South West Independence Limited

South West Independence Limited Care at Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
South West Independence Limited Care at Home is a supported living service providing personal care to people living in their own homes. We inspected one of the services which provides personal care to three people living in a shared house.

People's experience of using this service and what we found
People living at the service were not safe. People had not always had a thorough enough assessment and transition period which had impacted on other people already receiving a service. Staff had not always been able to keep people safe. Whilst incidents had been logged and reported similar incidents had not always been prevented.

The service had not taken steps to ensure that the Mental Capacity Act 2005 was followed to protect people who lacked capacity. There were restrictive practices in place, which had not been assessed and recorded in line with the Mental Capacity Act 2005.

Infection control risks had not been assessed and monitored. We identified one specific infection control risk to people living at the service and staff. There was no risk assessment or management plan in place for this. There was no specific plan in place to reduce and manage the risk of Covid-19. In one toilet there was a shared hand towel and no paper towels which increased the risk of cross-infection.

Risks to people had not been assessed and plans put in place to mitigate these risks. Some risks had not been identified whilst others did not have suitable management plans. Risk assessments were of poor quality. Care plans were not always accurate and had not always been updated to reflect the most current information.

Staff had not always been recruited safely; the provider's recruitment policy had not been followed Records sent to us following the inspection demonstrated staff had received training.

There was poor governance and oversight of the service. The provider had failed to ensure people received person-centred care following the new admission. Systems had not been operated to ensure the accuracy and effectiveness of care records, infection control risks had not been monitored and the provider had failed to comply with the Mental Capacity Act (2005).

The provider had not met the duty of candour regulation and had not informed relatives of the incidents at the service.

Staff morale was low, staff felt they had not been listened to about the unsuitability of the arrangements made for people receiving a service. Staff expressed distress at the unhappiness and disruption this caused

to people. Staff evidently cared about the people they supported and were focussed on their welfare.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 04 January 2019).

Why we inspected
We received concerns in relation to safeguarding people and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report. We have received an action plan from the provider and action has been taken to mitigate risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for South West Independence Limited Care at Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified seven breaches in relation to person-centred care, safety, safeguarding, staffing and recruitment, governance and duty of candour.

Please see the action we have told the provider to take at the end of this report.

Follow up
The provider sent us an action plan promptly following feedback about the inspection.
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

South West Independence Limited Care at Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in 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. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 03 August 2020 and ended on 06 August 2020. We visited the office location on 03 August 2020.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager.

We reviewed a range of records. This included three people's care records and two medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We raised concerns with the local authority safeguarding team. We liaised with the local adult safeguarding lead and the head of commissioning. We spoke with the chief executive and operations manager who submitted an action plan. We reviewed staff training records sent by the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse. A compatibility assessment had not always been completed before people moved into shared properties. One person's care record identified physical risks to others. The provider had failed to assess the impact and management of these risks on other people living at the service.

● People were not protected from assault by others and staff described how people had become distressed and frightened.

● Staff told us that it was difficult for everybody. Suitable arrangements had not been made to ensure people were compatible to live in the same house. One person was funded for one to one care. However, staff said they needed a greater amount of staff support. This impacted other people living at the service, who did not receive their funded time.

● Two people experienced care which no longer met their needs. They were no longer able to have their possessions in communal areas of the service as these were at risk of destruction or use as weapons. One person had their developing independence hindered as they were no longer able to participate in meal preparation which they enjoyed. Staff told us they tried to take people out in the community more. However, this was because their home situation was so disrupted, not as a way of meeting their care needs.

This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The provider had not fully assessed risks to people and put measures in place to mitigate these risks. We identified a number of risks to individuals at the service which had not been identified and mitigated. There was no risk assessment in place for one person in respect of behaviours that might challenge. Whilst a behaviour support plan was available this did not identify the specific risks or how these would be minimised to other people living at the service.

● One person who had a known history of harmful behaviour had no risk assessment in place. This meant that staff may not be aware of these risks or how to manage them. Part of their care plan stated, "All staff working with [Name] must carry out regular checks to reduce the change (sic) of choking."" There was no further information or risk assessment to guide staff about the specific risks and actions needed to mitigate this risk. The person was regularly supported by agency staff who would need to know these risks and how

to support the person safely.

● This risk of one person's specific behaviours was not included in the environmental risk assessment covering the service which also made no mention of the safe storage of hazardous substances.

● Risk assessments for two people living at the service were of poor quality. For example, both people had a risk assessment entitled, "Abuse risk assessment". This stated, "[Name] is vulnerable, therefore they are at risk of abuse". The risk assessment referenced the recruitment procedures, which were not followed, and use of body maps to record any bruising. The risk assessment stated, "Any potential referrals to the home for potential clients are assessed as to whether they are suitable to live with existing clients, and to ensure any risk of abuse is not increased." This risk assessment had not been followed and had not been sufficient to protect people.

● One person had statements in their care plan that implied they were at risk of touching people inappropriately, however there was minimal information to explain this. However, there was no evidence in the risk assessment or care records of this. The risk assessment offered no evidence of potential risk behaviours and did not consider that the person may be at risk from others. There was no information about how the person expressed themselves sexually or how to support them with this safely.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● Staff were not always recruited safely and the provider's recruitment policy was not always followed. We looked at the recruitment records of four members of staff and found three staff members did not have full checks completed before starting to work with people at the service. For example, one staff member had a reference giving dates of employment in 2018 where they were employed for 15 days. Their second reference was supplied by a friend five weeks after they started work at the service. References had not been obtained from their most recent employer. The registered manager told us they had applied for, but not received, this reference. However, there was no risk assessment in place to determine the safety of employing them.

● A second person had only one reference. Whilst emergency Covid-19 legislation allowed for the streamlined recruitment of staff it requires a suitable risk assessment be in place. No risk assessments were in place where full recruitment checks had not been completed.

This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not always deployed suitable numbers of trained and experienced staff. One person was provided with one to one support. It was evident, through the behaviours they displayed after admission to the service, they required a higher level of support to keep themselves and others safe. This meant staff were unable to provide the assessed staffing needs to others living at the service. It was unclear how a reduced staffing level had been assessed as they had a higher staff ratio in another placement. The provider failed to fully assess this person's support and staffing needs which meant at times there were insufficient staff deployed at the service. There was no evidence the registered manager had re-assessed the person's support needs.

● One person had complex needs and could display behaviours which challenge. Staff received no specific

training in how to support this person or manage their needs. Staff told us, "Our training was not sufficient to support them."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Documentary evidence of staff training was received following the inspection. This showed the majority of staff at the service had received training deemed mandatory by the provider.

Preventing and controlling infection

● Staff had not followed the provider's policy on infection prevention and control which placed people living at the service and staff at risk of infection. One person had a particular behaviour which placed people at the service and staff at risk of contact with their body fluids. The behaviour occurred several times daily and on several occasions other people and staff had been impacted by this. There was no risk assessment in place to identify and mitigate this risk. Staff told us that the amount of cleaning needed took up considerable time. The provider's policy states, "At the commencement of care risk assessments are carried out on individual service users in relation to the prevention of infection." There were no risk assessments in place.

● This same person had additional behaviours which put themselves at risk of infection but no measures were in place to mitigate this.

● Staff at the service were not able to tell us of any specific measures in place to reduce the risk of Covid-19 transmission, such as hand washing. There was no written information to guide staff on managing and reducing risk. We observed a shared hand towel in the communal toilet downstairs at the service. We notified the team leader about the risk of cross infection and the requirement for disposable paper towels to be available. Staff removed the shared towel but were unable to locate any paper towels.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● There were suitable systems in place to obtain, store and administer medicines. However, there were no easily accessible protocols for staff about when and how to administer 'as required (PRN)' medicines. Staff who knew people well were able to describe how one person indicated pain but there was no information in their care plan or their medicine records. This meant agency staff would be unable to understand when the person needed pain relief. There was no information available within the persons electronic medicine administration record about the amount of pain relief, symptoms and which medicine to give. There was a section available for this but it had not been completed. There was guidance in the person's paper care records but this was not easily accessible as it was not stored with the medicine records. This meant there was a risk of inappropriate administration of medicine.

We recommend the provider add the protocols regarding as required medicine to the electronic medicines administration system.

Learning lessons when things go wrong

● The provider failed to learn from incidents and put measures in place to prevent the risk of recurrence. One person at the service had displayed physical aggression which resulted in numerous incidents with detrimental impact on others. One person at the service demonstrated several risks but suitable measures

were not always taken. No risk assessments or management plans were put in place.

● Additional plans and risk assessments to prevent recurrence were not put in place.

● Staff knew how to report incidents but told us they did not receive feedback about any measures implemented in response to incidents.

Inadequate

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture at the part of the service we inspected was not positive and did not promote good outcomes for people. The quality of life for people living at the service was significantly impacted in a negative way. One person was not supported to have a suitable and successful transition which resulted in significant distress for others.

● Staff told us that two people were very unhappy and restrictions had been introduced to try to keep people safer. This included moving people's possessions, removing anything that might be thrown, staggering mealtimes, and introducing trips out of the service aimed at removing people from a situation rather than meeting their needs or wishes.

● Systems in place at the service had not identified a lack of accurate care plans. A member of staff told us, "There was not a lot of information about [Name]. A lot of it wasn't accurate." The lack of capacity assessments and best interest decisions meant the provider could not be sure they were meeting the needs of the people in the most appropriate way.

● There was a lack of plans in place to identify the new risks to the safety and well-being of people living at the service. Staff and relatives told us that two people initially living at the service were happy and had made progress with their independence. Staff told us this had now been negatively affected due to the risks within the service.

● The systems in place at the service had failed to identify that one person living at the service deemed to lack capacity had no evidence of any capacity assessment in their care records. There were restrictive practices in place such as locked doors, locked cupboards and one to one support. The lack of any capacity assessments or best interest decisions meant the provider could not be sure that care was being delivered lawfully or in the person's assessed best interests.

● A relative of one person told us, "[Name] does not like to share." Despite this they had been placed in a situation which involved shared communal space, with no strategies in place to manage this.

This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with were caring and concerned about the safety and well-being of people. They were upset about the negative impact people were experiencing. All the staff we spoke with described the impact on both the people supported and their colleagues. It was evident from statements made their concerns focussed on the happiness of the people they supported. The registered manager told us that they had contacted social service within a week of the transition to say that it was not working.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not acted on duty of candour. People's relatives had not been informed of the safeguarding concerns. We asked the registered manager to do this on the day of the visit to the service, however this had not been done four days later.

This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The provider had not met their regulatory requirements. We have identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a lack of systems in place to monitor the quality and effectiveness of the service delivered to the people at the service. The provider had failed to keep people safe. Shortfalls in care plans and risk assessments had not been identified. Where risks had been identified there were not always suitable measures in place to mitigate these risks. There was no system in place to monitor infection control procedures, particularly in regard to specific infection control risks from one person .

● There was no system in place to monitor the safe recruitment of staff which resulted in unsafe recruitment practice.

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

● Staff told us morale was low. We were informed staff members had previously enjoyed their role. A recent inappropriate admission to the service had led to staff feeling out of their depth. Staff were clear it was not the fault of the person but that it was an inappropriate placement and they could not cope. The registered manager told us that staff had worried been happy about the new placement as they were not sure it was the right place. The registered manager told us, "I thought we could make it work."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us, and meeting minutes confirmed, they had raised concerns about being unable to support people safely at the current time. Minutes show that the person's previous support staff said they needed two staff for personal care. This was raised by staff but no action taken.

● Staff said they were able to approach the registered manager and senior staff about people's safety and well-being. However, no actions had been taken which reduced the risks or improved people's well-being.

● There was no evidence to show others living at the service were supported to have an input about a new

admission. There was no evidence of a safe and suitable transition process.

● One person did not use speech to communicate. There was nothing in their records to demonstrate the provider had considered this and looked at ways to enable them to participate in a new admission to the service.

● We received an initial action plan from the provider aimed at addressing the issues identified. The provider had begun an investigation and reviewed management arrangements. Additional management support was provided at the service promptly after the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Significant changes at the service had a negative on people's safety and well-being. Their needs and choices had not been considered

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not assessed and mitigated. People were not protected from the risk of infection

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective system to monitor the quality of the service

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

	proper persons employed The provider had not ensured recruitment checks were carried out before employing staff

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not informed relatives about safeguarding incidents which had taken place at the service

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff deployed to meet people's assessed needs