk of potential harm and had not been identified through quality assurance processes. We discussed this with the registered manager who told us that senior staff should be identifying this when completing daily check and would look into this.

• One person had three separate behaviour plans dating back to 2011, this meant staff did not have clear guidance to follow.

• Concerns identified with records included, inaccurate risk assessments and care plans, lack of information relating to consent and lack of incident and accident analysis. For example, one care plan stated the person needed a restricted diet for epilepsy but no evidence as to why this was in place. The epilepsy plan written by professionals did not detail this and staff could not tell us why these restrictions were in place.

• The provider used feedback forms to seek people's views on the quality of the service provided. For two years consistently, feedback forms from either people, staff or relatives said there had been a decline in care. We saw staff and relatives had received outcomes. However, The nominated individual, who was also the quality assurance manager, could not tell us what had been put in place for people who were receiving care, who felt their care had declined during the last 12 months.

• Incidents were recorded at the end of the month but not analyses for patterns and trends, a professional told us "I have highlighted that the analysis does not actually analyse anything, it simply shows how many times something has happened. I have raised this with the provider, but it has not been actioned" The Registered Manager told us they identified issues and reacted to any changes but could not show us the documentation to evidence this.

A failure to have effective systems and processes in place to assess, monitor and improve the quality and safety of the service provided to people was a breach of the Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

•The registered manager had notified Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities. They displayed the previous CQC inspection rating in the office and on the provider's website

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care
• There were multiple sites that the registered manager oversaw. Staff told us they saw the registered manager between one and four times a month, depending on the site, and they told us that the registered manager was approachable.
• Not all relatives knew who the registered manager was.
• Staff had a good understanding of whistleblowing and told us they knew how to access policies relating to this.
• We saw meetings had taken place with some people and short- and long-term goals had been set.
• One relative told us they had met with the staff and discussed a lack of activities, they said they had seen some short-term improvements and hoped this would continue.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were records to show relatives and health professionals had been involved in some decisions about care and treatment. However, there was not always evidence to show that people had been involved in decisions. Care files lacked evidence to show how decisions had been made and best interest decisions and capacity assessed.
• Care plans stated religious preference. The registered manager told us "we have people who are religious, and some choose to practice this. We support them when they want to access their place of worship"

Working in partnership with others
• Staff communicated frequently with the GP and other professionals when required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient governance systems in place to monitor and improve the quality of the service.

The enforcement action we took:

We served a warning notice to the provider.