A & A Healthcare Services Limited

A & A Healthcare Services Limited

Inspection report

1st Floor, Sorrel Horse House
1 Sorrel Horse Mews, Grimwade Street
Ipswich
Suffolk
IP4 1LN

Tel: 01473212089

Date of inspection visit:
22 August 2017
23 August 2017

Date of publication:
16 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

A & A Healthcare Services is a domiciliary care service offering personal care and supported living to people in their own home. All of the people who used this service had multiple diagnosed conditions including Attention Deficit Hyperactivity Disorder (ADHD), autism, mental health disorders, a learning disability and epilepsy. The people who were supported by this service displayed multiple behaviours that challenge. At the time of our inspection six people were using the service, the majority of whom were receiving 24 hour support.

We carried out this announced inspection on 22 and 23 August 2017 and this was their first inspection since being registered in January 2016. Notice was given so that the service staff could arrange for some people using the service to speak with us.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The people who used the service were not always safe and well cared for. People's care records included detailed risk assessments and guidance for staff on the actions necessary to keep people safe. However, risk assessments and the resulting guidance on how to help people to manage distressed behaviours was not followed by staff consistently.

Risks within people's environment were not always properly assessed. To protect people from leaving their home without staff support and putting themselves in danger, some of the people who use the service were locked in at their home and the key was removed from the lock and kept by the staff supporting that person. There were no risk assessments in place around people not having free access to leave the building in the event of a fire or other emergency situations. Nor did people have an individual personal emergency evacuation plan (PEEP) in place so that staff and emergency workers knew what support they needed in times of emergency.

People did not always have sufficient staff on duty to provide care and support to people when needed and as planned. Staff told us and care records stated that there were occasions when they were unable to start their shift on time.

People were not fully protected by the service's recruitment procedures, not all staff members were checked to ensure that they were of good character and were able to care for the people who used the service.

The provider had medicines policies and procedures in place which guided staff on how people were supported with their medicines, where required, safely. People's care records included guidance on the type of support that they required with their medicines. However, there had been occasions when people did not

get their medication on time and when it had not been available to them.

Staff were provided with training in safeguarding and they understood their roles and responsibilities in this subject, including how to report concerns. There had been a high number of safeguarding referrals that were being investigated by the local authority safeguarding team at the time of our inspection.

People did not always receive an effective service. Care staff felt that they received the training they needed to meet people's needs, however, we have been told by the local authority safeguarding team and other healthcare professionals that the staff did not always appear to be trained and supported well enough to support this group of people who had complex support needs.

Care records showed that for those people less than 18 years old appropriate consent had been sought for the provision of care and treatment. However, one person had recently reached 18 years and was being restricted from leaving their home alone because they would be at risk of being hurt or hurting others. The registered manager had not taken sufficient action to ensure that they were being restricted within legislative guidelines under the Mental Capacity Act.

People were not always supported to eat a healthy diet. Staff did not support people to make positive choices in eating and drinking to stay fit and not to eat or drink things that affected them adversely.

People were not always supported to have access to healthcare services. Healthcare appointments were missed.

People were not always supported in a caring way. People's relatives and professionals involved with people who used the service believed that some staff did not take sufficient action to build up a trusting and caring relationship between them and the people they worked with, saying that the staff were not consistent with their approach with people. Staff did not always show respect towards the people they supported.

People did not always receive care that was personalised and responsive to their needs. People's care plans were personalised to include detailed information about them, but care plans sometimes took a long time to be put in place. Staff were not always proactive in supporting people and sometimes did not follow the care plans to avoid confrontation.

The service listened to people's experiences, concerns and complaints, but the registered manager had no systems in place to record them, which would to allow us to see the complaints made or evidenced what action was taken.

Quality assurance systems were not robust enough and had not identified the concerns we found. The registered manager was also one of the directors of the organisation. The staff they managed told us that the registered manager was supportive. However, relatives and social care and healthcare professionals felt that the service was not well led.

The overall rating for this service is 'Inadequate' and the service has therefore gone into 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our

enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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

People's care records included detailed risk assessments but these were not always followed by staff consistently.

Risks within people's environment were not always properly assessed.

People did not always have sufficient staff on duty to provide care and support to people when needed and as planned. People were not fully protected by the service's recruitment procedures.

There were medicines policies and procedures in place but there had been occasions when people did not get their medication on time and when it had not been available to them.

Is the service effective?

Inadequate

The service was not effective.

Care staff received training. But staff did not always appear to be trained and supported well enough to support this group of people who had complex support needs.

People were not always protected from being restricted within legislative guidelines under the Mental Capacity Act.

People were not always supported to eat a healthy diet and they did not always have access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported in a caring way. Staff did not always develop caring relationships with people or find ways to work with them in a positive way.

People who could communicate verbally had opportunities to speak with the registered manager to express their views.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care that was personalised and responsive to their needs. People's care plans sometimes took a long time to be put in place and staff sometimes did not follow the care plans.

The service listened to people's concerns and complaints. But they were not recorded in a way that enabled us to see the complaints made or evidenced what action was taken

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems were not robust enough and had not identified the concerns we found. Relatives and social care and healthcare professionals felt that the service was not well-led.

A & A Healthcare Services Limited

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 checked 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 was this service's first inspection since they were registered in January 2016. The inspection took place on 22 and 23 August 2017 and the visits on both days were announced. Notice was given so that the service staff could arrange for some people using the service to speak with us.

The inspection team consisted of two inspectors.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make.

Also before the inspection we reviewed information we held about the service, such as notifications and information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with three of the six people who used the service and the relatives of two people on the telephone and by email. We also spoke with the registered manager and four care staff. We looked at records in relation to six people's care. We also looked at records relating to the management of the service, six recruitment files, training and systems for monitoring the quality of the service. We also received feedback about the service from the local authority and other healthcare professionals.

Inadequate

Is the service safe?

Our findings

This service does not always support people safely.

The people who used this service had multiple diagnosed conditions. Some of which included attention deficit hyperactivity disorder (ADHD), autism, mental health issues, a learning disability and epilepsy. Because of their complex diagnosis the people that were supported by this service displayed multiple behaviours that challenge. This behaviour often resulted from the interaction between personal and environmental factors and included aggression, self-injury, withdrawal and disruptive or destructive behaviour.

Due to people's complex needs they were supported by a range of health and social care professionals. These professionals did not always feel that the service worked well with them. Before our inspection we asked for feedback from some of the professionals involved with the service. Seven of them contacted us to share concerns they had about the service people received. Two family members also contacted us to tell us that they also had concerns about the way their relatives were supported related to their safety.

People's care records included detailed risk assessments and guidance for staff on the actions they should take to reduce the risks. However, risk assessments and the resulting guidance on how to help people to manage distressed behaviours were not followed by staff consistently. For example one person's social worker told us that, "Staff do not always have the same approach and this in turn sends mixed messages to the customer." This led to them becoming distressed on several occasions and putting themselves and the staff in danger of harm.

A family member told us, "There are things that [my relative] is better not eating or drinking. But [the staff] aren't consistent and don't stick to the care plan or risk assessment. They just give in, so when other staff sticks to the guidelines and say no [my relative] gets upset and breaks things up, hurt themselves or threatens the staff. This worries me so much; anything could happen my [relative] just isn't safe." They went on to tell us that this led to their relative being more and more restricted and losing out on opportunities to follow their interests and hobbies.

Daily records evidenced that the staff approach was not consistent and people who used the service were therefore not having their individual needs met. This, on occasion meant that they were not protected effectively from risk.

One person needed one to one support when they accessed the community, however on one occasion they persuaded staff that they were able to leave their home alone. As a result of this they were able to make a purchase that put them and their wellbeing at risk. Disciplinary action was taken against the staff and the incident was reported to the local authority safeguarding team.

Risks within people's homes were not always properly assessed. Some of the people who used the service were locked in to their home and the key was removed from the locks and kept by the care worker

supporting that person. This was done to protect people from leaving their home without care worker support and putting themselves in danger. These people had been assessed as not having the capacity to make an informed decision for themselves.

Two people shared a house, both shared some of the communal facilities, the kitchen and laundry for example. One person's care plans called for the main front and back doors to be locked at all times and for them and their staff to be locked in together within an area of the home that did not give them access to the outside doors. At night there was one care worker on duty who was awake and another who was asleep, who could be called on if needed. However, neither of them were based in that person's part of the building and the person was locked in alone. We were told by the registered manager that the night staff did go in to check the person at regular periods. The person did not have access to a call bell, but would not be able to use one. This meant that the person would not easily be able to evacuate the building in the event of an emergency situation, for example, if a fire broke out.

This person's care plan showed that they had a tendency to being violent towards staff if they were distressed or worried. Staff were knowledgeable about the behaviours the person presented, the care plan give detailed instruction. However, at times there were no other staff in the building available to help in this situation, the telephone was kept locked in the staff sleep in room and would not be easily accessible if needed. This meant that if the person or staff needed assistance to leave the building or get help they would not be able to easily access it.

There were no risk assessments around this person being locked into a confined area in the building, nor were there any evacuation plans in place in regards to this person's evacuation from the building in an emergency. Neither were there similar risk assessments and guidelines in place for other people who were locked in their homes. Nor did people have an individual personal emergency evacuation plan (PEEP) in place so that staff and emergency workers knew what support they needed in times of emergency.

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

People did not always have sufficient staff on duty to provide care and support to people when needed and as planned. Staff told us and records stated that there were occasions when staff were unable to start their shift on time. This was because they regularly worked with one person and directly went to work with another person straight afterwards but they had not been given rostered time to travel from one to the other. This meant that staff were often late arriving for people's visits or having to cut short the previous visit to get to the next person on time. This resulted in people having to wait for staff to arrive, which sometimes affected their plans for the day.

Care records showed when this lateness had happened and identified the result this had on the people who used the service. One care record stated, 'Today I started my shift late at [location] due to my delay arriving on shift, the reason for that was that I was leaving a shift with another service user at the same time I was meant to start the shift with [named person].' The record went on to record the effect that had on the person they were late for, 'When I met [named person] they were a little agitated because of me being late.' On another occasion it was recorded, '[Named person] is getting really annoyed because staff is late.' The next shift recorded, '[Named care worker] did the hand over and said that [named person] was annoyed because [they were] late the previous night and I was late [because care worker did not turn on time to release them to get to their next shift.]' On another occasion it was recorded that a person was, 'Really annoyed that people [staff] kept changing [their] shifts.' This was because they were told at 2.30pm that the care worker going to support them at 3pm had been changed.

This sort of uncertainty was disappointing and particularly unsettling for people living with autism as were all of the six people who were supported by this service. All of the people's care plans specifically said that unexpected changes to their routine were difficult for them to handle and could potentially trigger behaviours that challenge, possibly leading to violence and aggression.

The registered manager told us that they felt there were enough staff on duty to keep people safe, when asked about staff not having enough time to get between people's visits, they said staff had agreed to do follow on shifts and they encouraged staff to help each out by getting on shift on time and getting the hand over done quickly. However, shifts were not planned to have hand over time and if staff were late this impacted on people's care.

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

Some staff members had started work before their references had been received. One staff member had signed their contract in November 2015, one reference was dated 24 November 2016, their second reference was on the services' reference form but was not dated and the writer had not completed the form with their name, position in the company or date. Neither had they offered any means of being able to evidence it came from the company claimed. For example it had not been sent with company headed note paper, nor was it company stamped. However, it had been addressed as having come from the same employer as the first one.

Another staff member who started work in March 2017 had one reference dated 23 May 2017. Again there was no evidence that the reference was authentic, no follow up telephone check had been made to check its authenticity and the second reference chased later had been sent in June 2017. This indicated that, although the service's recruitment policy said they required two references in place before employing new staff, it had not waited for them both to be received before new staff started work. On this occasion the staff member was dismissed in June 2017 after it was discovered that they had been involved in inappropriate behaviours with one of the people who used the service.

A third staff member had been employed since August 2014 and had one reference in place and there was evidence, in the form of a copy of a letter sent out, that the second was still being chased in February 2017. Another had started work in March 2017. There was one reference in place, but we saw a copy of a letter on file that showed the second was still being chased.

The provider allowing staff to start work before references being received is 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 medicines policies and procedures in place which guided staff on how people were supported with their medicines, where required, safely. People's care records included guidance on the type of support that they required with their medicines. Staff had been provided with updated medicines training. There were competency observations on staff when supporting people with their medicines to ensure this was done safely. However, there were incidents recorded where people had not received their medicines on time and on one occasion an important medicine that was needed to protect one person during a prolonged seizure was misplaced for a number of hours, which led to them not being able to take part in activities outside their home until it was found. It was found in another person's backpack in the boot of the car they had both been in the day before. No action had been taken to get this medicine replaced before it was found.

Care records showed that on occasion people's medicines were not ordered on time and people had to wait for it to be obtained before they could have their medicine. It was recorded that on one occasion a person was not given their night time medicine after a staff member was late to arrive on shift and thought the staff on the previous shift had given it.

One person's relative told us, "My [relative's] medicines go missing and end up being given late, or sometimes not at all. But it's so important that [they] have it on time to keep [them] and everyone else safe."

This is a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were provided with training in safeguarding and told us that they understood their roles and responsibilities in this subject, including how to report concerns. Where safeguarding concerns had arisen, the service had reported this appropriately.

Inadequate

Is the service effective?

Our findings

People do not always receive an effective service.

Staff told us that they felt that they received the training they needed to meet people's needs. The registered manager told us about the systems in place for training staff. This included a range of training methods such as face to face group training and DVD training. However, records showed and we had been told by the local authority safeguarding team and other healthcare professionals, that the staff did not always appear to be supported and trained to support this group of people who had complex needs. We were told that the management team had not taken advantage of specialist training they had been advised was essential around using positive supporting techniques.

The registered manager said that they had trained the staff in this area, but specialist healthcare professionals in this area of expertise did not feel that the training was of sufficient quality and it was not aimed at this particular client group. Incidents had happened that the professionals did not think were handled effectively by staff. They had advised the service to undergo the training being offered. This was also reflected in feedback we had received from other professionals. One told us that they had made appointments on several occasions to provide the staff team training and informal supervision type sessions around someone who used the service and had specific needs, but when they arrived on the agreed date there were no staff in attendance. Training records showed that less than a third of the staff had received Positive Behaviour Support (PBS) training.
Training records also showed that of 47 staff, 19 had received activities and exercise training, three had undertaken conflict management training and 27 had completed challenging behaviour training.

Only one staff member had received specialist autism training and two had taken an introduction in autism course. One relative said, "When talking with staff it has become apparent that a lot of them have either no training in autism or have a poor understanding of it and the complex conditions that come with it."

This meant that the staff were not sufficiently trained to meet the needs of the people they supported. This is a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care worker we spoke with told us about their induction which included shadow shifts where they were introduced to people using the service.

The registered manager told us that all staff were provided the opportunity to have one to one supervisions and team meetings. They had recently started these supervision sessions. We saw evidence that these meetings took place.

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.

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 were being met.

People were being restricted from leaving their home on their own because they would be at risk of being hurt or hurting others. Two of which had been assessed as not having capacity to make an informed choice in this matter, one person had not had their capacity assessed in this area. There had been no best interest meetings to agree these restrictions. When asked why in relation to one person, the registered manager showed us an email they had sent to the local authority in April 2017 asking for a best interest meeting to be arranged to review the practice of locking that person in their home. However, there was no response; the registered manager had made a comment in the email to the effect that if they did not get a response they would assume they were able to continue with the practice without a best interest meeting being held. The registered manager had not made an attempt to follow up on the original request to arrange a meeting. The email indicated that the registered manager was aware that best interest meetings relating to the deprivation of liberty should have taken place.

People were being supported by the service which is registered to provide personal care in their own homes. For the people's movements to be restricted in this way the service, working with the local authority placing the people in the care of the service, should have made an application to the Court of Protection. This was because people's movements and hence their liberty was being restricted. The registered manager assured us that they would take action to rectify this oversight.

This is a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, who had been assessed as it being essential that they had one to one staff support throughout the day and especially when they accessed the community, were not always supported to have access to healthcare and specialist support services. Records showed that healthcare and specialist support and therapy appointments were missed. One healthcare professional told us, "Appointments are often missed, when asked why, staff said things like, 'They didn't realise' or 'It wasn't on the calendar/on the board' and 'We weren't told by management', it's such a waste of time." Another said, "I have had experiences where, despite the patient informing staff early on in the day that [they] didn't want to attend [their] appointment, [the staff] have not made contact to let me know this, hence wasting my time."

New appointments were made. However, records showed that they were often missed. People not being supported to attend their healthcare appointments and not receiving specialist support and counselling may have a detrimental effect on the health and wellbeing of the people concerned.

This is a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to eat a healthy diet. People's care plans stated that they should be encouraged to plan their meals in advance and to sit with staff to write a shopping list so they could be advised on making healthy options and to develop their independent living skills. Care plans talked about the person being supported to cook their meals with promoting independence in mind. However, daily care notes recorded that some people mainly opted for take away meals and frozen meals and were not

encouraged to choose healthy options. Those people who did have restrictions on their food and drink intake to help manage behavioural issues often refused to avoid them. One person's relative told us, "So far, since [they] moved in to [their] flat, [they] have put on one and a half stone in weight."

The people affected in this situation had capacity to make decisions around the food they chose. The guidance in their care plans recognised that people had the right to make decisions that others may disagree with or think was unwise. However, these people had recognised the consequences of choosing to eat and drink items that had been recognised as affecting them badly and had agreed to the guidelines in their the care plans for staff to support, guide and encourage them to stick to their agreed plans to eat healthily. This was evidenced by them signing the care plans to signify that they had read and agreed to them.

However, people's relatives and social care professionals did not feel that staff used this guidance to effectively support people. They told us that they believed that staff were taking the easy option to save argument. One person's relative said, "My [relative's] behaviour is badly affected by certain drinks, [they] have agreed to only have one can a day, but they know that if [they] insist the staff give in because they want an easy life." A professional told us, "The staff are not proactive in planning meals…. When I visited there was a huge pile of pizza packets and rubbish in a pile by the table."

Requires Improvement

Is the service caring?

Our findings

People were not always supported in a caring way. Staff we saw interacting with people displayed caring attitudes and it was evident that they had developed a good rapport with the people they were working with.

However, two people's families and the professionals we spoke to that were involved with people who used the service, believed that some staff did not take sufficient action to build up a trusting and caring relationship between them and the people they worked with, saying that the staff were not consistent with their approach with people. They avoided confrontation and were punitive towards people rather than using positive behaviour techniques to help people manage their behaviours. One person's relative said, "They [the staff] say things like, 'If you don't tidy up, we won't go out this afternoon.' Rather than trying to persuade [my relative] nicely."

One social care professional told us, "When approached, the staff always say they are unable to motivate my customer…. They need prompting, and encouraging but is very able, and when working with [them] myself, has always been eager to engage." They went on to say that since receiving support from the service they had stopped following most of their interests. Another social care professional commented, "I do not find the support workers proactive, or able to think 'outside the box'."

One person's relative told us, "They [the service] think they have positive behaviour skills, but they are punitive. Always threatening one punishment or another." We saw evidence of care worker's thinking in a punitive way in people's daily records. One person did not cooperate with a care worker encouraging them to tidy their home after an activity the night before kept them awake most of the night. The care worker on duty that day recorded in the person's daily notes that the staff on duty had discussed how they could avoid this behaviour in the future and it was agreed that they would not allow that person to carry out that activity again.

One person's relative said, "The staff don't respect my [relative] and talk about [them] in front of [them]. My [relative] is volatile and they say things like, '[They're] going to go, [they're] going to go!' Which of course upsets [them] and [my relative] does 'go' as they say." The relative explained that behaviour specialists have advised staff using positive behaviour techniques when working with their relative, but feels that the staff's behaviour is, "The exact opposite of positive behavioural interactions." The term, 'They are going to go.' Is not an appropriate, professional or respectful way to talk about people either within their hearing or not.

People told us that they were included in discussions about their care plans and were able to decide what went into them. One person told us that, "I know about my care plan, we talked about it. But I haven't looked at it much. Where people were able they had signed their care plans to indicate that they had seen the care plans and agreed to their content.

Daily records showed that staff respected people's privacy and did not enter their rooms without being invited.

Inadequate

Is the service responsive?

Our findings

The people who used this service were not always able to tell us what they thought of the service they received. However, people's relatives and the seven social and healthcare professionals we spoke with told us that the service was not responsive towards people's needs.

Care plans were in place for all the people who used the service during our inspection. However, one relative told us that it took nine weeks before their relative's care plans were fully in place. The registered manager assured us that they had put an initial individual support plan (care plan) in place when the person first started using the service. However, we saw that none of the care plans or risk assessments in place were dated before their start date. The earliest one we saw was dated seven days after they had joined the service. Others was added over the next two months, the care plan giving staff guidance on how to manage the person's behaviours that challenge was not put into place until 23 days after they had started receiving support. Staff not having access to a care plan in a timely manner meant they would not be able to support people in a way that met their needs and there was a risk that people might be provided with inappropriate care.

People's care plans were personalised to include information about them, such as guidance on how staff should support people to manage behaviours that may challenge others, as well as their hobbies, interests, preferences and life history. This information would have enabled staff to get to know people quickly and to offer support in the way they wanted to be supported. Care plans were detailed for staff to follow and were kept under regular review, but some staff told us they found them difficult to follow because of the challenges people presented them. This made them unsure of what action they needed to take in certain circumstances.

People's relatives and social care and healthcare professionals told us that they believed that staff did not always follow people's care plans and were not consistent in the way they supported people. One social care professional told us, "The one issue I have had is around staff consistency in the way they manage behaviours as they do not always have the same approach and this in turn sends mixed messages to my customer. For example, some staff will let [my customer] have energy drinks although there is a protocol in place because of the behaviours that may follow as a result of consuming these drinks. Staff are supposed to support [them] in reducing the intake of these drinks and some do, but there has been reports of other workers letting [them] get these which in turn has an effect on [their] behaviour."

Another social care professional said "I do not feel that staff are consistent in promoting [my customer's] independence, as they tend to do household chores for [them], such as cooking and cleaning, all which my customer can do, with supervision. In my view they are disabling [them] in order for [them] not to "kick off" as [they] tend to shout at staff when they ask [them] to do something."

One social care professional told us that they believed that staff did not know how they should be working with the person they supported to encourage them to engage with them or taking part in activities in and outside their home. They acknowledged that the person they supported did not understand professional

boundaries and their lack of desire to engage with people made it hard to motivate them, but the professional had not seen any progress in their development. They could not understand this lack of development as they were on a support package that included developing their independent living skills. The person, whose funded one-to-one hours had been cut to four hours a day, needed support in keeping their home clean and tidy, but the professional had not seen evidence that this was being given. They said that the house was often untidy and unclean and the person was no nearer being able to live independently. Staff not following people's care plans in supporting people to do their everyday chores around the house, or doing it for them deskilled people and did not support them to develop their skills to enable them to achieve their potential and to live independently.

The person also needed support to go out locally and to take part in meaningful activities. Before they started receiving support from the service, the person had many interests and was active in the community. However, records showed that the person had chosen to restrict their activities to one interest, meaning they left the house only when necessary, spent most of their time alone in their bedroom and did not interact with people. A healthcare professional felt that this happened because the staff did not find ways to engage with the person and were not proactive in motivating them to plan activities that they enjoyed in advance and then motivate them to keep to the plans and take part in the activities. This indicated that the service did not protect people from the risk of social isolation and loneliness and did not recognise the importance of social contact and companionship.

The registered manager told us that when the person was receiving more funded one-to-one hours they did take part in a greater range of activities. They believed that the cut in funding contributed to the person isolating themselves because the staff were not there to motivate them.

A senior social care professional told us the service was working with some of their most complex customers. However, the service had assessed their needs and said they were able to support them. In the professional's opinion they believed that staff were, "Inexperienced, poorly trained and lacking motivation to support them and were not pro-active in engaging the customers. However I do feel if the staff were more proactive and knowledgeable there would be a more effective working partnership between them and our customers."

A healthcare professional also acknowledged that the people supported had multiple complex needs, but felt that advice from professionals was not always heeded. For example educational programmes had failed for one person in the past. Thought, evaluation and formulation about how and why this happened was conducted by a member of their team and another educational programme was identified and put in place. But the service did not follow professional advice and after a week it failed, resulting in negative experiences for the person.

One person's care plan had detailed guidance for staff around the use of their mobile phone during the day and at night time. They used their phone frequently as a means of communicating with their family and friends. However, they were vulnerable to being coerced into making unwise decisions and being exploited. There had been no capability assessment of whether they were able to recognise these risks. However, during discussions with the person and their parents it was decided to protect their welfare by restricting when they could use their mobile phone and their other electronic devices.

Their care plan stated that the person only used their mobile phone within earshot of staff and that they did not take their electronic devices into their bedroom when they were alone or at night because they continued to use it to make calls and text people into the early hours of the morning.
However, the daily care records showed that the person was not asked to leave their devices downstairs

when they went to their bedroom either during the day or at night. The records showed that staff recorded that they heard the person talking on their phone as late as two or three o'clock in the morning most nights. This made them reluctant to get up in the morning, take part in planned activities or carrying out their day to day tasks around their home. This led to conflicts with staff and records showed that this triggered their behaviours that challenge, which in turn led to them missing out on planned leisure activities and opportunities to develop their life skills enabling them to live independently.

One person's relative told us that they felt let down by the service because of the lack of progress their relative had made towards developing their independent living skills.

This is a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily diaries were mainly task led, poorly written and did not give details of support given to the person to help them manage their behaviours. Nor did these records identify the person's wellbeing, just what they had done. For example some records read as lists of times that things happened, but offered no detail about whether the person achieved what they had set out to do or how the person felt about it.

We saw evidence in daily care records that staff did listen to people when they said they wanted to talk on a day-to-day basis. We also saw evidence that the registered manager visited people in their homes and asked how they would like to be supported and if there were any changes they wanted, we also saw that they discussed their expectations and tried to motivate people to engage with the local community. The registered manager confirmed that detailed records of these meetings were not kept, but undertook to keep records in future.

The service had a complaints process in place that was accessible to people. People told us that they felt their complaints were dealt with to their satisfaction, but their relatives and professionals said that communication with the service was sometimes difficult, with emails not being replied to immediately.

The registered manager confirmed that they did not keep records of complaints received and how they were dealt with but undertook to keep records in future.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at the service. The registered manager was also one of the directors of the organisation.

During our visit the registered manager was open in their conversations with us and acknowledged concerns that we raised with them and undertook to take action to make improvements in those areas.

The provider told us that they carried out quality assurance audits and we looked at the records they held of those audits. They reviewed care plans, carried out spot checks and monitored staffing levels. However, the registered manager had failed to identify the concerns we have found during this inspection, which indicated that they were not proactive in monitoring the quality of the service people received and have failed to take action when improvements were needed.

People's relatives and social care and healthcare professionals told us that communication with the service was not always effective, emails were not answered, important information was not shared with relevant people and guidance and advice was not always followed.

One healthcare professional said, "I have found communication incredibly difficult with [the service]. Often emails are not responded to, every time this happens and I raise it with them as an issue I am told to include another person to the email list, I have lost track of all the people I am supposed to include."

The registered manager explained that they felt the quality of their internet server was one of the reasons for the poor communication within the service and they had taken steps to improve their internet access.

One social care professional told us that a new person moved into the home of the person they supported with very little notice to the person living there. The person they supported found it very difficult to manage change and they thought the person should have been given more time to be prepared for a new occupant moving in to share their home. The professional was also concerned that the person was not given an opportunity to meet the person and get to know them before it was decided that they would move in.

The local authority safeguarding team contacted us about a concern they had raised with the registered manager but felt it had not been dealt with in a timely manner by them. They believed that staff were at risk while working with one person, however the registered manager continued to put those particular staff members on the rota to work with that person, meaning that the staff remained at risk. The safeguarding team spoke with the registered manager again, but it was not until after a long discussion that they agreed that the staff would not work with that person again.

Comments on the management of the service from social care and healthcare professionals included, "At meetings held, I have found [the registered manager] and [their] team professional, and punctual…. However, they seem to do and say all the right things, but in practice, this does not seem to filter down to the support workers." And, "I believe the management have the right intentions, but don't always

communicate it down to staff."

This is breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they got on well with the manager and the management team and said that they were supportive, especially at difficult times, when staff had experienced difficult shifts for example.

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 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there were sufficient numbers of staff available to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving a service that was responsive to their needs because the provider had failed to ensure that staff followed people's care plans and the guidance in them.

The enforcement action we took:

We issued a notice to the service not to take on any new contracts to support people and to report to the commission monthly to inform us of action they have taken to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that people were only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The enforcement action we took:

We issued a notice to the service not to take on any new contracts to support people and to report to the commission monthly to inform us of action they have taken to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people were kept safe by having effective risk assessments in place or ensuring they were followed. People's medicines were not always managed safely.

The enforcement action we took:

We issued a notice to the service not to take on any new contracts to support people and to report to the commission monthly to inform us of action they have taken to safeguard people.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that there were robust systems in place to audit the quality of the service they offered to people or to be able to recognise the breaches we identified during our inspection.

The enforcement action we took:

We issued a notice to the service not to take on any new contracts to support people and to report to the commission monthly to inform us of action they have taken to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that the staff they employed were fit and safe people to work with the people they supported.

The enforcement action we took:

We issued a notice to the service not to take on any new contracts to support people and to report to the commission monthly to inform us of action they have taken to safeguard people.