Alo Care Ltd

Alo Care Community Services

Inspection report

417-419 Lymington Road
Highcliffe
Christchurch
Dorset
BH23 5EN

Tel: 01425280250

Date of inspection visit:
10 March 2017
13 March 2017

Date of publication:
19 July 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We received concerns in relation to the management and running of the service. As a result we undertook a comprehensive inspection to look into these concerns.

The inspection took place on 10 and 13 March 2017 with further evidence and phone gathered following these visits. Alo Care Community service is registered to provide personal care to people living in their own homes. At the time of our inspection, the service was providing support to four adults. Three people in receipt of support required 2:1 staffing. All four people required 24 hour support and one person only received a service during the weekend as respite support.

As a condition of registration the service must have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager registered with us was not managing the carrying on of the regulated activity at the time of the inspection.

The provider organisation was in an unsettled state at the time we inspected due to several changes in the management structure. The provider organisation had brought in a consultancy to assist with the organisational structure and we spoke with them during the inspection. Alo Care Community was being managed by the group manager and team leader at the time of inspection. Neither of these staff had previous management qualifications or experience.

The consultancy firm had spent time identifying gaps in the provision at the service and there was an action plan identified to meet these at the time we inspected. Some improvements had been implemented but the majority were in the planning stage and it was not clear about who would be overseeing these actions once the consultancy left.

People receiving support had complex needs including learning difficulties, mental health and autistic spectrum disorder. Some people were unable to communicate verbally and needed support to communicate in ways which were meaningful to them. Each person needed support to develop and maintain relationships both with staff, relatives and other people.

.

The service was providing accommodation for people without the correct registration in place to provide this regulated activity.

People were not supported safely because there were no systems in place to monitor or manage the risks people faced.

There were risks that people did not always receive their medicines as prescribed because there were some inaccuracies and errors in recording and no systems in places to monitor these.

Where there were identified safeguarding concerns, there were no effective systems in place and the service had not alerted external agencies about these concerns.

Staff had appropriate pre-employment checks but references did not consistently include assurances about previous conduct. Staff had training in some relevant areas, but they were not enabled to access further training and did not receive supervision or support to develop their knowledge or skills.

The service did not have capacity assessments in place for people in line with legislation and did not have paperwork available to assess a person's capacity or make a decision in a person's best interest where this might be required.

We observed some staff with people and saw that they knew people well and understood how to offer them choices in a way which was meaningful to them.

There were no systems in place to monitor whether people were receiving a balanced diet or share how people had been or what activities they had been involved with. The electronic recording system meant that staff were unable to access information from previous shifts to see how people had been and what support they had received.

People did not have access to consistent methods of communication which were meaningful for them. Staff understood how to communicate with people but the lack of consistency meant that people were not effectively enabled to make decisions about their support.

People did not receive person centred care which meant that there was an increased likelihood that they may become upset and staff did not have clear guidance about how to meet people's needs.

Care plans identified goals which people wanted to achieve but did not include any plans about how to enable people to work towards achieving these.

Communication with relatives and professionals was not effective and we were consistently told that relatives were not updated or informed about how their loved one was being supported. Where complaints had been made, there were no consistent records of these and no evidence of investigations or outcomes from concerns raised. There was evidence that other electronic records had been altered by management to remove references to the use of restraint and to reduce the severity of incidents.

There were no systems in place to monitor the quality of services provided or to identify gaps or improve practice. There was a lack management oversight and staff did not have clear roles and insufficient management support.

Relatives all told us that the changes in organisational management were positive and gave examples of issues with the previous management structure. Monthly meetings had recently been introduced to enable relatives, staff and other professionals to meet and discuss how people were being supported and raise ideas and suggestions for improvements.

People had care plans which included a 'pen picture' which gave details about how people showed that they were upset or anxious and what support from staff would be helpful for people.

Staff understood how to support people when they became upset and consistently told us that they used restraint options as a last resort. They were able to explain what approaches they used to calm people and

understood what triggers people had which could cause them to become upset.

Staff spoke with genuine affection abut people they supported and were enthusiastic about suggestions and ideas to improve the support for people. They felt that the changes in management were positive and wanted the chance to move forwards and improve the service for the people in receipt of support.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach under the Health and Social Care Act 2008. The overall rating for this service is 'Inadequate' and the service is therefore placed into '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 time frame. 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.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

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 protected because the service did not have appropriate systems in place to protect people from harm.

People were at risk of not receiving their medicines as prescribed.

Risks people faced were not consistently managed safely.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to make decisions in line with legislation and where people lacked capacity, there were no best interests decisions in place.

Staff did not have the correct support to develop their knowledge or skills.

People were not supported to maintain healthy diets because this was not effectively monitored.

People did not have effective access to health services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not supported to communicate in ways which were consistent or meaningful to them

People were not provided with person centred care which met their needs and preferences

People were not supported to develop independent living skills.

Staff understood how to offer people choices and respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not consistently supported to work towards identified goals.

Communication with relatives and other professionals was poor and they were not included in decisions about people's care or treatment.

Complaints were not consistently recorded, investigated or responded to.

Relatives and staff spoke positively about the introduction of monthly meetings to discuss people's support.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have the correct registration to provide accommodation to people.

Staff were unsupported and did not have clear roles or responsibilities.

The service did not consistently keep accurate and contemporaneous records.

There were no effective systems in place to monitor the quality or services or identify areas for improvements.

Alo Care Community Services

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 inspection took place on 10 and 13 March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and able to assist us with the inspection.

The inspection was carried out by two inspectors and after the inspection visit we completed phone calls with relatives and professionals who were involved with the service to gather their views.

We spent the first day of inspection at the office and the second day visiting people. We continued to gather evidence following our visit to the office for the location because some information was not forthcoming. Where information was not provided, this was identified within the report
Before the inspection we reviewed information we held about the service. The provider had not completed a Provider Information Return (PIR) because we had not requested that they do so. A PIR is a form that asks the provider to give some key information about the service, what the provider does well and what improvements they plan to make. We gathered this information during the inspection. We also spoke with commissioners to obtain their views about the service.

During the inspection we observed staff interactions with three people who used the service and spoke with two further people. We also spoke with four relatives, five staff, the group manager, team leader and a management consultant appointed by the provider. The registered manager for the service was not available during the inspection. We spoke with four professionals who had knowledge about the service and observed care practices throughout the inspection.

We looked at the care records of four people and reviewed records relating to how the service was run. We also looked at four staff files including recruitment and training records. Other records we looked at included Medicine Administration Records (MAR), accident and incident information and daily notes.

Some information was not available when we visited the service and we requested that this was sent to us. Not all of the information we requested was supplied.

Inadequate

Is the service safe?

Our findings

People were not protected from the risks of abuse because situations where people had been placed at risk of harm had not been reported to external agencies to enable investigations to take place. We found records of nine allegations of potential abuse which had not been reported or investigated. For example, we were informed by a relative that they had found a large bruise on their loved one and had not been informed by the service about this. The incident had not been reported by the service and was raised with local authority by an external professional. Staff had recorded in the daily notes that the person had a 'red mark' but there was no incident form or body map completed. The service is required to raise any concerns with external agencies and also to notify CQC. Another concern had been raised that staff members had been behaving inappropriately with a person by arguing in front of the person. This was being investigated by the local authority but again, had not been reported by the service. Other concerns included an allegation that a person had been given a drink containing an ingredient to which they had a known allergy and they were subsequently sick. Other reports that staff had neglected people and not provided necessary care and support.

One staff member had limited understanding about how to protect people from abuse. They advised that they understood that people were at risk of financial abuse but said that they had not yet had training in protecting people from abuse. Relatives were not all confident that their loves ones were supported safely by the service. One said "I hope (name) is safe when they are there". Another relative explained that they had asked an involved professional to check the physical condition of their loved one every week to check for any marks or bruising. These additional checks were felt to be needed by the relative to monitor any signs of harm. They told us "we have to put our absolute faith and trust that they are supporting (name)".

Systems and processes were not being operated effectively to prevent abuse of people. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not consistently recorded accurately. This meant that there was a risk that people would not receive their medicines as prescribed. We looked at the Medicine Administration Records (MAR) for three people and found that for one person, there was a duplicate MAR for the same dates. This meant that the medicine had been signed for twice and staff were not clear about why this had occurred. This mistake could not have occurred if staff were following safe administration practice by signing the MAR after administering the medicines. We were only able to see the MAR for the few days prior to our visit and did not see records prior to this. A complaint form identified that on 18 February 2017, staff counting medicines noted that a person had not been given a prescribed medicine. It detailed that this medicine was then given but daily notes did not identify when this was given and this had not been reported as an error.

One person received a prescribed medicine which was not recorded on their MAR. Their care plan indicated that this medicine, prescribed to supplement nutrition was required three times a day but this was not included in the person's MAR. This meant that staff were not signing to confirm that this medicine had been given as prescribed and the only place this was recorded was in daily notes and these records were not consistently completed. For example, between 11 and 12 February 2017 there were seven daily records for

this person but none of them recorded that they had been given this prescribed medicine. On 19 February there was one daily record which indicated that they had received this medicine twice. No daily records we looked at stated that this had been received three times daily as prescribed. A staff member told us that the nutritional supplements had been on the person's home for a while and it was not clear why these were not included on the person's MAR. Another staff member told us that this supplement arrived with their other medicines each weekend. Both staff were clear that the supplement was required three times each day. However, it was not possible to monitor whether the person had received this medicine because there was insufficient recording in place.

The team leader explained that they took the MAR from people's homes to head office. However, there were no audits completed of the MAR to identify whether there were any gaps or errors in how people received their medicines. One person did not have pain relief included in their MAR. However daily notes showed that they had been administered pain relief on 20 and 28 February 2017. Daily notes indicated that the person was able to tell staff when they were in pain but because this medicine was not on their MAR, there was no guidance about when pain relief may be needed or how the person liked to receive this. Where other people had medicines prescribed 'as required', there were protocols in place which indicated when these medicines were needed and how the person liked to receive them. Staff told us that they had received training in administering medicines and this was reflected in the training matrix for the service.

There were no procedures in people's homes about how staff would support a person to safely evacuate their home in the event of a fire. Although people lived in their own properties, staff provided support 24 hours a day and would have needed to support someone to evacuate their home safely should this be needed. The staff training matrix indicated that of the 15 staff only three of these had undertaken fire safety training.

People's risks in relation to eating and drinking were not managed safely. One person was at risk of malnutrition. The persons relative and professionals expressed concern that the person's weight and food intake was not monitored regularly. The person was also supported to eat foods that were unsafe. Daily notes indicated that on 18 and 27 December they had eaten a food which was identified as unsafe in their care plan because the person was at risk of choking. Another person had a risk associated with their drinking. There was no risk assessment or plan to manage this risk and the person had become unwell as a result of this risk not being managed. Staff told us they would ensure that a care plan was in place relating to this risk. The service did not have any systems in place to monitor whether people had enough to eat or drink. Some staff recorded this information in people's daily notes but this was not consistent recorded.. Staff were unable to look back at what people had eaten or drank on previous shifts which meant that it was unclear if these risks were managed.

The service had not ensured that people received safe care and treatment. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment files included interview records and appropriate pre-employment checks. Checks with the Disclosure and Barring Service (DBS) were in place before staff started. Some references for staff contacted only dates of employment and therefore did not provide evidence of good conduct. This was an area for improvement and we saw that there was an action plan in place which detailed that a full audit of staff files was planned to ensure that there was consistency and that all files included sufficient references.

Other risks people faced were well managed. For example, one person was at risk when using the bath. There was a risk assessment which identified the potential risks and gave guidance to staff about how to

prepare the person and the environment before supporting with a bath. It also gave guidance for staff about what actions to take should the person need urgent support while in the bath. Staff understood these risks and were able to explain how they managed these in line with the risk assessment. Another person was at risk if they ate too fast. They had an assessment which gave guidance about how to manage this risk and staff told us how they supported the person to manage this risk in the way outlined in their risk assessment. Another person had a number of allergies. Their risk assessment gave information about what they needed to avoid and signs for staff to look for if the person had an allergic reaction. Staff were able to tell us about these allergies and what actions they would take if they noted any symptoms of an allergic reaction.

People were supported by sufficient numbers of staff to meet their identified needs. Three of the people receiving support required two staff to support them during the day. We looked at the staffing rotas for six weeks which confirmed that this level of staffing was provided. Where agency staff were used, these were consistently planned to work with a more experienced member of staff. One newer staff member told us that they always worked with a more experienced member of staff to support people.

Inadequate

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people live in their own home the Court of Protection makes decisions about when a deprivation of liberty is in that persons best interests. During this inspection we noted one person who was deprived of their liberty by order of the Court of Protection.

There were no consent forms in place for people and the service had not considered whether people had the capacity to make decisions about their support in line with MCA. People needed to make decisions about all areas of their care including support with medicines, possible use of restraint and agreement for staff to provide support. There were no capacity assessments in place or evidence that decisions had been made in people's best interests. Relatives advised us that their loved ones were not able to make decisions about their support and some were considering applications for legal powers to make decisions on people's behalf. The service had no records about whether relatives had any legal powers to make decisions for people but had not identified their responsibilities under MCA to consider capacity and consent of people who used the service.

One person had a tenancy agreement in place which had been signed on their behalf by a member of staff. There was no MCA in place or consideration about whether the decision was in the person's best interests. The staff member did not have any legal power to sign documentation on behalf of the person. A relative of the person told us that they would not have been able to sign this document or understand what it meant.

One staff member told us that they just attended MCA training and was able to explain how they would assess whether someone had capacity to make a decision. They told us "people we support lack capacity and we need to be aware of that". Another staff member explained how they sought consent from a person and gave an example about whether the person wanted a bath. If the person indicated that they did not want this, staff respected this decision. An action plan identified that all care files needed to contain decision specific MCA documentation. This told us that the consultancy had identified this gap and planned actions, however the provider did not have the required considerations in place at the time of inspection.

The service had not sought consent or acted in accordance with the Mental Capacity Act 2005 where people lack capacity to consent to support. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training in some topics which were relevant for people but were not supported to consider additional development options. Training was offered in a range of areas including positive behaviour

management, emergency first aid and learning disabilities. Where someone had epilepsy, staff told us that they had received appropriate training to understand how to support the person when they had a seizure. The majority of staff had also undertaken training in how to communicate using Makaton, however no-one at the service currently used this method of communication. Staff did not have access to other condition specific training which related to people they supported. For example, no training was offered in Autistic Spectrum Disorders. This was relevant because two people using the service had this diagnosis. In addition, staff told us that when they had asked for further training in areas they felt were relevant to people, they were not supported by management to access these. A staff member told us that they had repeatedly asked for training in mental health in order to better understand how to support a person who used the service but this had not been provided and they had stopped asking. The training matrix for staff identified that there were gaps in training staff had received. For example, of the 15 staff, six had not received training in communication using a picture exchange communication system (PECS) which was used by two people.

Staff received an induction into their role but the majority had not been supported to undertake this. The service had a training matrix which identified that three out of the 15 staff had received this. Staff told us that they had shadowed other staff to get to know people who received a service and understand their complex needs as part of their induction. One staff member told us that their induction had been sufficient and the shadowing had been enough to get to know people.

Staff also told us that they did not receive supervision and we saw that there were very limited supervision records for staff with most not having any recorded supervision. We saw that following the management changes, supervision sessions were booked in for staff but it was not clear about who would be undertaking the supervisions for staff or when these would be commencing. There were no systems in place for staff to meet with their manager to discuss their performance, best practice or identify learning and development needs. Competency checks including medicines and understanding about behaviour management techniques were planned by the management consultant but had not commenced at the time of inspection.

Relatives felt that some of the staff had the correct knowledge and skills to support their loved ones, but this was not consistent across the staff group. One relative explained that staffing over the previous few months had not been good and that they had asked the service to provide more experienced staff. They felt that only a few staff had the right knowledge and skills and were concerned that other, more inexperienced staff were less able to support their loved one's complex needs. The relative of another person spoke positively about some of the staff but did not have confidence that all staff had the necessary skills and knowledge to support their loved one. All relatives we spoke with told us that some of the 'core' staff were excellent at their jobs. One stated that the staff were "brilliant" and another told us about three staff who supported their loved and described them as "great and on the ball". A professional told us that the staff they were familiar with understood how to communicate with the person and had the right skills to do so. The impact on people was that they were not receiving a consistent level of support because staff did not all have the knowledge and skills to support people effectively.

Staff had not been supported through supervision or to access further learning or development. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not consistently have access to health professionals where needed. People's care plans provided information about what support a person may need before attending any appointments but not all staff were aware of this. For example, two people's files indicated that staff should use a social story to support them to prepare for any health appointments. One staff member was aware of this and explained how they used a social story with the person. Another staff member was not aware that this was needed and did not

think any support was required. A relative advised us that their loved one had an appointment booked with a health professional in December 2016. Staff had not supported the person to attend this and therefore the appointment had been missed. A professional advised that they had found difficulties in working in partnership with the staff to support people's healthcare. They told us they had been "raising issues since commissioning…phone calls and emails were not returned". We requested information about access that people had with healthcare services but we were informed that professional visit records were not available.

Some people required assistance to ensure that they ate safely. For example, one person needed encouragement to eat slowly and we saw that they were having their breakfast in two separate servings to ensure that they did not eat too quickly. Where someone was at risk of choking, staff were able to explain how they prepared the person's food in way which was safe for them to eat and this was reflected in the care plan for the person. The menu plan for one person identified that they should have some portions of fruit every morning and daily notes evidenced that this was provided as outlined.

Staff understood how to support people when they became upset and consistently told us that they used positive behaviour management (restraint) options as a last resort. They were able to explain what approaches they used to calm people and understood what triggers people had which could cause them to become upset. For example, a staff member told us that a person could become upset if they were hungry or if staff were talking and not including them in their discussions. They explained the approaches they used to support the person to calm themselves and we saw that these were consistent with the information in the person's care plan.

Requires Improvement

Is the service caring?

Our findings

People were not supported to communicate in ways which were consistent and meaningful to them. For example, one person used an online method of communication and a picture exchange communication system (PECS) at another service they were supported by and with their family. Their family and the other service advised that these were the person's preferred methods of communication. They did not have the same access to these at Alo Care Community Service which meant that the person had reduced options about how they communicated with the staff there.

Staff were able to explain how the person used gestures and items to communicate their wishes, however the person who had communication difficulties was required to use a less effective means of communication because staff at Alo care were not utilising their preferred method. The person had an Autistic Spectrum Disorder which affected their communication and ability to manage change. Their relative explained that routine and structure were important and that they could become frustrated at this change. Staff were able to tell us about communication aids the person used and that they planned to implement these but this had not been done at the time of inspection.

Another person used a picture exchange communication system (PECS) which their relative told us had been working well. However this system was not available at the inspection and staff told us that the person did not use this as it had been broken. Again staff told us that they were going to work on developing a new PECS system with the person using signs that they understood but this was not in place at the time of inspection. People did make efforts to communicate their wishes to staff, this could have been done more effectively with access to their preferred systems.

Staff told us about one person and described them as tactile. We observed that they touched staffs arm, hugged and clapped hands with staff. Their relative explained "(name) is a tactile person…I'd expect to see staff being tactile and holding hands while walking…(name) will get comfort from that". The person's care plan did not include information about the person's needs in relation to tactile contact with staff. There had been changes to the persons support staff following some staff being suspended. Following this, staff understanding was that they should not have physical contact with the person. A staff member told us "We're not supposed to have affectionate contact….if (name) approaches, we back away". Staff told us that they had been given these instructions verbally by management. Records stated that 'the changes that have happened in staff' may have been a reason for them becoming upset more frequently. An incident report on 16 March 2017 stated '(name) came over to staff and tried to engage in a hug, staff encouraged (name) to high five instead however this appeared to increase their agitation'. The person was therefore being denied appropriate, tactile contact with staff due to miscommunication from the service. This meant that staff did not have consistent guidance about how to enable the person to form positive, caring relationships with staff or other people.

One person was not receiving person centred care which reflected how they wished and needed to be supported. They required 24 hour support from two staff and their care plan outlined that they may become upset by seeing the same staff consistently. It stated that there should be 'regular changes of staff as a

preventative consideration'. Staffing had not been planned to meet this identified need and we saw that one staff member was sometimes on the rota to work seven days a week with this person. Staffing rotas were provided for seven weeks from 13 February. We saw that on four of these rotas, the staff member was planned to provide in excess of 120 hours a week with this person. Their relative explained "(staff member) had moved in" to their loved one's home. The consultant confirmed that the staff member had been told by a manager that it was ok to stay at the person's house and they had been living semi-permanently there. The relative had raised concerns on several occasions with the service since October 2016 but had received no feedback. A concern was subsequently raised with external agencies and following this, the member of staff was removed from the rota for the person. The provision was not person centred but had been designed to provide accommodation for the staff member.

We were advised that work had been started to change rota's so that the people's support was planned in a person centred way and encouraged staff to form appropriate and positive relationships with people. Staffing rotas showed that the person was supported by one staff member who knew them well while other newer staff were introduced. One staff member had worked with the person a few times and told us that they were always on the rota with a more experienced staff member.

People were not always supported to be as independent as possible. One relative explained that their loved one needed support to develop independent living skills and staff needed to assist them to plan, budget and choose their own foods. There were no plans in place about how to achieve this. On one occasion a staff member was observed by a relative to be on the phone while the person stood looking at shelves of food but did not offer guidance or support to decide what to buy. On another occasion a relative reported that their loved one had been taken to buy food and had chosen food which was more expensive and they did not have sufficient money. Another shopper had paid the shortfall at the till when the person was told they did not have enough. Staff had been with the person but had not supported them to budget to ensure that they had sufficient money. The relatives of another person felt that they were able to manage more independently with the correct support from staff. There had been a meeting with the person's family in March 2017 which had identified that 'Some behaviour plans are also needed and guidance for staff to allow (name) to become more independent and help (name) to take some more responsibility'.

The service had not effectively planned or provided people with person centred care designed to meet their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some staff with people and saw that they knew people well and understood how to offer them choices in a way which was meaningful to them. For example, a staff member suggested a place to visit to a person. The person declined this suggestion and the staff member suggested two other choices. The person was then able to decide which one they wanted to visit. Another staff member explained how they supported someone to make choices when they were in the community. One staff member explained how they were working with a person to enable them to manage situations where they were not able to do things immediately. This could make the person upset and the staff member was using visual prompts and cues to work with the person. A staff member explained how a person communicated with them when they were out. They told us that the person linked arms with staff and if the person gripped their arm more tightly, this indicated that they were anxious and the staff member provided additional reassurance to support the person to manage these feelings.

People were supported to maintain their privacy and care plans and daily notes reflected that staff were respectful when people wanted time alone. Staff explained how they supported a person to have a bath and provided them with privacy but ensured that they maintained their safety. Daily notes referred to people

having personal time when they wished. Staff were respectful of people's homes and we observed that they introduced themselves to people when they arrived. One person preferred to let people into their home themselves and staff told us this when we visited and ensured that we waited for the person to come and invite us in to their home.

Requires Improvement

Is the service responsive?

Our findings

Complaints made by people were not recorded and the service was not able to provide any records of complaints made, or investigations and actions taken as a result of complaints. Records in people's homes did not include any information about how to complain. A relative told us "I've put in several complaints" and explained that they had met with a senior manager but never had any feedback from the concerns they raised. Another relative told us that they had reported concerns about their loved one to a senior manager but had not received any feedback from this. Complaints made internally by staff were recorded electronically but these were not consistently acted upon. We asked to look at internal complaints raised between 18 December 2016 and 8 March 2017. Complainants included all Alo Care Ltd staff and not only staff who worked with the Alo Care Community Service. We were provided with records of 37 complaints during this time, with the majority raising issues with other members of staff, including senior management staff. There were no records about how these complaints had been handled, whether they had been investigated or responded too. This demonstrated that the service did not have systems in place which were responsive to concerns raised and meant that areas for improvement and action were not identified.

Complaints were not consistently recorded, investigated or responded to. This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans identified goals for people but did not include details about how to work towards these with people. For example, one person had a goal which stated 'For (name) to start working on developing an understanding of personal space and appropriate relationships'. There was no guidance for staff about how to support the person to work towards this goal. Another person's care plan identified one of their goals as '(name) to use their picture exchange communication system (PEC's)more regularly'. This person did not have a PECS at the time of inspection so it was clear that this goal was not being progressed with them and that their care plan had not been updated to reflect this. There were no reviews of people's care plans which meant that goals were not discussed to determine whether the person was progressing or had achieved their goal, or to set new goals which were meaningful to people. Staff were positive about ideas and suggestions they had about what people had identified that they would like to do and were enthusiastic about supporting people to achieve their goals. Staff understood people's likes, dislikes and interests but did not have the support or management oversight to be able to progress these ideas with people in ways that met their needs. Goals identified by people and staff were not reflected in people's care plans.

People supported by Alo Care Community Service needed one or two members of staff to support them when they accessed the community. Although we saw evidence that people went out frequently, there were no clear goals for people about what they wished to do or plans to achieve this. For example, a staff member told us that a person wanted to look into learning to drive and the person confirmed with us that they were interested in this. There were no plans in place which identified this goal or plans about how to support the person to work towards this. A relative explained that staff did not seek or arrange activities for their loved one and said "(name) wasn't doing anything and never went out….I arranged everything". They explained that they had asked on a number of occasions for their loved one to be supported to consider employment but this had not been arranged and the relative had searched and found employment which their loved one

undertook weekly.

Relatives gave examples where the service had not been responsive. One relative told us that the mobility vehicle belonging to their loved one had been damaged in December 2016 and the relative was not informed of this. Another relative explained that they had asked to see correspondence for their loved one and said "I ask and never get it". They explained that this made it difficult to be aware of any updates or changes with professionals involved. Relatives also told us that they had asked to have copies of staffing rotas so that they knew which staff were supporting their loved one, but these had not been provided. One said "We have never had rotas so never know who is on. When I ring staff they can't tell me who is on next".

Relatives told us that communication had been poor at the service. A relative explained "they don't communicate, we never knew what was going on". Another told us "we don't know what's going on from one day to the next". Another said "lack of communication is appalling and (there is) no adequate handover". Monthly meetings had been started in March 2017 and these were viewed positively by relatives who had been able to be involved in decisions about the support their loved ones received.

There were no systems in place to gather feedback from people in ways which were meaningful to them. Daily notes were recorded electronically by staff and we looked at what was recorded. Because of the system in place, staff were unable to see information about people after it had been recorded. This meant that it was not possible to access information about how a person had been on the previous shift, what they had eaten or drunk or what activities they had been involved in.

Relatives felt that the service had been more responsive since the management changes. For example, One relative had asked again for a rota and said "(name) immediately sent me a rota". They had felt this to be a positive reflection about the management changes. A different relative said "we were told when (name) had an accident….which was good, but it's the first time". The service had also just implemented communication books in people's homes which again was felt to be a positive change by relatives and staff. However these had not been used at the time of inspection so we were not able to determine whether this would improve communication at the service.

During the inspection, the service introduced monthly meetings so that each person, their relatives and involved professionals could regularly meet and discuss changes and progress. Relatives were positive about the meeting they had been involved with but told us that this was the first meeting of this type that they had ever been invited to and these had not been in place prior to the inspection. Records from the MDT were goal focussed and recognised the views and wishes of people's loved ones. They included actions plans and timescales for improvements and progress to be implemented but it was not possible at inspection to see whether these were followed up as planned.

People had care plans which included a 'pen picture' which gave details about how people showed that they were upset or anxious and what support from staff would be helpful for people. For example, one person's information stated 'it helps me when you give me space if I need it'. Care plans provided histories of people before they received a service from Alo care Community and gave detail about how they wished to be supported with every day tasks. For example, one person's plan detailed 'When washing (name's) hair staff must be mindful that they do not like water going in to their eyes and can become quite upset if this happens.' Staff were able to tell us about people's likes and dislikes in line with the information in people's care plans.

Inadequate

Is the service well-led?

Our findings

There had been changes in the management of the organisation immediately prior to our inspection. Some information and records we requested to assist our inspection were not provided for us to review.

There were no clearly defined roles or responsibilities for senior staff and the senior manager was not clear about their role in the organisation or who was responsible for specific areas of the service. For example, staff training had been led by one senior manager who had been suspended. This meant that their roles and responsibilities had needed to be met by other management staff and these roles had not yet been outlined or confirmed. The team leader was knowledgeable about people but had not been given a clear outline of their role or the authority to manage the community staff team. They did not have a job description or senior management oversight to guide and support them to lead the team of support staff. There were no staff meetings in place to provide staff with the opportunity to discuss and develop good practice.

Staff spoke positively about the recent changes which had been made to the management team. Relatives all told us that there had been serious issues with the management oversight of the service. One relative explained "They advertise as a full visibility company, but they are not". Another said the provision had been "shambolic since they started". They described issues which had arisen on the person's birthday and Christmas which had been caused by poor or mis-communication.

Relatives explained that they had been given incorrect or misleading information. One explained that a meeting about their loved one had been cancelled twice by management. When they did have the meeting they were given incorrect information. They had concerns about a staff member and were told that the staff member was working less shifts with their loved one. Staffing rotas showed that the staff member was in fact working seven days a week with this person on at least four weeks after this meeting took place. This evidenced that the relative was given incorrect information by the registered manager. Two relatives and a professional explained that management had told them that they would be moving to electronic communication but that this never materialised. One relative explained they would consider moving their relatives support provision to a different provider if a suspended member of staff were to be reinstated.

Staff were not encouraged to raise ideas or suggestions. A staff member explained that the "previous management team didn't listen to staff". Another staff member said "staff didn't have control or confidence about the structure (of management)". A professional explained there was a "lack of knowledge on the board about running learning disability services……..inadequate management oversight or modelling". The comment related to the management team prior to the recent changes.. The consultant explained that the directors of the provider organisation "recognise the deficits in their knowledge and have asked for training in every aspect of care". The service was not well led because it had not promoted a positive culture. Some records entered onto the electronic system had been altered by senior staff to reduce concerns. For example, an incident report in November 2016 had identified that staff had offered a person a reward if they calmed down. It also identified that restraint techniques had been used by two staff members. The altered version of the incident form removed the mention of the reward and removed the information about the protective techniques used.

Accidents and incidents were not consistently reported or used to identify trends or identify if changes to people's support was required. Some daily notes reflected that people or staff had sustained injuries including a cut to a person's finger and a person sustaining a bruise to their eye and hitting a staff member causing a bruise. This information was not reported as an accident or incident and no analysis was done to consider trends or whether and changes to support were required in response to these incidents.

There were no effective quality assurance systems in place at the service. We found that the last community care audit had taken place in July 2016. While some gaps were identified, others were not and no actions had been taken in response to the gaps highlighted. For example, the audit highlighted that staff had not received supervision and there were no staff meetings. There were completion dates for these actions of July and August 2016 respectively. However neither of these support systems for staff had been implemented at the time of inspection. The audit indicated that staff surveys had been sent out. These were not available for us to view at the inspection. The audit identified that there were no communication books in place for staff and that there were no regular fire checklists for people. Again these gaps had actions planned but these had not been completed. The audit did not highlight that there were no handover systems in place for staff to communicate effectively. There were no checks of medicines or oversight of daily notes. No methods for gathering feedback, monitoring or reviewing the support that people were receiving. The consultant working with the service had identified the gaps in oversight and we saw blank review forms and shift handover forms which were planned to be used. However there were no assurances about who would carry forward the required changes and improvements once the consultancy stopped working with the provider. This demonstrated that there were no systems in place to effectively drive high quality care at the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

One person received regular respite and stayed in one of the privately rented properties every weekend. The office manager explained that the person had "respite every weekend but extended sometimes" for longer if needed. They went on to explain that there was no tenancy in place for this and that the tenancy was between the landlord and Alo Care Community Service. We requested a copy of this and noted that the tenancy was in place as described. Because the person received respite provision and lived at this address every weekend, the provider is required to be registered to provide Accommodation for nursing and personal care at the Alo Care Community Service location. This meant that the provider organisation had breached a condition of registration by providing a person with accommodation.

This was a failure to comply with a condition of registration under section 33 of the Health and Social Care Act 2008.

Staff, relatives and professionals spoke positively about the team leaders for the service and also about the group manager. Feedback was that they trusted these staff and that when they had requested information or communication, these had been listened to and acted upon. One relative told us "(name) seems very proactive and I have faith in them". Staff spoke with enthusiasm about ideas and innovations to improve people's lives. One said "I feel better for the changes that have been made. I feel so much more supported and feel we are working as a team". We observed the team leaders taking calls from staff throughout our inspection and saw that they were encouraging, supportive and reassuring. A team leader was heard telling staff "If you've got any questions, just ring me or the group manager". Staff were unsettled but positive about moving forwards and making improvements. A staff member told us that the team leader was "helpful and supportive and easy to get hold of". Another told us "I have the faith now that I will have the support to progress". Another said "I hope they give us a chance, it can be amazing".

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	Section 33 HSCA Failure to comply with a condition There was a failure to comply with conditions of registration by providing accommodation for nursing or personal care.

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service had not effectively designed care to meet people's needs or preferences. People and those important to them were not enabled to participate in decisions about their support.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not consented to care and treatment. Where people lacked capacity, the service had not acted in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks people faced had not been identified and the service had not done all that was possible to mitigate any such risks.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because systems and processes were not established and did not operate effectively to investigate allegations of abuse.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not operate effectively an accessible system for recording, handling and responding to complaints made by service users or other persons.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not assess, monitor and improve the quality and safety of the service provided or maintain securely an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People employed by the service did not receive appropriate support, training, professional development or supervision to enable them to

carry out the duties they were employed to perform.

The enforcement action we took:

Notice of Proposal to cancel the regulated activity of personal care under section 17 (1) of the Health and Social Care Act 2008