London Borough of Hackney

London Borough of Hackney, Housing with Care

Inspection report

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Date of inspection visit:
23 November 2018
29 November 2018
03 December 2018
05 December 2018

Date of publication:
14 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place between 23 November and 5 December 2018 and was announced. The service was last inspected in February 2016 when it was rated 'Good.' In February 2016 we made a recommendation about how medicines were disposed of. We followed up on this recommendation at this inspection.

The London Borough of Hackney, Housing with Care provides care and support to people living in 14 'supported living' settings, so they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The 14 schemes were all located in the London Borough of Hackney and ranged in size from eight to 40 self-contained flats. Most of the schemes were designed to meet the needs of older adults, although some were specialised for particular groups including adults with learning disabilities aged over 50 and people living with a particular type of dementia.

There was one registered manager who was responsible for seven of the schemes. A second manager had applied to register with us who was responsible for the other seven schemes. 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.

People told us they felt safe and staff were able to describe the support they provided to ensure people were safe. However, care plans and risk assessments were poor quality, lacked details and were not personalised.

Risks faced by people in the receipt of care had not been appropriately identified and measures in place to mitigate risks were not clear or robust. There was insufficient information about people's medicines to ensure they were managed safely and records did not show people had been supported to take medicines in a safe way. Although staff had a sound understanding of safeguarding and incident reporting, the systems in place to monitor and respond to incidents and allegations of abuse were piecemeal and there was a risk that trends and themes were not identified.

People did not feel involved in developing their care plans and did not always feel they had been offered choice about their care provider. Care plans had not been developed in line with best practice and guidance for meeting people's specific needs. There was insufficient information about people's healthcare needs, dietary requirements, cultural background and sexual and gender identity. We made a recommendation about ensuring the provider was able to offer appropriate support about people's sexual and gender identity. There was a risk that people's preferences and needs would not be met because these were not recorded.

People gave us mixed feedback about the staffing levels in the service and the impact this had on their

experience of care. While some people felt there were enough staff who had time to chat, others found staff rushed and busy. Staff were recruited in a way that ensured they were suitable to work in a care setting. Some of the schemes had very high agency use, with half of their shifts being covered by agency workers. Staff received regular supervisions, but the records did not demonstrate they had received the training they needed to perform their roles.

People did not always know how to make complaints, but were confident that if they had cause to make a complaint their feedback would be responded to appropriately. Records showed complaints were responded to in line with the provider's policy. The systems in place for learning from complaints were not operating effectively.

People told us they liked living in the schemes and would be happy to stay there until the end of their lives. Information about people's end of life wishes was not captured and the provider was not following their end of life policy.

Staff at the registered location did not have access to all of the documentation about people's care, which showed a lack of good governance at the service. We also identified shortfalls in how information was recorded and the reliability of the IT systems in use. The quality assurance and audit systems were not operating effectively. They had not identified or addressed issues with the quality and safety of the service. A range of audits were completed by managers at different levels but there was no central oversight or action plan. Actions to improve the quality of the service were not embedded or sustained.

The management structure of the service was new, and the managers were committed to improving the service. Staff felt supported in their roles. Staff worked closely with other organisations to ensure people were able to be active in their communities and attend a range of activities if they wished.

We found breaches of four regulations relating to person centred care, safe care and treatment, staffing and good governance. Full information about our regulatory response is added to reports when all appeals have been exhausted.

The overall rating for this service is 'Inadequate' and the service is therefore in '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.

Medicines were not managed in a safe way and information about people's medicines was insufficient.

Risks to people were not appropriately identified or mitigated against.

Incidents and concerns about abuse were appropriately identified and escalated. It was not clear how the schemes ensured lessons were learnt and shared.

Feedback about staffing levels was mixed, and some schemes had high agency use.

Staff knew how to keep people safe by the prevention and control of infection.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not assessed in line with best practice and guidance. Care plans were generic and did not inform staff how to support people to achieve their goals.

Records did not show staff had received appropriate training for their role. Staff received regular, supportive supervisions from their managers.

Care plans did not contain sufficient information to ensure people's healthcare and dietary needs were met.

The schemes worked closely with other organisations, particularly housing providers, to ensure people's needs were met.

Staff understood and applied the principles of the Mental Capacity Act 2005 but records did not always show the MCA had been applied.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us care workers were kind and had a caring attitude, although some people found staff were too rushed to spend time with them.

Staff spoke about people they supported with kindness and compassion.

People's cultural identity and personal history were not always considered as part of care planning.

The service did not always ensure they provided a safe environment for people to disclose their gender or sexual identity.

Is the service responsive?

Requires Improvement

The service was not always effective.

People did not remember being offered a choice about how they received their care. Care plans lacked detail and were not personalised.

The provider worked with other organisations to ensure a wide range of activities were available to people who wished to engage with them.

People told us they would be happy to receive end of life care from the service, but the provider was not following their own policy about end of life care.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems had not operated effectively to identify and address issues with the quality and safety of the service.

The audits in place did not ensure improvements were sustained.

The systems in place did not always facilitate the management of the service or sharing of information.

People and staff spoke highly of the managers who were

committed to making improvements to the service.

Staff meetings took place regularly and gave staff the opportunity to be involved in developing their schemes.

London Borough of Hackney, Housing with 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 between 23 November and 5 December 2018. The provider was given 48 hours' notice of the inspection activity as the service provides care across a wide range of sites and we needed to be sure the information we needed would be available during the inspection.

The inspection was completed by three inspectors. The inspectors spent two days in the office and visited five housing schemes over two days.

Before the inspection we considered the information we had received from the service in the form of notifications they had submitted to us. Notifications are information about events and incidents that providers are required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 15 people and 26 members of staff including the service manager, a registered manager and a manager who had also applied to register with us, two administrators, five scheme managers, six team leaders and ten care workers. We reviewed the care files for ten people who used the service including care plans, risk assessments, medicines records and records of care delivered. We looked at eight staff files including recruitment, supervision and appraisal records. We reviewed various other documents, meeting records, policies and audits relevant to the management of the service.

After the inspection we required the provider to send us an action plan to address some serious concerns we

found during the inspection. The action plan they sent us demonstrated they understood the extent and range of our concerns.

Inadequate

Is the service safe?

Our findings

People told us the staff supported them to take their medicines. One person said, "I do my own tablets at the moment, but they would help me if I needed. I rattle like a pharmacy so it's nice to know they would help if it got too much." Another person said, "They make sure I've taken my tablets." Staff described checking the medicines containers supplied by the pharmacy and the medicine administration records (MAR) when supporting people to take medicines.

The provider did not have effective systems in place to ensure the safe management of medicines. All ten of the people whose files we reviewed needed staff to support them to take their medicines. None of the care files contained information about what medicines they were prescribed, any risks associated with these medicines or details of the support they needed to take their medicines. The only information available to staff was contained in the MAR and this was insufficient to ensure people were supported to take their medicines safely.

People had been prescribed medicines on a 'take as needed' basis. There were no guidelines to inform staff when to offer and administer these medicines. Some medicines prescribed on an 'as needed' basis should not be taken together. For example, co-codamol should not be taken at the same time as other products containing paracetamol as it contains paracetamol and this means there is a risk of overdose and liver damage. One person's MAR showed staff had recorded they had administered both these medicines on 18 occasions in a six week period. This meant this person was exposed to the risk of harm and overdose. Staff had also used codes that were not explained on the MAR and therefore it was not possible to tell medicines had been administered safely. The provider told us they would take action to ensure staff knew how to record and administer medicines properly.

Risks faced by people had not been properly identified or mitigated against. One person had been prescribed medicine for seizures. Their care plan contained no information about their seizures. The registered manager confirmed this person had a history of seizures. This exposed this person to the risk of harm as staff did not have any information about how to identify seizures or respond when they happened. Other health related risks, such as diabetes and other long term health conditions had not been appropriately mitigated. There was no information for staff to identify the symptoms of high or low blood sugar levels for people living with diabetes or guidance on how to respond to these conditions.

One person's care file stated they had a history of suicide attempts. Their risk assessment stated staff should monitor their mood and report to the GP if they thought they had become depressed or anxious. There was no information to describe how to identify depression or anxiety in this person. Another person had a history of self harm and there was no guidance about how to identify and mitigate concerns about their mental health.

Three people's care files referred to them requiring treatment from medical professionals for wound care. There was no guidance for staff about how to mitigate the risk of harm by ensuring treatment plans were followed to encourage these wounds to heal. One person's care plan made repeated references to pressure

wounds from 2016. The manager confirmed they did not currently have any pressure wounds but their care plan had not been updated to reflect the change in their circumstances.

The above issues with the lack of clear identification and mitigation of risk and management of medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with staff. One person said, "I feel safe, the staff are always very kind." Staff were able to identify the different types of abuse people might be vulnerable to. Staff knew how to report and escalate concerns they had in line with local safeguarding and whistleblowing procedures. Records showed scheme managers completed incident forms and raised concerns about allegations of abuse appropriately to their managers. Where appropriate safeguarding alerts were raised and investigations were completed. Staff meeting records showed staff were reminded about recording incidents and safeguarding concerns regularly. However, there was no record that staff were supported to reflect on learning from incidents and safeguardings through these meetings.

The provider had systems in place to ensure suitable staff were employed. Applications were reviewed and applicants had been interviewed by management panels who applied the provider's policy to ensure equality of opportunity in recruitment processes. Applicants' knowledge and skills were assessed through a standardised interview process. After successful interviews the service carried out checks of staff right to work, identity and character through references and criminal records checks. It was not clear that the provider established the relationship between the applicant and the referee so it was not always possible to see if the reference was a professional or character reference.

Records of recruitment processes were difficult to access during the inspection. The provider's systems required the documents to be scanned and uploaded to their online filing system. However, this had not been consistently done by the previous registered manager. Administration staff were able to access hard copy records from a locked cabinet, but this required the administrators to go through boxes of records that had not been clearly sorted or archived.

People gave us mixed feedback about whether they felt there were enough staff on duty to meet their needs. At some schemes people told us there were plenty of staff available to them when they needed. One person said, "I don't have to wait for staff." Another person said, "They're never short on coming here, they come on time." However, other people told us there were not always enough staff. One person said, "There could be more staff. If I pull the cord they will get here as quickly as they can." Another person said, "They help me when they have the time."

Rotas showed some schemes were covering half of the shifts with agency workers. Staff at some of the schemes told us they felt rushed at busy times of the day. All the staff told us absences were covered, either by agency staff or by team leaders providing additional support to people. The schemes had established links with named agency workers who were known to the people who lived in the schemes. Agency staff attended staff meetings and received supervisions in the same way permeant staff did which minimised the impact of unfamiliar faces.

Staff described maintaining appropriate hygiene to ensure people were protected by the prevention and control of infection. We saw personal protective equipment was available to staff from the offices in the schemes. We noted that one person was particularly at risk of infection due to an underlying health condition. Their care plan referred staff to guidance documents, but these were generic guidelines and did not clarify for staff what individual actions were required to ensure effective infection prevention and control or what the risks were to this person and others. Staff were able to describe the risks in conversation.

Inadequate

Is the service effective?

Our findings

The registered manager told us they met with people to plan their care based on the commissioning referral received from people's social workers. People confirmed they had meetings about their needs before moving into the supported housing schemes. However, the service did not have a set needs assessment and did not keep records of the assessment process.

The care plans produced were generic and did not reflect best practice in terms of people's individual needs. For example, one of the schemes specialised in supporting people with learning disabilities but people's care plans did not reflect how their needs may be different from those in an older adults' scheme. Care plans for people with long term, enduring mental health conditions did not reflect best practice in ensuring people's mental health was supported. For example, one person's profile described that they continued to live with residual symptoms of psychosis but did not inform staff how to support or respond to the person in relation to these symptoms.

People told us staff supported them to access healthcare services when they needed. One person said, "They [staff] would notice if I wasn't feeling too clever. They'll call the GP for me." Another person told us, "They will get the ambulance if you need it." Care plans contained information about people's medical history, however this was limited to the health concerns that led to their moving into the schemes. There was no information about what people's diagnoses meant in terms of their wellbeing or care preferences. For example, one person's profile described the findings of a brain scan in detail, but did not explain what that meant for the person and their needs.

It is well established as best practice in supporting adults with learning disabilities with their healthcare needs that people should be supported to have health action plans and attend annual health checks. Health action plans are documents that ensure that all the information about a person's health conditions and appointments are held in one place that is available to the person and all relevant healthcare professionals. We reviewed two files for adults with learning disabilities and their files did not contain health action plans and did not include information about annual health checks. One of these people spoke to us about the health appointments they attended, but the support they needed to book and attend the appointments and follow the advice of the healthcare professionals was not recorded.

People receiving care were living with a range of long term health conditions including diabetes, dementia, mental health conditions and other age and lifestyle related conditions that affected their wellbeing. Care plans did not explain the impact of people's health conditions on their support needs and preferences. For example, one person was diagnosed with high blood pressure and diabetes. Their plan regarding physical health stated they needed glasses to read and described facilitating GP appointments "when necessary" and informing healthcare professionals of "any changes." There was no guidance about how to identify changes in health or how to support this person to maintain their health.

Another person's medical history included high blood pressure and having a pace-maker fitted. The health section of their care plan referred to their need to wear glasses and attend optician appointments. There

was no information or guidance about the support they needed to manage their blood pressure or to ensure their heart health. This person told us they attended regular hospital appointments but the support they needed with this was not recorded. This meant there was a risk that people did not receive the support they needed to maintain their health and liaise with healthcare professionals as this support was not described.

People told us staff helped them prepare their meals. One person said, "They help with my meals, it depends what I've got in." In some of the schemes staff prepared communal meals, but this was not possible in other schemes due to the nature of the buildings. Staff told us some people preferred to cook from scratch while others had microwave meals delivered. Staff told us they offered people choices about their meals. Care plans did not include information about people's dietary needs and preferences, and did not contain information about whether or not people had meals delivered or required support to prepare them. Although staff were knowledgeable there was a risk that new, or unfamiliar staff may not provide people with the support they needed as this was not captured in the care plans.

The above issues with the assessments and lack of detail in care plans are a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular, supportive supervisions from their line managers. The provider's system required line mangers to upload supervision records to an online filing system. We found that this was only done when prompted by the registered manager following an audit. This meant records available were out of date although scheme managers uploaded records after being requested as part of the inspection. Records showed staff received regular supervisions that followed the provider's format which included discussions of individuals receiving care as well as service issues.

Although some staff told us they received the training they needed to perform their roles, this was not consistent across the service. Staff who wrote care plans and risk assessments told us they had not received training in writing personalised care plans since the service was established in 2014. This had affected the quality of the care planning across the service, where we found shortfalls in the levels of personalisation in care plans. The training records submitted by the provider were not clear and did not show staff had received the training they needed to perform their roles. For example, only three staff out of 212 had ever received training in diabetes care. Staff working in the schemes which specialised in providing care to specific groups such as learning disabilities, dementia or mental health had not received training in these areas. Records did not show staff had received training in responding to behaviour which might be challenging despite providing care to people who behaved in this way. In some schemes there was no record any staff had received training in safeguarding adults, despite this being an annual requirement of the provider.

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

At each of the schemes the relevant housing association provided housing related support and some activities for people living in the schemes who also received care from the provider. At some of the schemes the housing provider also had an office base. We saw staff from the different organisations liaised to ensure people's needs were met. For example, care staff would liaise with maintenance teams to ensure repairs were completed. We also saw housing staff would share concerns about people's care if these were raised. At several of the schemes there were joint meetings with the provider and housing association to discuss services on offer to people.

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 with appropriate legal authority. In community settings this is through applications to the Court of Protection.

We checked whether the service was working within the principles of the MCA, and whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff demonstrated a sound understanding of the MCA and understood that people's capacity to make decisions may vary depending on the circumstances. For example, staff told us they would not ask people to make complex decisions when they were under the influence of alcohol as that may have affected their capacity to make decisions. Records did not always support staff understanding of people's capacity to make decisions or provide guidance on how to facilitate decision making. For example, one person's care plan described how a relative managed their finances. However, there was no record that the family member had the appropriate legal authority to manage finances on their behalf. The team leader told us they would seek confirmation and appropriate records about this matter. A meeting record also showed a relative had put in place restrictions on their family members liberty without following proper processes and without any record of them having legal authority to make decisions on behalf of their family member. The registered manager established that the scheme manager had taken immediate action to remove this restriction.

Requires Improvement

Is the service caring?

Our findings

Across all the schemes we visited we saw staff interacted with people in a kind and positive way. Staff knocked on people's flat doors and enquired after their wellbeing in a polite and considerate way. People told us the staff were kind. One person said, "The staff chat to me, they are friendly and caring." Another person told us, "The staff are very respectful to me. They know I am very particular about how I like things and do not want them to interfere with certain areas. They respect my boundaries."

Although the interactions were positive, some staff told us they did not always have time to spend with people outside of providing care. One staff member said, "There could be more staff on the ground [this would help] provide a compassionate service, people would benefit from more time and hours, as well as staff wellbeing. We manage to do it, but it's at a push." One person told us, "They [staff] are busy. They can't sit around chatting all day."

Care plans explained that some people needed emotional support, particularly those with mental health needs. However, the care plans did not describe how to identify this need or what the support would entail. Staff described sitting and talking with people, and offering them reassurances.
Staff spoke with compassion about how they would support people who may be embarrassed or upset by their support needs. They described offering reassurances and taking their time to ensure people were at ease during the receipt of care.

People told us they were able to maintain their important relationships, or that staff would help them to do so if they wished. One person said, "I see my [relative] regularly but if I needed the staff to phone them they would." Staff told us they supported people to keep in touch with family members. One care worker explained how they supported one person to visit their relative who lived in a care home. Care files did not include details of people's significant relationships. Family members were referred to but only if they were involved in making decisions or if there were risks associated with their contact.

Information about people's lives before they received a service was extremely limited and usually only referred to their circumstances immediately before moving into the schemes. This meant it was not always clear the service was considering people's background, culture and values when developing support plans. For example, we visited one person in their flat and they had flags and artwork on display relating to their heritage. In conversation they were proud of the culture and described how it influenced their preferences. Their ethnicity in their care plan did not match the cultural heritage they told us about. Another person told us they did not like some staff to help them with meal preparation as they did not know how to prepare meals in line with their cultural requirements. We have explored in the effective domain that people's dietary preferences were not clearly described.

Care plans contained a section where people's sexuality could be recorded. We found that in some care plans rather than a sexual orientation staff had recorded the person's gender. In other files this was blank. Staff told us they did not support anyone who identified as lesbian, gay, bisexual or transgender. This was despite the service supporting over 200 people. Staff told us, "No one ever mentioned it [sexual orientation

and gender identity]." Though they acknowledged they would know if someone had previously been in a heterosexual partnership. This meant there was a risk that people who identified as lesbian, gay bisexual and transgender may not feel that the service offered a safe space for them to disclose their identity.

The provider information return stated staff had attended LGBT training. Despite the training matrix supplied by the provider showing they offered 3 different courses relating to equality and diversity, and a further seven courses relating to sexuality and sexual needs only 33% of staff had completed training any diversity training, and 41% had completed training in sexuality and sexual needs. Some of the course dates were from 2013, before the service was registered. Furthermore in three of the schemes no staff had received any training in equality, diversity or sexuality.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring the service is providing appropriate support to people regarding their sexual and gender identity.

People told us they valued their independence and staff supported them to maintain it. People described how staff supported them to keep their homes clean which helped them stay independent, or reminded them to use equipment to reduce the risks of falling and losing their independence. Staff told us they encouraged people to be as independent as possible. One staff member said, "If they can do something independently we won't interfere in that. We'll make sure we're available but that is all."

Requires Improvement

Is the service responsive?

Our findings

We saw care plans were signed as being updated every six months, or following incidents where people's needs had changed. However, care plans were not personalised and did not describe how to support people's individual needs. People we spoke with told us they could tell the scheme managers and team leaders if they felt things needed to change with their care, but did not recall having meetings about their care. No one we spoke with recalled being offered a choice about who provided their care. One person said, "It's just the ones [care workers] that come. I didn't choose who they are."

Across all the care plans reviewed the provider had taken an outcome based approach. Although the goals of support were included, the details of what a positive outcome would look like, and how to support the person to achieve it was not. For example, one person's wishes regarding their personal care were recorded as being, "Requires staff support with shaving every morning and prompt to choose clean clothes." The planned outcomes were, "To promote independence, to promote choice of what to wear, to maintain a good standard of care, to ensure one member of staff assist to wash / shower and shave." There was no information about this person's preferences or details of how care should be delivered. Other care plans referred to staff providing encouragement, prompts and assistance but this was not described.

One person's risk assessment referred to them having a hearing impairment. However, this was not mentioned in their care plan and there was no information or guidance for staff about how to communicate effectively with this person to ensure their needs were met. Another person's risk assessment described them as experiencing confusion due to dementia. There was no guidance in their care file about how to support them to be more orientated or how to respond if they became confused or distressed.

The above issues are a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were offered a range of activities by both the service and their housing providers. There were three welfare and activities coordinators who worked across the 14 schemes to facilitate a range of activities to suit people's tastes. Records showed people were offered group activities including coffee mornings, bingo, film club as well as trips to the theatre. People were supported to attend day centres and external activities with the combined support the provider and housing schemes.

Some people told us they liked the activities and we saw people engaging with a range of sessions that were taking place at the schemes we visited. For example, one person enjoyed playing cards, and at another scheme bingo. However, other people told us they knew activities were on offer, but did not feel they were suitable for them. One person said, "The activities don't really interest me. I've made my own arrangements with friends from outside." Records of tenants meetings showed activities were discussed and housing providers gave feedback to the provider based on what people said at these meetings.

Records of care showed people received support with their personal care, medicines and meal preparation as required. We noted the level of detail was limited, for example, staff did not record what meals people

were supported to prepare and eat, and rarely recorded any information about people's mood or presentation. This was despite care plans stating staff should be monitoring people's wellbeing. This meant there was a risk that changes in people's presentation may not be identified from the records.

Although not all the people we spoke with knew how to complain, they were all confident any concerns they had would be responded to appropriately. One person said, "I don't know how [to make a complaint] I've not had cause to. I'm sure [team leader] would sort it out if something came up." Other people told us they knew how to make complaints. One person said, "I know how to make complaints. I'd tell [scheme manager]."

The provider's complaints policy covered only complaints that required a written response; complaints made verbally and resolved within 24 hours were considered out of the scope of the policy. We reviewed the provider's responses to complaints made over the last year and saw they completed investigations as described in the policy. However, the audits completed did not include any lessons learned for the service, and complaints were not discussed in staff meetings. This meant there was a risk that lessons from complaints were not shared and issues could recur. There was no thematic analysis of complaints which meant themes to complaints were not identified and opportunities for learning were missed.

Care plans did not specifically address people's wishes for care should they reach the last stages of their life. However, people told us they would choose to remain within the schemes if they reached the last stages of life. One person told us, "I'd stay here to my last days. I trust them all to take good care of me." Staff told us they worked with the local hospice when people were approaching the end of their life. One care worker explained, "We work with [hospice]. They will send the nurses, or sometimes people will go and stay there if it's what they want." The provider's policy for supporting people at the end of their lives referred to best practice guidance and ensuring people were able to express their preferences and have these acted upon. The policy stated all staff working in the service should have training in end of life care. However, only 63% of staff had completed this training.

Inadequate

Is the service well-led?

Our findings

The management of the service had recently changed. The previous registered manager had left, and the plan for the service recognised the large scope of the role of managing 14 schemes. The provider had decided the role would be shared across two managers, one of whom had completed the registration process and the other was going through the processes at the time of our inspection. Each of these managers was responsible for seven supported housing schemes. Although only one was currently registered they shared responsibility and are referred to as 'the managers' throughout this section of the report. The management structures were clear, with scheme managers in place and team leaders for each shift. Some scheme managers worked across two sites depending on the size and nature of the needs of people living in the schemes.

The location address was the head office of the local authority. For a location to be correctly registered the regulated activity must be managed from the location address. We identified concerns about whether the office location was truly where the regulated activity was managed from. This was because information about people and staff was not available at this office. While the information relating to staff should have been uploaded to the online filing systems, it was not the usual practice for information about people to be available in the office as this was all kept at the schemes. For the regulated activity of personal care to be correct people must be able to choose their care provider, and their housing tenancy and care support must be separate agreements. People did not recall being able to choose their provider at several schemes and people did not have contracts or agreements regarding care provision. The provider took action during the inspection to make records available and has committed to reviewing their registration to ensure it is correct.

The managers told us a new system for online record keeping had been introduced and this was difficult for scheme managers to use, and often stopped working. We saw during the inspection that as the managers opened documents for us to review, the system would slow down and stop. On one occasion the managers had to contact their support desk to unlock the system and this took half an hour to resolve. The managers explained this led to scheme managers failing to update the online systems as it was a time consuming task that often did not work effectively. Staff supervisions were meant to be uploaded to this system, but the most recent records were six months old. One of the managers explained, "We have to chase the scheme managers to do these things [upload the documents]. We last did an audit of the staffing records six months ago and found the records had not been uploaded. They uploaded them, but the next audit is due which would have found the same thing." The managers recognised they needed to follow up on whether actions from audits had been sustained.

Staff told us the activities and welfare officers carried out quality assurance visits and sought feedback from people about their experience of care. We asked if there were action plans in place to address issues raised by people during these visits. Scheme managers told us they received emails about any issues and addressed these one by one. This meant there was no systematic or service wide analysis of the quality of support received by people, and no way of identifying if themes were scheme-specific or more general in nature.

The managers completed quality assurance visits and checks to the schemes. The scheme managers also completed audits of medicines records, signed off care plans and risk assessments and completed spot checks at night. However, there was no analysis of audits or related action plans for any of the schemes. The mangers explained that where they identified issues they would receive feedback from scheme managers that issues had been addressed. However, there was no clear audit trail and it was not captured that issues were followed up on future occasions to ensure they were addressed. Due to the nature of the way audits were captured it was not possible to see if issues were recurring or different issues were identified at each visit.

The provider sent us a record of audits completed and this showed there was no pattern or routine to the audits. For example, medicines were checked at one scheme in August 2017. The next medicines audit did not take place until June 2018. A night spot check was carried out in January 2018 where actions were identified, but the next night spot check did not take place until November 2018. At another scheme there had been an audit of "all mandatory documents" in July 2017, the next recorded audit was of medicines in September 2018.

The audit systems in place were not operating effectively to identify and address issues with the quality and safety of the service. They had not identified the poor quality of care plans and risk assessments. They had also not identified that medicines records were incorrect and that medicines practice had not been updated to reflect the guidance issued by the National Institute of Clinical Excellence (NICE) in March 2017, about medicines in home care. The provider submitted an audit of complaints, there were no lessons learnt recorded for any of the complaints audited. Scheme managers sent records of incidents, accidents and safeguarding records to the managers for review. We saw the managers reviewed these, and asked for appropriate follow up action to be taken. However, there was no overall audit or analysis so no themes could identified. This meant there was a risk that patterns to incidents, accidents and allegations of abuse may be missed as each was dealt with on an individual basis.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the managers supportive. One care worker said, "I think the team works well and the managers are all supportive. I've got a good team leader, then [manager] covers a group of the units, and [name] is the scheme manager. I like their approach. Very straightforward." Another staff member said, "[Manager] does a really good job and is approachable and helpful. I've never felt she hasn't been there. She is an absolute diamond." Both the managers demonstrated their commitment and dedication to the services during the inspection and expressed a clear desire to improve the quality and safety of the service. They were both relatively new to their current role and recognised there had been a steep learning curve.

Staff told us, and records confirmed each scheme had regular staff meetings. Although these varied depending on which scheme they took place in, we saw staff discussed people they supported and their needs in detail. All staff meetings included discussions around health and safety, infection control, record keeping, incident recording, safeguarding as well as activities taking place in the local community. Staff meetings records also showed staff were given opportunities to discuss the running of the service, as rotas, workloads and holiday planning were discussed.

The welfare and activities coordinators worked with staff from the schemes to ensure people were supported to engage with their local communities. We saw information about activities and events in the local community were on display throughout the schemes and people were able to get involved if they wished. The schemes worked with other organisations in their local area, including day services, theatres,

cinemas as well as supporting people to engage with events offered by their housing providers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not assessed in line with guidance and care plans were not personalised. Regulation 9(1)(3)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training they needed to perform their roles. Regulation 18(2)

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not appropriately identified or mitigated. Medicines were not managed in a safe way. Regulation 12(1)(2)

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant by March 2019.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant by March 2019