Headway Shropshire

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Inspection report

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25 June 2021

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Headway Shropshire is a domiciliary care agency that provides personal care and support to people with acquired brain injury, living in their own homes in the community. At the time of our inspection eight people were receiving the regulated activity of personal care.

Not everyone using Headway Shropshire received a regulated activity. CQC only inspects the service received by people provided with 'personal care': for example, help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

People's experience of using this service and what we found
People did not always receive consistent care and support from staff.

People were often supported by staff who had not been introduced to them and did not know their specific needs or preferences.

The provider had assessed the risks to people associated with their care and support. Although most staff members were knowledgeable about these risks there were instances staff had been deployed to support people without the necessary training.

People, their relatives and staff members were not always informed about changes within the organisation or management structure. Staff members were unsure what the vision of Headway Shropshire was or the organisations goals for supporting people.

Staff members did not always feel supported by Headway Shropshire. Although, supervision sessions were arranged for staff members, some felt unsupported and isolated.

The provider had systems in place to review the quality of support they provided. However, these systems needed to be developed in order to ensure people received care based on their preferences and their current needs.

Not everyone's care and support plans reflected their current needs or preferences.

People were protected from the risks of ill-treatment and abuse as the staff team had been trained to recognise potential signs of abuse and understood what to do to if they suspected wrongdoing.

When required, people received safe support with their medicines by staff members who had been trained and assessed as competent. Staff members followed effective infection prevention and control procedures when supporting people.

People were supported to have maximum choice and control of their lives and the provider supported them in the least restrictive way possible and in their best interests; the application of the policies and systems supported good practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

However, the service remains rated requires improvement. This service has been rated requires improvement for two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Headway Shropshire on our website at www.cqc.org.uk.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Headway Shropshire

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
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

At the time of the inspection Headway Shropshire did not have a manager registered with the Care Quality Commission. However, they had recently appointed a manager who had started their role and was in the process of applying to become a registered manager. This means they will, along with the provider, be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care provider and the provider is often out of the office supporting staff or providing care. We needed to be sure they would be in.

Inspection site visit activity started on 17 June 2021 and ended on 25 June 2021. We visited the office location on 18 June 2021 and again on the 25 June 2021 to see the provider and staff; and to review care records, policies and procedures.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and six relatives about their experience of the care provided. In total we spoke with nine staff members including five carers, a care co-ordinator the facilities manager, newly appointed manager and the nominated individual (chief executive officer). We reviewed a range of records. This included four people's care plans and records of medicines administration. In addition, we looked at a variety of documents relating to the management of the service, including quality monitoring checks and we confirmed the safe recruitment of staff members.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They failed to safeguard service users from abuse. This was a breach of Regulation 13, Safeguarding service users from abuse, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They failed to ensure staff members were recruited safely. This was a breach of regulation 19, Fit and proper person employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12, 13 or 19 although improvements were still required.

Staffing and recruitment

• People gave us differing views regarding the staff who supported them. Mostly people said they had an inconsistent service regarding the support they received. They told us they were not consistently supported by staff who knew them or their individual needs. One person told us they get very upset when different people keep arriving at their house that they don't know. Another person said, "It's very unnerving for someone with a brain injury to keep having different people turn up. You try to get to know someone and then a different person arrives."

• People and relatives told us they often receive staff rotas with shifts marked "Yet to be allocated." They said they found this disruptive and went on to say this isn't updated when staff have been allocated. One relative said there was a heavy reliance on them to cover calls which couldn't be staff but recognised this was with their agreement.

• Others described a consistent service where they had developed a good rapport with staff who they saw on a regular basis.

• The chief executive officer told us they had been working hard to recruit and to cover staffing shortages with the use of agency staff members. They recognised this had been difficult recently and were working with individuals to ensure they received consistent care which met their needs.

• The provider followed safe recruitment processes when employing new staff members. The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.

Using medicines safely

• Not everyone receiving support from Headway Shropshire had support with their medicines. Generally, people were safely supported with their medicines by a trained and competent staff team. However, on two

recent occasions a staff member had been allocated a shift without the necessary medicine training. On one occasion this was agreed with the family who completed this role. The second required the staff member to contact the office and trained staff were then allocated to provide the necessary medicines. The manager told us the first incident was as a result of staffing issues and the second was a scheduling oversite which should not have happened. However, all those we spoke with told us they received their medicines safely and on time.
• The provider had systems in place to respond should a medicine error occur. This included contact with healthcare professionals, investigation into any perceived error and, if needed, retraining of staff members.
• People had guidelines in place for staff to safely support them with 'when required' medicines including the maximum dosage within a 24-hour period to keep people safe. Staff members were aware of these guidelines.

Preventing and controlling infection
• Staff members told us they had received training in infection prevention and control and knew how to minimise the risks of infectious illnesses. This included updated training in response to the COVID 19 pandemic. Staff undertook regular testing however, the providers records regarding the results of these tests contained many blank results. There was no indication anyone was put at risk. However, the providers oversite of testing needed to be more robust to assure people staff members were safe to support them.
• Staff members had access to personal protection equipment which they used appropriately when supporting people.

Systems and processes to safeguard people from the risk of abuse
• Those we spoke said they felt safe and when receiving support from Headway Shropshire. One person said, "I feel alright. No one's ever done anything I have been concerned about."
• People were protected from the risks of ill-treatment and abuse as staff members had received training and knew how to recognise and respond to concerns.
• Information was available to people, staff and relatives on how to report any concerns.
• The provider had systems in place to make appropriate notifications to the local authority to keep people safe.

Assessing risk, safety monitoring and management
• People were supported to identify and mitigate risks associated with their care and support. The provider assessed risks to people and supported them to lead the lives they wanted whilst keeping the risk of harm to a minimum.
• We saw assessments of risks associated with people's care had been completed. These included, but were not limited to, risks related mobility and access to community settings.
• Staff members knew the risks associated with people's care and support and knew how to keep people safe whilst providing personal care.
• The physical environment where people lived was assessed by staff members to ensure it was safe for people to receive support. When improvements were needed staff members advised people on how to safely make changes. For example, we saw one person was supported to contact Shropshire Fire Rescue to ensure their home was safe in the event of a fire.

Learning lessons when things go wrong
• The provider reviewed any incidents or accidents to see if any further action was needed and to minimise the risk of reoccurrence. For example, all incidents, accident and near miss incidents were recorded and passed to the provider for their review. They analysed these incidents to identify if anything could be done differently to minimise the risks of harm to people.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider the provider had failed to ensure staff had received appropriate updated training or support. This was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 although improvements were still required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's physical and social needs had been holistically assessed. However, people, relatives and staff told us they believed the care plans to be out of date. Further to this they believed the electronic task system, used by the provider, did not marry up to the information contained in the written records. People told us this didn't impact on them as they were able to tell staff members how they liked things. However, people consistently told us they would like to be involved in a review of their care.
• The new manager had reviewed peoples care plans. However, we questioned how they did this without consulting with the person, relatives or staff members. They told us this was a paper-based review based on the information in the records. They went on to say they were scheduling in a full review of everyone's care needs with them and any relative or advocate involved.
• The assessment we did see included, but were not limited to, mobility, skin integrity and nutrition.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessment. Staff members could tell us about people's individual characteristics and knew how to best support them. This included people's religious beliefs, backgrounds and personal preferences.

Staff support: induction, training, skills and experience
• People were generally assisted by an appropriately trained staff team, albeit the one scheduling incident when a staff member was incorrectly allocated to a call. Staff told us they completed an induction which included computer-based training and shadowing other more experienced staff members until they felt confident. However, people and relatives felt confused by the shadowing process. One person said, "We have someone come only once to see us and then that's it. We may never see them again or they just turn up. Once is not enough to get to know us." The manager explained to us the induction shadow process is over two weeks, but it covers a wide range of people who were supported and not just one person. The manager recognised this may need to be better communicated to people and relatives to avoid confusion.
• Generally, staff members told us they received regular support and supervision sessions. These were individual sessions where they could discuss aspects of their work and training. However, some staff

members told us they felt unsupported and isolated. One staff member said, "I know I can go to the office but I often don't know who I am talking to as so much has changed which I haven't been told about. This makes it difficult if I need to raise something."

Staff working with other agencies to provide consistent, effective, timely care
• Staff members had effective, and efficient, communication systems in place. This helped to share appropriate information with those involved in the support of people. Everyone we spoke with told us they found the communication with staff was good.

Supporting people to eat and drink enough to maintain a balanced diet
• Not everyone required support with eating and drinking. When they did, they were supported to identify what they wanted to eat. When it was needed the provider monitored people's food and drink intake and any weight gain or loss.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to refer themselves to additional healthcare professionals including GP's and district nurses when it was needed.
• Despite people telling us they felt they care plans were outdated they felt well supported by staff members who were knowledgeable about their needs and how to support them. People felt this knowledge was effectively passed on to staff verbally rather than rely on paper records.

Ensuring consent to care and treatment in line with law and guidance
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.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• People were supported in accordance with the principles of the Mental Capacity Act 2005.
• Staff, and the management team, followed best practice when accessing people's capacity to make decisions and knew what to do to ensure any decisions made were in the best interests of the person concerned.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider the provider had failed to notify us of specific incidents which had occurred. This was a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. The provider failed to have effective governance systems in place. This was a breach of Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 and 17 although improvements were still required.

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

- Headway Shropshire did not have a manager registered with the Care Quality Commission at the time of this inspection. However, they had recently appointed a manager who was in the process of completing their registration with us.
- The provider and management team had introduced, and followed, some quality monitoring systems since our last inspection. These included reviews of incidents, medicines and risk assessments. However, the provider needed to ensure further checks were completed to drive and maintain good care. For example, checks to ensure people's care and support plans met their needs, checks to ensure people were allocated the right carer to appropriately support them and checks to address any gaps in Covid 19 testing.
- The provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.
- The management team had developed an action plan of improvements which they intended to maintain and further develop. This included, checks on records and care plan reviews.
- Staff members felt confused about the general direction and vision of Headway Shropshire. One staff member said, "We should be a specialist in brain injury and leaders in the area. But this all seems to be a little watered down which could be as a result of managers changing. We need to return to a place where we can fully support people's rehabilitation."

Continuous learning and improving care

- The management team was relatively new to Headway Shropshire. The chief executive officer started in

April 2021 and the newly appointed manager started in June 2021. Both told us they kept themselves up to date with developments and best practice in health and social care to ensure people received positive outcomes. This included regular interactions with health care professionals and membership with a local provider representative organisation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives told us they didn't know about the changes in Headway Shropshire and were unsure who the current manager was. Staff members also told us they were unsure about the current management arrangements. However, at the time of the inspection the new manager had only just commenced their role.

• People and relatives told us they had not received a formal update from Headway in some time and the regular newsletters had stopped. However, during this inspection we saw a new newsletter had just been developed which introduced the new manager and provided outcomes to the last client survey.

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 Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.
• We saw the management team, and provider, had systems in place to investigate and feedback on any incidents, accidents or complaints.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were involved in decisions about their care, albeit they felt their plans were outdated. In addition, they were asked for their opinion as part of a survey and spot checks. All the feedback we saw was positive.
• Staff members had differing experiences regarding the support they received from the management team. Staff felt information could be better managed and clearer information about changes to the management structure could be more forthcoming. However, they did say when they contacted the out of hours team they felt supported and appropriately advised.
• Staff members understood the policies and procedures that informed their practice including the whistleblowing policy. They were confident they would be supported by the management team and provider should they ever need to raise such a concern.

Working in partnership with others
• The management team had established and maintained good links with the local communities within which people lived. This included regular contact with local healthcare professionals which people benefited from. For example, GP practices and district nurse teams.