St. Michael's Support & Care Limited

St Michaels Support & Care

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was the first inspection of this service at this location. We gave the provider two days' notice of the inspection, to ensure the registered manager would be present. It was also to help arrange visits to where people were receiving the service, as the service is spread across a wide geographical area including Watford, Enfield and Ilford.

The service provides care and support to people living in six 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

CQC only inspects the service being received by people provided with 'personal care', which is help with tasks related to personal hygiene and eating, including the prompting support needed where someone may not undertake those tasks without being prompted. For these people we also take into account any wider social care provided. There were 30 people using the service in this way at the time of our inspection visits.

The service had a registered manager. This 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 registered manager was present during the inspection visits, but in their new role as a locality manager. The service's new manager (the 'DCA manager') was also present during the inspection and had applied to the Care Quality Commission to become the registered manager.

People using the service were positive about it, telling us for example, "I think that this is a really good service" and "It's one of the better places I've been." Most people felt able to recommend it. Community healthcare professionals also spoke positively about the service. Staff said they would recommend the service.

However, we found service quality varied between schemes. At one Enfield scheme there was too much focus on supporting people's autonomy regardless of the impact on them. Some people were therefore not getting the support they needed to address cleanliness and food hygiene matters in their flats, and personal hygiene matters. The tone of some care records was disrespectful, adding judgements instead of reporting the facts of what occurred. Occasionally reports were not made where incidents occurred.

Where there was doubt that a person had capacity to consent to aspects of the care and support the service proposed to provide them, the service did not always assess the person's capacity. In one instance, where someone withdrew consent, it was not listened to, which caused them unnecessary anxiety. The provider was not therefore ensuring the service followed the requirements of the Mental Capacity Act 2005.

We found the service had not been deploying sufficient numbers of suitable staff to support people at the

Enfield schemes to stay safe and meet their needs. There had been a reliance on the scheme manager to cover vacant support hours, meaning they had not been able to manage the schemes effectively. We believe this contributed to the concerns we found at the Enfield schemes.

Systems of supporting people to take their prescribed medicines were not entirely robust across the service. Medicines stock checks were either sometimes inaccurate or people had not been supported to take their medicines as prescribed. The specific medicines training one person needed their staff to have in respect of their epilepsy had not been provided, leaving them at unnecessary safety risk should they have a seizure.

There were a number of governance systems embedded at the service, which helped to promote a positive and inclusive culture that achieved good outcomes for many people. However, they had not been effective at addressing the concerns we found.

The service supported people to express their views and make their own decisions about their care and support. Staff had built good relationships with most people and communicated well with them. Most people were given emotional support when needed. This had helped some people's recovery and development. It was seen as an achievement when people developed enough to move on from the service.

An Ilford scheme had recently made the final of the supported living section of a national award. This was primarily for helping people to live as independently as possible in the community and significantly reduce behaviours that challenged the service.

The service's systems, processes and practices safeguarded people from abuse and ensured appropriate action occurred when safeguarding concerns were raised. This was particularly evident at the Watford scheme, where responses to incidents and safeguarding matters included increasing staffing levels and installing CCTV at the scheme entrances.

The service supported people to follow their interests and access the local community when requested. It helped people to develop, re-establish or maintain relationships that mattered to them.

People were supported to maintain good health and nutrition, and to access appropriate healthcare services, both for physical and mental health. The service worked in co-operation with other organisations to deliver effective care and support. This included for assessing the needs of new people to make sure the service could meet their needs and wishes.

The service generally made sure staff had the skills, knowledge and experience to deliver effective care and support. Staff received good overall support for their roles in working with people. Robust staff recruitment procedures were followed to minimise the risk of unsuitable people being employed.

The provider engaged with and involved people using the service and staff in the development of the service. People's concerns and complaints were listened to, and used to improve the quality of care.

This is the first time this service has been rated Requires Improvement. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Reasonable precautions were not always taken to ensure people were safely supported. This was in respect of medicines management across the service, and infection control at an Enfield scheme.

The service did not deploy sufficient numbers of suitable staff to support people at the Enfield schemes to stay safe and meet their needs.

The service's systems, processes and practices safeguarded people from abuse and ensured appropriate action occurred when safeguarding concerns were raised. Robust staff recruitment procedures were followed. Most accidents and incidents were appropriately responded to, although occasionally reports at the Enfield schemes were not made where incidents occurred.

Is the service effective?

Requires Improvement

The service was not consistently effective. Where there was doubt that someone had capacity to consent to aspects of the care and support the service proposed to provide them, the service did not always assess the person's capacity.

People were supported to maintain good health and nutrition, and to access appropriate healthcare services, both for physical and mental health matters. The service worked in co-operation with other organisations to deliver effective care and support. This included for assessing the needs of new people to make sure the service suited them.

The service generally made sure staff had the skills, knowledge and experience to deliver effective care and support.

Is the service caring?

Requires Improvement

The service was not consistently caring. Many people were treated with kindness, respect and compassion. However, our findings at one Enfield scheme demonstrated there was too much focus on supporting people's autonomy regardless of the negative impact on them.

Staff had built good relationships with most people and communicated well with them. Most people were given emotional support when needed. This had helped some people's development.

People were supported to express their views and make their own decisions about their care and support. Their independence was promoted.

Is the service responsive?

Good

The service was responsive. It enabled most people to receive personalised care that was responsive to their needs. Some people were well supported with recovery programmes and to develop independent living skills.

The service supported people to follow their interests. It helped people to develop, re-establish or maintain relationships that mattered to them.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Whilst the provider had a number of useful governance systems, they had not addressed the concerns we found.

However, there were a number of governance systems embedded at the service, which helped to promote a positive and inclusive culture that achieved good outcomes for many people.

The provider engaged with and involved stakeholders such as people using the service and staff in the development of the service. The service also worked in partnership with community professionals in support of this.

St Michaels Support & Care

Detailed findings

Background to this inspection

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

This inspection took place on 24, 25 and 31 January 2018, was unannounced, and was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was phoning people using the service to ask them their views of the service.

We gave the service 48 hours' notice of the inspection visit to ensure the registered manager would be present and to help arrange visits to where people were receiving the service, as the service is spread across a wide geographical area ranging from Watford to Ilford. The registered manager was present for the inspection, but in her role as a locality manager for some of the provider's services. The manager of the service (the 'DCA manager') was also present during the inspection, and had applied to CQC for registration as manager of the service.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

Inspection site visit activity started on 24 January 2018 and ended on 31 January 2018. It included visits to four of the supported living schemes, on 24 and 25 January, to meet people living at those schemes, staff working with them, to see how staff interacted with people, and to check records kept at the schemes. We visited the office location on 31 January 2018 to meet the registered manager and office staff, and to review care records and staff files.

There were 30 people using the service at the start of our inspection visits. During the inspection, we spoke with 17 people using the service, eight support staff, two scheme managers, the registered manager and the

DCA manager. We also contacted a local authority and other community professionals involved in the service for their views, receiving two replies.

During our visits we read 11 support plans for people using the service and other records about people's care and support including for medicines, incidents and care delivery. We looked at the personnel files of five staff members to look at their recruitment records, training and supervision. We read records about the management of the service such as staff visit rotas, incident summaries and quality audits. We also requested further specific information about the management of the service from the management team before, during and after our visits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "Support is provided: No drug dealing, no threats, as I have experienced before." Another person said, "If there's an argument or any noise in the house then staff would soon sort it out."

People told us the service helped them manage medicines where needed. One person said, "I have a dosette box which organises my meds for me; I self-administer." Another person told us, "I pick up meds myself from the hospital pharmacy and bring it back to the house for staff to check it before putting it in the locker in my room." A third person said, "I take them myself but I am supervised when I do so."

People who needed support with their medicines received this from staff who were assessed as competent to provide this. There were assessments of needs and risks relating to each person's medicines. These resulted in individual support plans ranging from the service looking after people's medicines to people collecting their medicines from pharmacists and looking after them themselves. There were individual guidelines in place for when anyone had medicines prescribed for non-routine matters, for example, as-needed painkillers. Records were kept of medicines coming into the service and being returned to the pharmacy. Records for one person showed staff had identified they were about to run out of medicine and so took action help the person address this.

However, we found inconsistencies with the accurate recording of people's medicines. The provider had recently introduced a stock check sheet for anyone's medicines that the service looked after. It replaced a more detailed version that included checks on whether there were any discrepancies between the current stock and the previous week's stock. The management team explained weekly audits were also used to identify discrepancies; however, we found these did not consistently manage that.

We found the current stock checks were either sometimes inaccurate or people had not been supported to take their medicines as prescribed. In an Ilford scheme, staff had recorded how many weeks' supply was left rather than the numerical amount of stock, which meant accurate records for the purposes of audit were not being kept.

At the Watford scheme, weekly stock control records were sometimes inaccurate. One person was taking 28 tablets of a certain medicine a week. However, a stock control for the first two weeks of January went from 62 to 50, despite records of them taking the medicine as prescribed. The following week, the record was 116. This was 112 new tablets supplied, plus four instead of six remaining. This meant in the fortnight, two tablets were not accounted for. There were similar discrepancies for stock check records of their other medicines.

At that scheme, another person's dosette box across the previous week showed they were usually taking just one of two prescribed pain-relief tablets. The current Medicines Administration Record (MAR) did not record any occasions when they took only one tablet. The stock count of this medicine indicated the person took two paracetamol each day. The evidence at this scheme suggested stock counts were not accurate as they did not always check the actual available stock.

One person's inhaler had not been recently signed for when we checked their MAR. There were four omissions across the previous 24 hours for one inhaler, and two for the other. Whilst the scheme manager explained the MAR was used to remind staff to prompt the person to use their inhalers which they looked after themselves, the recording omissions did not help to demonstrate the prompting was consistently provided.

A risk assessment dated January 2018 showed one person at an Enfield scheme had potential need for a specific medicine if they had a seizure. However, staff and the management team confirmed staff working with this person had not had training on administering that medicine safely. This put the person at unnecessary risk of harm. Their care plan was out-of-date in respect of epilepsy as it stated the last seizure was in 2016. Their care records included a seizure in December 2017 that resulted in hospital treatment. This had not been recognised in the January 2018 risk assessment. This was not ensuring the safe care of the person.

Whilst there were no infection control support concerns across much of the service, when we visited people at some Enfield-based schemes, we found three people had not been supported to keep their flats clean and hygienic. One person's kitchenette had fat and grease marks on most of the work surfaces and on the walls. There were food stains on walls and items of crockery. In their fridge, there was a smell of rotten food and some meats had started to mould. One such packet of meat had a best-before date 14 days previously. Eggs had a best-before date of 27 September 2017. It was evident the person was unable to maintain a clean and safe environment without staff support.

Records showed there had been weekly health and safety checks of the person's flat, usually written by the person to state if there were any concerns, though occasionally indicating staff presence too. However, these had not identified the above concerns. We saw the matter had been risk assessed, but the cleanliness matters had not been discussed in the person's most recent fortnightly keyworker session. This was where the management team told us to expect follow-up work if staff had concerns. The management team acknowledged there had not been a clear support structure in place for this person to follow up consistently on health and safety matters identified from this process.

Another persons' weekly health and safety checks identified rubbish had not been removed and cooking equipment was not clean; however, the check the following week still identified these matters for action, rather than either check stating that any action had been taken. The service was not safely supporting these people with the control of infection.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team told us monthly infection control audits were now to start taking place at all schemes. Whole scheme monitoring reports noted that annual audits had not yet been completed.

The service had systems to ensure sufficient numbers of suitable staff supported people at some schemes to stay safe and meet their needs. For example, one Ilford scheme had two vacancies that were being recruited to. Whilst this process was taking place, staff took on extra shifts to ensure there were suitable cover arrangements. During our visit we saw enough staff to meet people's needs and support them. This was reflected in the way people did the activities they wished to safely. The staff rota also showed that support was flexible to meet people's needs.

People at the Watford scheme had varied views in respect of staffing consistency. Two people told us it

concerned them. One said, "There's a lot of temps, which is unsettling. I've had enough of it, it's hard to bond." However, some people did not think agency staff were used much, and two other people found no concerns with agency staff, for example, "I don't really notice the difference between permanent and agency staff, which is a good thing." Rosters showed there was regular use of staff from both local agencies and the provider's team of staff hired to work flexibly at different services whenever needed (bank staff). Staff told us, "This means we don't have to keep inducting new staff." The management team told us of ongoing recruitment for this scheme, and of a second staff now always working at night due to increased needs at the scheme.

The service was, however, not supplying enough staff to meet people's needs at two Enfield schemes. This was because since November 2017, the combined hours worked by support staff at those schemes was significantly less than the combined support hours funded for those schemes. It was an average of 27 hours short per week across the nine weeks preceding the inspection. This included being 47 hours short for 336 funded support staff hours in the first week of January. This put people at unnecessary risk of unsafe care that did not meet their needs. The management team told us that, in terms of consistency, the scheme manager covered some of these shortfalls. Whilst that may have helped, there was separate funding for the scheme manager role. This may have impacted on their ability to manage those schemes effectively.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff personnel files showed the provider had a robust staff recruitment procedure. Applicants were interviewed by two members of the management team, and were required to take a written exercise to demonstrate knowledge and written skills. Checks were also made before offering employment, including appropriate written employment references, identification, right to work, and of criminal records (DBS disclosures). Written risk assessments were undertaken where these checks identified potential concerns. This was good practice and helped to protect people from the risk of unsuitable staff being employed.

The service had systems to assess and manage risks to people, to balance their safety with their freedom. Care records showed there was clear information for staff on how they should approach a person who was upset or distressed, and actions they should take if this occurred. We saw that staff put this guidance into practice. Staff told us of checking on people's welfare if they had not been seen in the morning, but not to be imposing towards them. However, they had to raise alerts as per written guidance if people had not been seen for 24 hours.

People's care files included up-to-date risk assessments related to individual safety matters. This included for everyone in respect of potential relapses in their mental health. Other risk assessments were based on particular risks to the person, such as for medicines management, hygiene, community presence, addictions and self-harm. The information provided strategies for staff to enable people where possible. Staff were aware of risks to individuals and consequent strategies, as they told us they shared risk information when concerns occurred plus during shift handovers and staff meetings. Records showed updated risk assessments were brought to the attention of staff.

We had been notified of incidents at some schemes of the police attending due to aggressive behaviours from people using their service or by their visitors. Staff told us they had training in dealing with aggressive situations. This included working on trying to calm situations through discussion, liaising with the colleagues and senior staff for advice, and calling the police as a last resort. There were risk assessments for people whose behaviour challenged the service that focussed on how to respond to them individually. Staff told us these were reviewed following incidents and information was discussed within the staff team to

ensure everyone was aware of risks and how these were being managed.

The service's systems, processes and practices safeguarded people from abuse. There was an extensive safeguarding policy in place. Staff had to complete training on safeguarding people from abuse, and records showed essential information was covered on the first day of work for the provider. Staff we spoke with knew what constituted abuse, and how they were expected to report any concerns to managers. They knew to raise concerns higher if they did not think matters were being addressed. Managers knew they were required to report allegations to the local authority and the CQC.

The service had procedures to learn lessons and make improvements when things went wrong. Records showed many incidents, accidents and safeguarding matters were responded to appropriately at an individual level and information about these fed into broader analysis. They included referrals to external agencies, such as local authority safeguarding teams or people's local authority care co-ordinators. The management team confirmed that any learning as a result of accidents or incidents was discussed with the staff directly involved with the care of the person. Other staff were also made aware of changes overall through individual and group meetings.

There had been a number of recent incidents at the Watford scheme. This prompted a review of associated safety arrangements that involved the input of the local authority. Staff and managers explained there was now CCTV at the premises entrance areas, to help identify any visitors whose behaviour caused safety risks. One person confirmed this, saying there was a theft and so "they put CCTV up." The scheme's compliments folder included praise from someone about the CCTV. The management team told us incidents were reviewed at monthly staff meetings. However, at this scheme, as with some others, they were now starting to review and document all incidents on Mondays, to ensure better reflection on safety and more timely responses, particularly after the weekend. There had also been placement reviews for some individuals involved. Finally, they told us of improving the continuity of staff at that scheme in recent weeks, which staff and records confirmed.

We found three incidents arising at the Enfield-based schemes across the previous five months that had not been reported as incidents. This included hospital treatment of one person, an ambulance being called for another person that did not result in hospital admission, and the discovery of an agency staff member failing to administer someone a medicine. It was therefore unclear what action had been taken to minimise the risk of reoccurrence. It was also not possible for the service to effectively oversee risks to people's safety and welfare at these schemes. The management team agreed to address this matter to ensure no reoccurrence.

Requires Improvement

Is the service effective?

Our findings

People told us the service was effective. One person said of the scheme they lived at, "It's a well-run house, a good stepping-stone after hospital." Another person told us, "I enjoy living here." Staff reported an effective service that helped people to develop. One staff member said there was good teamwork amongst staff, adding, "We have amazing clients who have worked so hard and have achieved great results in their recovery." Records and feedback demonstrated the service had been effective at supporting some people to improve their quality of life, for example, in developing independent living skills and reducing behaviours that challenged the service.

However, we found the service was not always working within the principles of the Mental Capacity Act 2005 (MCA). This 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

People told us there were no unreasonable restrictions in using the service, with medicines support and smoking in rooms being occasionally mentioned as understandable exceptions. Most people felt there were no restrictions at all, for example, "There's nothing that I'm not allowed to do." People had signed consent documents for medicines support. Where plans to change this for one person had recently occurred, the consent form had been reviewed and updated with their involvement. The management team told us two people were subject to Court of Protection orders, neither of which impacted on the service being delivered to them. There were systems in place to ensure staff received updated training on the MCA.

At the Enfield scheme, a staff member told us everyone there had capacity to make their own decisions. However, we met one person there whose flat showed they had support needs in terms of kitchen cleanliness and disposing of items in their fridge when out of date. Recent records confirmed this, along with showing additional needs around personal hygiene. The management team confirmed the service had not undertaken any capacity assessments of the person's ability to make informed decisions or consent to support in these areas.

Following our visit to that scheme, the management team showed us a support agreement for disposing of food items that the person had now signed. However, a subsequent notification of the police attending to the person as a result of staff removing food from the person's fridge showed the person was not continuing to consent to that agreement. They had called the police to try to stop staff removing the food. As the service had not undertaken an assessment of the person's capacity to consent to this decision, and had not stopped removing the person's food when their behaviour showed they had withdrawn their consent, the service had acted contrary to the MCA.

Records showed the service had requested the person's social worker to assess the person's capacity for the

above decisions. However, as the service was to provide the care and support relating to the decision, such as encouraging and supporting them with cleaning and hygiene matters, the responsibility under the MCA of assessing the person's capacity to consent to the decisions was theirs, not the social worker's.

The provider had a policy on consent that followed the guidance of the MCA. One of its principles was that the service would "make decisions on behalf of people who use our services only if there is evidence that they cannot make the decision (at the time it needs to be made) because of mental incapacity." Their policy had not been followed for the above person.

The care file for another person at this scheme whose risk assessments showed they needed some support with keeping their flat clean and free of trip hazards, had capacity assessments for a range of decisions dated October 2014 and undertaken by the service. There was nothing in place to evidence a review of these assessments, to make sure the person retained capacity for the decisions. As the person was wearing blood-stained trousers from an accident they told us happened a while ago, we were concerned they may no longer have capacity to make their own decisions for all aspects of hygiene support.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service assessed people's needs and preferences to help ensure they could meet these. For newer people using the service, we saw records from previous care providers, indicating the service took these into account. Scheme managers told us they visited people to assess their needs, and enabled people to visit the scheme before decisions were made to offer a service. The management team told us the whole process was not only to ensure the service could meet the person's needs but that they would not put others at the scheme at risk.

The whole service generally worked in co-operation with other organisations to deliver effective care and support. One person told us, "Staff help with remembering my appointments." Another person said, "The staff say that they can't stop me from cutting but we can send you to get the right help." A third person spoke of attending a local resource centre that had been arranged with the support of the service. Staff and the management team told us of liaising with relevant community professionals where concerns arose about people's mental health, and of encouraging people to attend community support groups and counselling sessions. Records in people's care files confirmed this. Community professionals also informed us the service worked with them to support people towards good outcomes.

The service was sometimes using the Recovery Star system of regularly supporting people to holistically review their mental health. However, at one scheme, this had not yet been set up for one person despite them being at the service for two months. Two other people had them in place but without a review and update of their progress within that system. We did not see the system in use at another scheme. The management team acknowledged the systems was not yet properly embedded across the schemes, but there were plans to address this.

The service supported people to live healthier lives, have access to healthcare services and receive ongoing healthcare support. This related to physical health as well as support with mental health conditions. One person told us, "They do listen, especially when it comes to my physical ailments." Records showed that people were supported to register with a local GP if needed upon starting the use the service. Their care files showed good attention was paid to supporting community healthcare appointments. Where one person had unexpectedly refused to attend one appointment, the house diary showed a further visit had been booked. One person had diabetes. The management team told us staff supported them to plan appropriate

meals. Staff confirmed this, adding they helped educate the person on good nutrition for diabetes. People's care plans included good focus on maintaining or developing good physical health.

The service supported people to eat and drink enough and generally guided people to maintain a balanced diet. People told us of no concerns with nutritional support. For example, one person said, "They help me prepare something to eat." Staff at some schemes told us when people ate unhealthy diets they would "have a chat and find out why," to encourage healthier choices. People's care plans included what dietary support they needed and wanted. For example, one person's plan included weekly menu-planning support in respect of nutrition and health needs; another person's clearly indicated their preference of a vegetarian diet. People were supported to go food shopping where needed. Where appropriate, weight charts were kept and staff monitored how much people had to eat.

People told us they felt staff had the skills and knowledge to support them. Staff told us they completed online and face-to-face training. This included role-specific matters such as for understanding and supporting people who self-harmed or were aggressive, and on schizophrenia awareness. One staff member said, "I feel that Caretech has an excellent training programme and gives ample opportunities to gain further knowledge." Another staff member told us they could discuss issues with the management team and request additional training. This gave them guidance and support to carry out their roles.

Staff told us they had completed an induction for the scheme they worked at, including shadowing experienced staff and reading about people's support risks and needs. The process took at least five days before they started working alone. Records of this induction varied across schemes, but it was evident staff had induction processes tailored to the needs of people living at each scheme. They also attended a two-day formal induction for the provider within the first three months of working at the service. This also included a further two days training on working with the challenges that people using the service faced.

Staff told us they had regular developmental supervision meetings that included focus on their support, how working conditions were, and how people using the service were progressing. They said they could bring any issues to these meetings for discussion. Staff files showed regular supervision sessions that considered a wide-range of role-related support, annual appraisals, and occasional written competency checks of the understanding of particular policies such as for safeguarding people from abuse and appropriate professional boundaries.

Requires Improvement

Is the service caring?

Our findings

The service generally ensured that people were treated with kindness, respect and compassion. People described staff as "friendly", "helpful", "good to me", "polite" and "approachable." They praised the approach of staff. One person said, "Staff are good to me. They're not always like that in other places." Another person told us, "Staff will sit down and listen to you if you had something to say or share." A third person said, "Staff have so much patience, they stay calm and help you." A fourth person added, "I have my own space which the staff respect. They will knock on my door and await an invitation to enter before coming into my room." One person also told us of staff pre-warning them about fire-alarm testing.

However, our observations at an Enfield scheme showed there was sometimes a passive approach from staff in supporting people, despite us observing that people had unmet needs. For example, some people required safety support in their accommodation, keeping their living space clear from clutter and maintaining a hygienic environment. This included one person whose kitchenette had fat and grease marks on most of the work surfaces and on the walls, unwashed pots and pans, and out-of-date and moulding items in their fridge. Whilst there were recently recorded safety checks of this person's environment, staff had not helped the person to improve their living conditions.

One person was wearing a pair of trousers that had been heavily stained with blood. They said this was due to a fall "before Christmas." A staff member told us it was the person's choice to wear these trousers. This approach did not show due care towards the person. The management team told us this should have been identified and discussed in the person's recent fortnightly keyworker sessions. However, there was no specific reference to that in the record of the session.

One person we met at an Enfield scheme was still in their night clothes at 15:30. We saw no staff intervention to ask if they wanted assistance to wash and dress. Care records for this person showed other occasions when they had spent the day in night clothes. The records did not indicate staff offered them support, only that they sometimes encouraged the person to get dressed. There were also documented occasions when the person was told they were not welcome in the office if they did not get dressed.

This person told us they had not used their shower because they were afraid of slipping on the floor. Their care records for November 2017 and January 2018 included occasional references to them not having had a shower for several months. The management team confirmed there was no risk assessment relating to the person's hygiene support needs as the person was seen as independent for this, despite recognising that the person was refusing to take a shower. This matched the person's latest care plan dated November 2017, which simply stated that the person was able to attend to their personal hygiene and so did not provide staff with any support guidance in that respect. This whole approach to the person was not treating them with dignity and respect.

We identified concerns on the tone of care records relating to the above person. An entry in January 2018 stated they "took pleasure" in a behaviour that challenged the service and had "tried to antagonise and bully staff." Another entry stated the person was being "disruptive" without explaining how. The records

were adding judgements instead of reporting the facts of what occurred. The management team demonstrated they had identified this concern themselves and were taking action to address matters. However, a similar value judgement was seen in the person's September 2017 records, meaning the disrespectful reports had been occurring for a while.

The above evidence demonstrates failures to treat two people with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff displayed a positive and supportive attitude towards people. One staff member told us it was important to develop a trusting relationship with people, and to have an "open and flexible approach", as "nagging can discourage." Another staff member said the service provided "friendly staff who are easy to get along with and always there to go extra mile to support the customers."
The service provided most people with emotional support when needed. People at different schemes confirmed this. One person told us, "They are there when you need them." Another person said, "Staff listen to me all the time and are always at hand to offer support." A third person explained, "If I have a bad day or an issue to raise then I'll sit down with them and discuss anything and everything that may be bothering me, and they would listen."

Staff and managers told us of one person who used to self-harm before using the service, but who had hardly done so since. They attributed this to the approach of staff and the scheme manager, who were always accessible and that "we listen", which enabled the person to make their own decisions. This emotional support helped the person develop trust in the service. They also cited the physical set-up of the person having their own flat within the scheme, as this allowed more privacy than other shared-space arrangements, and that there were weekly planning meetings with the person.

The service supported most people to express their views and be actively involved in making decisions about their care and support. People told us of being consulted about their support, and of their opinions being valued. One person said, "I am involved in my care plans. They will show it to me and if I'm happy I will sign it off. If not, I would make my comments on the relevant pages for them to make any necessary adjustments." Another person told us, "I would sit down with a couple of key staff and go over what they would like to cover in the care plan. I feel that I have some input."

A few people also told us of weekly review meetings with keyworkers at which their views helped form planning agreements. Staff confirmed this occurred, explaining it was a "collaborative effort" that people could have a copy of agreements if they wanted although few people did. Records of these weekly plans covered a broad range of topics, for example, around attending community support groups, developing independent living skills, planning meals, and addressing concerns with landlords.

The service supported people to develop their independence. People told us they were independent but staff supported them if requested. One person said, "Staff are there to help when I need them." Another person told us, "I do GPs, doctors and all appointments by myself. I'm at the stage of moving on now so I don't need that help." A third person said, "They give you control."

Staff told us they supported people's independence. One staff member spoke of being proud of "supporting the customer to believe in himself and have courage to get employment and now looking forward to start his life independently." Staff and managers told us of one person who staff supported with specific community trips as they lacked confidence to go out easily alone. As the person's confidence was building, they were agreeing to plans to make certain trips more independently. We were also shown minutes from a recent multi-disciplinary meeting for one person where greater independence with medicines was agreed.

The person's medicines risk assessment was promptly updated, and the new approach was already being followed. This helped ensure the person was being supported to be as independent as possible.

Good

Is the service responsive?

Our findings

The service enabled most people to receive personalised care that was responsive to their needs. Staff and managers knew people as individuals, which helped people's support needs and preferences to be responded to. People told us they were involved in making decisions about their care, and most people told us of getting staff support when they needed or requested it. For example, one person spoke of having staff support in the community just with using public transport. Another person told us of their developing religious identity, adding, "I'm sure that if I wanted to take things more seriously then staff would provide the necessary support." A third person told us the name they preferred staff to call them. This was recorded in their file, and staff we spoke with knew it. They also told us weekly safety checks in their flat had been agreed for a different day of the week than most people's, at their request. Their care plan confirmed this.

People's support plans and records contained details about their likes and dislikes, what was important to each person, what their support needs were and how staff should support them. Care records confirmed most people received support in line with their plans. There was usually information about people's life histories, which provided staff with a timeframe and understanding of people's experiences. Support plans were reviewed on a regular basis, to help ensure they continued to reflect people's current abilities, needs and preferences.

Multi-professional review meetings took place regularly, to check that people's needs were being met at this service. The service ensured a report on the person's progress was available at the meeting, and that a record of the meeting was written up so that agreed plans could be promptly actioned.

The service supported people to follow their interests. People told us this was the case. One person told us of a group they attended, saying, "Staff used to come with me sometimes but most of the time now I go on my own." A staff member told us, "Service users are encouraged to take up meaningful activities in order to help them occupy their time instead of just spending all days in their flats." The management team told us the service was set up to support people to engage in appropriate activities of their choosing in the community. Care plans and review documents we saw reflected this. Whilst there was no activity provision at each scheme, support was provided if people wished to organise their own group activities, as most schemes had a communal living area.

Staff helped people where needed to go shopping or to visit friends and family. Some people had routines where they would visit places on a regular basis, while other people had more flexible plans. One person we visited indicated they had enjoyed their trip out with staff to have a coffee. Staff confirmed that this was the first thing the person did each time they went out.

The service supported people to develop and maintain relationships that mattered to them. At one scheme, records and staff feedback demonstrated people were encouraged to try to make contact with family members if they had become estranged. Staff supported people at their own pace with this. There was a visitors policy which stated that visitors were welcome with the agreement of the person using the service as long as it did not adversely impact on other people. Staff told us people could have visitors but there were

contractual and safety arrangements for visitors to sign on entering the premises and they were not able to stay overnight. People using the service confirmed this was the case. One person said, "We can have visitors here if we want, although there is a curfew time." Another person told us, "Sometimes people stay overnight with advanced planning."

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. Everyone told us they knew how to complain, for example, "If I made a complaint I know that the matter would escalate until it reached the right person who can make the decisions going forwards." However, most people clarified they had never needed to complain about the service. Comments included, "I would make a complaint but I have never felt the need to", "I would complain if I was unhappy with staff, but I have never had to do so" and "I've never had to complain because the staff here are sound." People were reminded of the complaints procedure in the service guides they were given and through the procedure being displayed in communal parts of some schemes.

Staff confirmed they knew what action to take should someone want to make a complaint. They were confident the management team would deal with any given situation in an appropriate manner.

Records showed a system for logging, recording and investigating complaints. This showed, for example, people being supported to promptly address issues relating to fellow tenants and their landlords. However, there were occasional concerns about how the service operated too. For example, one recent complaint was from someone who felt agency staff gained access to their flat without permission, even though this was only to provide them with medicines support. Records showed the matter was resolved to the complainant's satisfaction. A formal outcome letter reminded the person of further options if dissatisfied with how the complaint was handled and resolved. Complaints were reviewed within monthly scheme reports to the management team, and within staff meetings at schemes and across the whole service, so that learning from complaints could be shared.

Requires Improvement

Is the service well-led?

Our findings

Whilst we found there to be a number of qualities of a well-led service, our overall inspection findings including the regulatory breaches demonstrated the service was not always well-led. Quality and risk audits were not consistently effective as they had not identified the concerns and service shortfalls that we found.

There were some other concerns that did not demonstrate fully effective governance of the service in support of promoting the welfare of people using it. During our visit to the Watford scheme, the fire alarm panel was flashing to indicate a fault. Records showed this had been the case since 13 November 2017. Records and staff feedback reassured us that the fire alarm was still activating when needed. However, we were concerned that the fault had not been chased up after being reported for over a month, and required our involvement to help progress matters further. Records showed similar concerns with the emergency lighting being faulty since 19 October 2017 at that scheme. Neither matter was confirmed as fixed at the time of drafting this report.

The service kept oversight of overall staff training achievements. However, this did not include service-specific training such as the specific epilepsy training one person needed their staff to have, or for mental health awareness amongst all staff. We found three newer staff had not yet received that training. That governance system was not therefore fully effective.

The provider had a separate audit process that reviewed standards of care and support at each scheme. Their January 2017 audit of an Enfield scheme identified a number of concerns around infection control, applying the principles of the Mental Capacity Act 2005, and ensuring people were treated respectfully. Whilst there was a completed action plan in response, our findings indicate the process had not been effective at addressing the identified concerns.

The provider's governance framework had a number of strengths at monitoring service quality and welfare risks, and therefore taking action when appropriate. Audits took place at schemes that included for medicines, health and safety, and people's files. There were also monthly reports from each scheme by which the provider and managers could oversee specific quality and risk matters.

The provider's compliance and regulation team reviewed systems and processes at the service's office across two days in the autumn of 2017. We saw an extensive report arising from this, of what worked well and what needed improving. Our findings showed that a number of improvements had been made in line with the plan, for example, on staff file omissions in respect of recruitment and induction training.

The service promoted a positive and inclusive culture that achieved good outcomes for many people. At most schemes people were quite comfortable talking with staff and managers. The DCA manager and scheme managers we met knew people using the service well. They spoke positively of people using the service, and could identify people who had progressed. It was seen as an achievement when people developed enough to move on from the service. One scheme within this service had recently made the final of the supported living section of a national award. This was primarily for helping people to live as

independently as possible in the community and significantly reduce behaviours that challenged the service.

Staff told us they had a number of opportunities, such as staff meetings and handover meetings, to discuss the running of the service. They told us of good team work, for example, "Communication is good" and "Everyone brings experience and we discuss people lots." We saw this occurring. For example, staff had written up the minutes of one person's recent review meeting in advance of receiving the official minutes. The scheme manager explained this helped ensure actions were promptly taken for the benefit of the person. We saw examples to demonstrate that matters had already been actioned.

Staff told us they had approachable managers and that "suggestions are listened to" and given serious consideration. One staff member spoke of their manager's "encouragement and support to shine in my job role." A whistleblowing policy was available which staff confirmed they had received training on. This helped show the organisation was open in their expectation that staff should use this system if they felt this was necessary.

The provider engaged with and involved stakeholders such as people using the service and staff in the development of the service. People told us of being invited to occasional scheme meetings, and of sometimes attending. As one person put it, "We discuss issues relating to the service." Records showed these occurred between one and three-monthly depending on the scheme and the willingness of people there to attend. They covered a range of topics including people's concerns and feedback, group activity planning, health and safety matters, outstanding repairs, and scheme updates. Actions were agreed where needed and reviewed at subsequent meetings.

Surveys on service quality had been sent to people in December 2017. Results showed generally positive feedback across a range of questions, but with potential to review and act on weaker areas. The management team told us of a previous survey in the summer of 2017, results of which were discussed with people in meetings and if needed, individually, to aim to improve on services. It would therefore be possible to compare survey results.

Staff across most schemes had been provided with a similar survey in December 2017. Results had been collected to reflect staff working at different schemes. Whilst results were generally positive, there were distinctive and different areas to work on in respect of each scheme. The management team were considering how to make improvements as a result of the surveys.

The service worked in partnership with other agencies to support care provision and development. For example, the report from a local authority monitoring visit at the Watford scheme during the early summer of 2017 included much praise. The few actions arising from it had been addressed, such as for displaying the complaints procedure more prominently. For the Ilford schemes, we saw accommodation and progress reports were sent to the local authority on a fortnightly basis. This helped keep placements under review and enable close and proactive work with that local authority.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons failed to ensure that all service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons failed to ensure that care was only provided with the consent of the relevant person. This included acting in accordance with the Mental Capacity Act 2005 where the service user was unable to give such consent because they lacked capacity to do so. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that care was provided in a safe way to service users, including through: •Ensuring that persons providing care to service users had the competence and skills to do so safely, •The proper and safe management of medicines, and •Assessing the risk of, and preventing, detecting and controlling the spread of infections. Regulation 12(1)(2)(c)(g)(h)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons failed to ensure sufficient numbers of suitable staff were deployed to meet service users' needs at all times. Regulation 18(1)