

Pinkney Services Limited

Pinkney Services Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement 
Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Inadequate 

Summary of findings

Overall summary

We carried out a comprehensive inspection of Pinkney Services Limited on 5 and 6 April 2018.

Pinkney Services Limited is a domiciliary care agency. The service provides support to adults and younger adults with learning disabilities or autistic spectrum disorder. It provides personal care to people living in their own houses and flats in the community and to people in supported living arrangements.

Supported living is where people receive support so that 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. Where the service does provide any wider social care, we also take this into account. At the time of the inspection the service was supporting seven people.

Pinkney Services Limited has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a registered manager in post. 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.

This was the first inspection of the service since it was registered with the Care Quality Commission (CQC) in December 2016.

Medicines were not always being safely managed. Recording of administration of people's medicines was an area of practice that required improvement to make sure people were safe from the risk of avoidable harm. The service had not always supported people who received support to maintain a clean and hygienic home environment to manage and prevent risks of infection.

Following a period of temporary management cover while the registered manager had been absent, management of quality, risks, staff performance and regulatory requirements had not been always been effective. The service did not always consistently involve and engage with people, the public and staff to gain their views and input on how to develop the service.

The service had not submitted notifications of events that had occurred in line with CQC registration requirements, such as incidents involving the Police and allegations of abuse.

Quality assurance and information governance systems were not always effective. Quality and safety issues

had not always been identified. Where these had been recognised, these had not always been acted on in a timely manner. There was no formal development plan in place to allow the service to continuously review, learn and improve the quality of its support.

The registered manager had a clear vision for the service to deliver high quality care that empowered people with learning disabilities and autism to be independent and achieve what they wanted from life. However, staff had not always had support to take account for their performance and know what was expected of them to fulfil their responsibilities. Staff did not always work collaboratively or effectively.

Management were not always seen as visible and approachable by staff. Some staff found the feedback from members of the management team had been inconsistent and was not always constructive. Some staff felt unsupported and not always confident information was shared with them in a timely and transparent manner.

People had been assessed for risks to their well-being. People were involved with making choices during their risk management processes and any restrictions on their freedom were kept to minimum. Some people's risk assessments lacked details about control measures needed to minimise risks to them and risks to people were not always monitored and managed effectively.

Staff reported accidents and incidents if these occurred. However, the service could not always evidence they had taken appropriate action and supported staff to understand and prevent the risk of incidents happening again.

Staff received an induction and received training. Staff training requests were not always delivered in a timely manner. Formal supervisions, appraisals, team meetings, on-site observations and spot checks had not been taking place regularly. This increased the risk that staff practice might be inconsistent or they might not know how best to deliver effective support to people.

There were processes in place to help ensure safe recruitment, however some paperwork to evidence staff suitability was not present at the time of the inspection. There were effective systems and processes in place to keep people safe from abuse. People were protected from any discriminatory abuse they might encounter. There was enough staff and people received their expected support from the service.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA). People, or an appropriate person, had consented to their care. There were mental capacity assessments in place that recorded people's ability to be able to make decisions about certain activities in their lives. Best interest meetings had been carried out to make sure people had received the correct support to make any decisions they were not able to.

People's physical, psychological and social needs had been assessed before they started using the service. The service shared information with other relevant people such as family members and health and social care professionals to make sure people had consistency with receiving the support they wanted and needed.

People's support decisions were always respected. One person said, "I tell them what I want to do and then we do it". The registered manager was committed to providing a service where people with learning disabilities had support to lead as normal a life as any other person.

Staff supported people to monitor their well-being and access healthcare services. People had effective

support with their eating and drinking, including any specific nutritional and dietary support needs.

People told us they thought staff were kind and listened to their views and made them feel that they mattered. People felt included and in control about decisions to do with their care. Staff communicated with people in ways they understood to remove barriers to people or staff understanding each other.

People were treated with compassion and empathy and encouraged to be as independent as possible in all areas of their support. People were treated with dignity and their privacy was respected. Staff understood their responsibilities to maintain people's confidentiality and could explain what these were. The service collected, stored and shared people's information in line with the principles of the Data Protection Act.

People told us they received personalised care. A relative told us, "They understand him. I think he is in the best place that he has ever been". A health professional said, "They are person centred in their working and approaches with the client I have been involved in".

People contributed to the planning of their care and support. Other appropriate people, such as relatives and health and social care professionals, were also involved in this process. People's care was regularly reviewed. The service responded quickly and made any necessary adjustments to people's support if their needs changed.

Staff knew people well and used information from a number of sources to understand details about who a person was and how this influenced how they needed and wanted to be supported. This included knowing about people's personal backgrounds, preferences, life history and aspirations. People also had care plans in place that contained information about people's physical, mental, emotional and social needs.

People were encouraged and supported to develop and maintain relationships with important people in their lives to help them avoid becoming socially isolated. People had support to follow their interests and take part in meaningful social activities and be part of their local communities.

The service provided information about care and support for people with a disability or sensory loss related communication need, in line with the principles of the Accessible Information Standards (AIS). People told us they knew how to and felt confident to raise a complaint. Any complaints that the service had been received were formally acknowledged and investigated in line with the provider's policy.

The service valued staff well-being and promoted inclusion and respect for staff equality rights. For example, they had arranged for workplace adjustments to be made to accommodate staff members' disabilities and dyslexia. The service worked in partnership with the local authority and health and social care professionals to share information and gain advice to help improve people's care.

Full information about the Care Quality Commission's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Medicines and risks to people were not always safely managed.

People were not always protected from risk of infection.

Staff did not always have support to help understand and prevent incidents and accidents.

There were systems and processes in place to keep people safe from abuse, including discriminatory abuse.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff did not always have regular training or supervisions and appraisals.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA).

People's physical, psychological and social needs had been assessed and their support decisions were respected.

People received effective healthcare and eating and drinking support.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were kind and compassionate.

People felt included and in control about decisions to do with their care.

Staff communicated with people in ways they understood.

People were encouraged to be as independent as possible.

Good ●

People's privacy, dignity and confidentiality were respected.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care and contributed to planning and reviewing this.

The service responded quickly if people's needs changed.

People developed and maintained relationships and followed their interests.

Information about care and support was provided for people with a disability or sensory loss related communication need.

Is the service well-led?

Inadequate ●

The service was not well-led.

Management of quality, risks, staff performance and regulatory requirements was not effective.

People, the public and staff were not always involved in developing the service.

Staff did not always have support to understand their responsibilities and account for their performance.

The service worked effectively in partnership with other agencies.

Pinkney Services Ltd

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 inspection took place on 5 and 6 April 2018 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to allow enough time for the provider to arrange for us to visit people in their own homes on the day of the inspection.

The inspection team consisted of an inspector.

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.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

During the inspection, we visited three people in their homes to talk with them and observe their care. We spoke with two support workers, the manager, deputy manager and the registered manager. We spoke with two relatives of people who use the service on the telephone. We received feedback via email from a health professional who has worked with the service to deliver support to people.

We reviewed care records for seven people and 'pathway tracked' two of them to understand how their care was being delivered in line with this.

We reviewed staff training, supervision and recruitment records, medicines records, care plans, risk assessments, and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas and other records related to the management of the service.

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yeah I feel safe just being here with them". People's relatives told us they thought the service was safe. One relative told us, "I think [name] feels safe at the service and is fine around the staff". Despite this feedback, we found several areas of practice that required improvement.

There were systems in place for recording, ordering, transporting, storing, administering and disposing of medicines properly. However, recording systems were not always safe. Medication Administration Records (MARs) were in place. MARs included information about people and details about how the medicines they needed should be taken or used and how often. MARs were then signed to record that people had taken their medicines.

However, MARs had not always been signed by staff. This meant it was not known if they had received their medicines as intended. The registered manager and management team were not aware that signatures had been missed. There had not been investigations into the reason for any missing signatures. This meant it was not known if people had not had their medicines, why this was or if people had help to seek medical advice, if they had missed them.

Staff followed best practice guidance to support people with preparing and handling food safely. Staff received infection control training as part of their induction training. Plastic gloves were used by staff when supporting people who required support with their personal care. However, we found that support for some people to maintain a clean and hygienic environment in their own homes required improvement.

We visited one person who needed encouragement to help them maintain a clean and hygienic home. Staff had to physically support the person by carrying out cleaning tasks for them if they were struggling to do this. The person's home was very dirty throughout. In particular, their bathroom toilet and floor was covered with impacted faeces and there were stains covering the walls and sink. Carpets and bedding were heavily stained. There were very strong offensive smells of urine throughout all of the person's house.

There were no records of any support to educate the person on the importance of maintaining a clean home environment, or upskill them to do this independently. There were no consistent records of regular cleaning tasks staff had supported the person with during visits. Any support that was being given by staff had not prevented the accumulation of dirt and extreme levels of uncleanliness observed during the inspection. This meant there was a risk of infection and cross infection to the person and staff supporting them.

The person received limited time for support with cleaning from staff. The service had recorded the need for staff to support them to deep clean their home and replace their carpets due to the excessively unclean environment. They had alerted the local authority to the issues and considered requesting funding for more support to help ensure the person could maintain a clean home.

However, these actions had first been identified several months ago but were still outstanding at the time of the inspection. There was no agreed date for the deep cleaning and replacement of carpet to be completed

by. There had been no recent dialogue with the local authority to move forward and agree the right support for the person and resolve the issue. This meant a high level of risk of infection to people and staff had remained on-going for a protracted period of time.

People had been assessed for risks caused by potential hazards to their well-being. There was support in place for people to minimise the risk of any hazards. The service respected people's independence. People were involved with making choices during their risk management processes and any restrictions on their freedom were kept to minimum. A member of staff told us, "The service is here to help people understand what safe choices are, not take control of their lives".

For example, one person liked to go to the pub. Their support needs meant this activity had historically presented risks to the person's safety and well-being. The service discussed this with the person and agreed they would support them to go to the pub at quieter times during the day. This reduced the level of risk so they could continue to enjoy their choice of activity as safely as possible.

However, people's formal risk assessments did not always have a lot of detail about how to manage risks safely. Staff could explain the control measures they used to keep people safe and were updated by management of any changes to these. However, some people using the service needed support to manage complex and high-level risks. The lack of formal guidance for staff increased the chance that they could not know, or consistently support people with the appropriate control measures to take to keep them safe. For example, lack of detail about how to control the risk of infection for the person who required support to keep their house clean could be a contributing factor to the failure to prevent this risk.

The failure to consistently ensure safe use of medicines, take timely and adequate measures to ensure prevention and control of infection and effectively monitor and manage risks to people is a breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the registered manager on day one of the inspection. They were taking immediate action to investigate the gaps in the MARS. We and received assurances they would immediately prioritise supporting the person with their planned deep clean. The provider also contacted the local authority to ask to urgently review the person's level of need for increased support with maintaining a clean and hygienic home.

Staff completed daily notes and accident and incidents forms. These were then reviewed by the registered manager who took action to keep people safe in response to incidents. Most staff said the registered manager discussed with them about what had happened and how to keep people safe following an incident.

However, staff told us that there was not always a formal or in-depth de-brief or handover following incidents. Although accident and incident forms and de-brief forms were in place, they were not always used and did not always record actions taken in response to incidents. This meant the service could not always evidence they had taken appropriate action and supported staff to understand and prevent the risk of incidents happening again. This is an area of practice we have identified as requiring improvement.

There were processes in place to help ensure safe recruitment. All staff had undertaken a satisfactory Disclosure and Barring Service (DBS) check before being formally offered a job. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Staff also had to successfully complete an application form, submit two satisfactory references and pass an interview before starting work. Staff then had to complete training and observations to a required safe standard

during an induction and probation period before being offered a permanent position.

However, these processes could not always be evidenced. Some staff had named two referees, but did not have two completed references on file to evidence these had been received and checked as per the service's safe recruitment policy. This is an area of practice that requires improvement. We discussed this with the registered manager, who advised this was due to missing paperwork and would take steps to locate these as soon as possible.

There were systems and processes to keep people safe from abuse. Staff knew how to recognise and report any signs of abuse and had received safeguarding training. This helped them know how to help stop or prevent abuse happening to people. The registered manager worked in partnership with relevant agencies in response to any safeguarding concerns. This helped agree a plan to keep people safe.

Staff knew of the importance of protecting people from any discriminatory abuse they might encounter. Staff had conversations and shared resources with people about their rights and how they were legally protected from discrimination under the Equality Act 2010. Staff helped people speak out against instances when this occurred or they were concerned people were being treated unfairly because they had a learning disability. This helped empower people to recognise and challenge abuse situations.

People told us there was enough staff and they always received their expected support from the service. People said most of their calls were on time. The rota was written to allocate shifts to match people with staff who were best suited to them and their needs. The registered manager confirmed the service had recently been under recruited. Management had temporarily covered any shifts to ensure people's needs were met. This arrangement was now being reviewed as the service had now recruited more staff.

Other aspects of medicines management were being managed safely. Where appropriate, risk enablement assessments were in place for some people who self-administered their medicines. This helped make sure self-administration was a safe enough thing for them to do. Some people were prescribed medicines on a 'when required' (PRN) basis. Guidance was in place to describe the requirements for offering and administering PRN. Staff received medicines training and their practice when supporting people with medicines was regularly observed.

Is the service effective?

Our findings

People told us they thought their care and support choices were respected and this helped them to achieve the outcomes they wanted. People's relatives said the service was effective and helped people have a good quality of life. One relative said, "They do things he likes to do, he is always happy". We found that some aspects of how the service supported staff to deliver effective care required improvement.

People told us they thought staff had the right skills, knowledge and experience to meet their needs. One person said, "They are well matched, they are into my kind of things, music, going out and to the gym". Staff received an induction that met the Care Certificate standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

After their induction, staff had regular training and could request additional courses if they felt they needed it. We received mixed feedback from staff about their training. One staff member told us refresher training and new requests were made readily available. However, one staff told us how they and other staff were still waiting for additional training they had requested to learn more about how to meet a person's needs. Due to the delay in receiving this, they did not think all of the staff team had the right skills, knowledge and experience to deliver consistently effective support.

The acting manager confirmed some training was still due to be delivered and there could be delays caused waiting for spaces and dates on available courses. This is an area of practice we have identified as requiring improvement. The acting manager acknowledged this and told us they had recently undergone a 'Train the trainer' course to deliver training themselves to help avoid any delays.

Staff received regular guidance from the management team to help make sure their practice was effective. This included discussions, observations and unannounced spot checks. Management consulted with other health and social care professionals to share information with staff based on best practice recommendations. A medical professional who worked with the service said this was effective and told us, "They have good links with health professionals...they implemented changes in practice when advised".

Although staff said this guidance was helpful, they also said managerial support was mostly informal, unscheduled, unrecorded and usually offered in response to incidents. The registered manager confirmed formal supervisions, appraisals, team meetings, on-site observations and spot checks had not been taking place regularly. This increased the risk that staff practice might be inconsistent or they might not know how best to deliver effective support to people. This is an area of practice we have identified as requiring improvement.

The Mental Capacity Act (MCA) 2005 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. We checked to see if the service was operating within the principles of the MCA and found that it was.

People told us and their care plans documented that they, or an appropriate person, had consented to their care. There were mental capacity assessments in place that recorded people's ability to be able to make decisions about certain activities in their lives. Best interest meetings had been carried out to make sure people who were not able to make certain decisions had received the correct support to do so. Staff received MCA training and told us about how they followed the consent and decision-making requirements of this legislation when supporting people.

People's physical, psychological and social needs had been assessed before they started using the service. This process involved the person and any other relevant people such as family members and health and social care professionals. If a person was joining or moving to the service, documents and any important information from previous support services was obtained and referred to when completing assessments. This timely co-ordination helped to make sure people had consistency with receiving the support they wanted and needed.

People's support decisions were always respected. One person said, "I tell them what I want to do and then we do it". The registered manager was committed to providing a service where people with learning disabilities had support to lead as normal a life as any other person. Staff understood this and helped make sure people's differences were not a barrier to them achieving their preferred support outcomes. One staff said, "I am here to help people. I wouldn't tell them they couldn't do anything, we treat everyone in the same way as you would treat anyone".

Staff supported people to monitor their well-being and access healthcare services if concerned this might be necessary. This helped people to make informed decisions about their health and understand which treatment options were available. One person said, "Staff come with me and if I don't understand they will tell me what the doctor means". People had 'Hospital Passports' that detailed their health, social and communication needs. People could then share this important information quickly and easily with medical professionals so they knew how to deliver the most effective healthcare support for them.

People had effective support with their eating and drinking needs. Staff encouraged all people using the service to maintain a healthy and balanced diet and explained why this was important. People had been assessed to identify any specific nutritional and dietary support needs. This allowed staff to be aware and offer the right support to help them manage these needs effectively. For example, one person had been advised to eat a low sugar diet. Staff supported one person to go shopping and had explained how to understand information about calories and different food groups on food labels. The person told us, "When we go to the shops I can now use the traffic lights to help pick food that is good for me. Staff will advise me about other food which doesn't have traffic light labels".

Is the service caring?

Our findings

People told us they thought the staff were kind. One person said, "They very friendly, we have a laugh and a joke, it's all quite relaxed". Another person said that the staff were, "Nice". A health professional told us, "In the contact I have had with the service...I have found them to be very caring".

People told us staff talked to them about their support and listened to their views. Staff told us they always tried to explain any information, answer any questions or accommodate any requests people made about their support. This made people feel included and in control about decisions to do with their care. One person said, "I can talk to them, they are quite flexible and will move the days I have my support if I tell them that I would like this".

Staff told us it was important to make sure they communicated people in ways they understood. This helped make sure people knew they were being listened to and that their opinions mattered. A relative told us staff knew the most appropriate way to speak with their family member. They told us, "The way I've seen them talk to him is very good, it is the kind of way I would speak to him". For people where their protected characteristics meant it was necessary; Makaton – a language programme that uses signs and symbols - and pictorial communication resources were used to remove barriers to people or staff understanding each other.

Staff spent time getting to know people as individuals by talking to them and their families. This helped them to recognise when people needed support and how to respond in a meaningful way. One staff told us knowing people's unique personality traits allowed them to offer compassionate support at the right times, "Be patient. You need to know how to react in a positive way so you can show empathy and build up confidence between you". A person said this approach made them feel like staff understood and respected their feelings, "They will listen. We will have a chat and if I said I needed some time and space they would give it to me".

People were encouraged to be as independent as possible in all areas of their support. One person told us, "I go to with staff to the doctors, but I ring up myself to make the appointments. If I can do it I will. If I ask, they prompt me if I get stuck". A relative told us the service was very focused on promoting independence for their family member saying; "As much as they can they encourage him to do things himself, he does his cleaning himself and his shopping himself with some prompts".

Staff said they always looked to empower people to do as much as they could themselves. One staff gave us an example of how they approached this when supporting people; "One person hesitates when speaking but if you give them time they can say what they want themselves, even if it takes a while". A person said staff respected their preferences and this encouraged them to be independent, "They help me, give me advice so I can make choices".

People told us that staff treated them with dignity and their privacy was respected. One person said, "They always talk to me in a nice way". People could request support from staff of a particular gender, so they felt

comfortable and dignified if they wanted to discuss intimate issues or required personal care support. Staff told us it was important to let the person lead their support at all times and to not step in unless people gave their permission. One staff said, "We promote people's choice, we don't act on our own will".

Staff understood their responsibilities to maintain people's confidentiality and could explain what these were. The registered manager explained how the service collected, stored and shared people's information in line with the principles of the Data Protection Act.

Is the service responsive?

Our findings

People told us they received personalised care. A relative told us, "They understand him. I think he is in the best place that he has ever been". A health professional said, "They are person centred in their working and approaches with the client I have been involved in".

People contributed to the planning of their care and support. Other appropriate people, such as relatives and health and social care professionals, were also involved in this process. This helped to make sure that staff knew about people's levels of independence and offered them the right support. One person told us how they had planned how their support was delivered with their social worker. They said, "I agreed to this, it doesn't worry me, it helps me do what I want".

People's care was regularly reviewed with them and any appropriate people who were involved in their support. Reviews were planned regularly and also took place on an ad hoc basis if it was thought that a person's needs might have changed. Management and staff also communicated on a daily basis verbally and via communication books to share information about people's needs. This allowed the service to respond quickly and make any necessary adjustments to people's support.

A relative told us the review process was effective and the service was proactive at recognising any changes and then taking action. Their family member's support needs had increased in a number of areas as they had got older. They said, "They are responding very well to his needs, they have adapted to his changes well". This helped to maintain a good quality of life for the person.

Staff knew people well and could explain details about who a person was and how this influenced how they needed and wanted to be supported. This included knowing about people's personal backgrounds, preferences, life history and aspirations. Staff gained this information from talking to people and their relatives. This helped them to understand how to deliver person centred support so people could live the life that they wanted. People also had care plans in place that contained information about their physical, mental, emotional and social needs.

However, compared with the informal knowledge of staff, plans lacked detail about how to provide responsive, personalised support. This increased the risk that staff might not understand people's needs or the importance of the personal motivations that influenced them. Having this information recorded decreases this risk. It also helps to make sure that people's needs and choices are clearly recorded, so they remain in as much control of their support as possible. The registered manager acknowledged this and was in the process of reviewing and amending plans to include more person centred detail.

People were encouraged and supported to develop and maintain relationships with important people in their lives. Staff told us how they supported people to make and send cards to relatives and friends if they were not able to do this independently. According to people's level of need, staff helped arrange transport or went with people so they could regularly attend social groups and visit friends.

The service recognised the importance of people having healthy relationships with other people and the negative impact this can have if these break down. People had received support to understand and learn about respecting established social boundaries where these had been breached. This had allowed people to repair and maintain friendships that mattered to them and helped them avoid becoming socially isolated.

People had support to follow their interests and take part in meaningful social activities. One person had a passion for music. Staff had helped them to join a local group where they regularly wrote, performed and broadcast their own compositions at a community music studio. The person also liked animals and staff supported them to volunteer as a dog walker several times a week. Other people also had support to carry out activities they enjoyed and go out to places that interested them.

The service provided information about care and support for people with a disability or sensory loss related communication need, in line with the principles of the Accessible Information Standards (AIS). These included 'Easy Read' formats and pictorial materials being available for people. Staff could also read and explain using accessible language or Makaton written correspondence to people, so they understood information about their support.

People were encouraged to raise any concerns they had. The service provided people with a copy of their complaints policy in an 'Easy Read' format. People told us they knew how to and felt confident to raise a complaint. One person said, "It hasn't happened yet but I would say something if it did. I would have a word with the registered manager and I know we would talk it out". Another person said they had raised a complaint and, "The registered manager dealt with it, it got resolved. I feel comfortable about it".

The registered manager told us they took complaints very seriously and if a complaint was received they used this as chance to see what could be learned, including making any improvements to the service if necessary. We saw examples of where complaints had been received and formally acknowledged and investigated in line with the provider's complaints policy.

Is the service well-led?

Our findings

People told us the registered manager and management team were approachable. One person said, "I see the registered manager now and again, he is friendly". Relatives told us they thought the service was generally well-led. One relative gave feedback that they felt the service did not always enable and encourage open communication. We found although there was evidence of a clear vision of person centred care, the service was not well-led and required improvement in several areas of practice.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the registered provider of the service.

However, the registered manager and provider had elected to nominate an 'acting registered manager' since January 2017. We were told this was due to the registered manager and provider experiencing a period which had restricted their involvement with the service. The registered manager and provider had not notified the CQC of a period of extended absence. The acting manager had not formally registered with the CQC and had been undertaking the role on a part-time basis with support from another deputy manager. Alongside their registered manager duties, the acting manager was also expected to carry out regular support worker duties.

The acting manager told us they had not felt supported to understand the full requirements of their role and did not have enough time to always carry out their managerial responsibilities. They said, "I have not been supported. I have struggled and fallen behind". This had meant that management of quality, risks, staff performance and regulatory requirements had not been always been effective. The registered manager acknowledged this and said, "This has not been a well-led service".

The service had not submitted notifications of events that had occurred in line with CQC registration requirements, such as incidents involving the Police and allegations of abuse. These had not been submitted because the acting manager had not been aware of their responsibility to do so and the registered manager and provider had not ensured they had been aware of this. These notifications are required by law to be delivered without delay. This is necessary so that, CQC can monitor and assess the need for any regulatory action.

The failure to submit statutory incident notifications is a breach of the Care Quality Commission (Registration) Regulations 2008 Regulation 18: Notification of other incidents.

The service did not operate formal quality assurance and information governance systems. Information about the quality of people's support was mainly shared verbally or via text message between staff and management or gained from sources such as communication books, medicine records and accident and incident forms. The acting manager used this information to keep an informal record of issues and then

prioritised actions according to the most urgent levels of risk to the quality and safety of service delivery.

However, this informal quality assurance process was not always effective. Quality and safety issues had not always been identified. Where these had been recognised, these had not always been acted on in a timely manner. For example, issues regarding medicines, infection control and lack of consistent support for staff had not been recognised or had been allowed to continue for protracted periods of time without effective action being taken.

Without formal audits of quality assurance information, there was no formal system or records available for all levels of management to review the quality and safety of the service. This presented an increased risk that issues would continue not to be identified or actions not taken promptly. The lack of consistently accessible information available also impacted on the ability of the service to be able to continuously review, learn and improve the quality of its support.

The registered manager had a clear vision for the service to deliver high quality care that empowered people with learning disabilities and autism to be independent and achieve what they wanted from life. Staff we spoke with told us they were aware of the service's commitment to supporting people in a person-centred way and treating them equally.

However, the lack of an effective governance framework meant staff had not always had support to take account for their performance. Processes such as supervisions, appraisals, disciplinary and team meetings had not been consistently taking place for over a year. Staff told us the lack of clear accountability processes left them feeling unsupported and unsure of how they were expected to fulfil their responsibilities to realise the service vision of high quality care.

The lack of direction and positive reinforcement of shared performance expectations meant staff did not always work collaboratively or effectively. For example, staff had taken to confronting and challenging each other face to face and via service communication books regarding support and practice issues. This allowed staff conflict and service delivery issues to remain unresolved and had led to the creation of a negative team culture.

Management were not always seen as visible and approachable by staff. One staff said, "Management are always busy. The registered manager is not fully involved". Some staff found the feedback from members of the management team had been inconsistent and was not always constructive. Staff found this made them feel de-valued and de-motivated and felt these issues had been a contributing factor to recent high staff turnover.

Due to sporadic and inconsistent formal contact with management, staff told us they were not always confident they had been made aware of potential risks or compromises to service delivery. One staff said, "There are no clear lines of communication or open sharing of information. Issues are not always followed up".

We found the above failures to ensure consistent and effective management and governance of the service is a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these issues with the registered manager. They acknowledged their period of absence and issues with the interim management arrangements had impacted negatively on the leadership and governance of the service. They confirmed they were now in a position to commit to fulfilling all aspects of

the registered manager role on a full-time basis and ensure the service was well led. They were also restructuring their management support team, to remove issues caused by staff with dual support worker and managerial duties.

Although encouraged, the lack of team meetings and individual supervisions had limited staff involvement in developing the service. People and their told us they had been sent a survey asked about their views on what could make the service better in the past, but this had not happened recently. We received mixed views from people's relatives about how the service encouraged and enabled open communication. One relative told us they were not always confident the service shared information about what was not working well and did not offer support or opportunities for them to contribute to solutions. We found involvement and engagement with people, the public and staff is an area of practice that requires improvement.

The registered manager told us the service valued staff well-being. Staff gave us examples of how the service had implemented flexible working arrangements to support them when experiencing personal and health issues. The service promoted inclusion and respect for staff equality rights. For example, they had arranged for workplace adjustments to be made to accommodate staff members' disabilities and dyslexia.

The service worked in partnership with the local authority and health and social care professionals to share information and gain advice to help improve people's care. A health professional told us, "The service followed up on action points that were set" when working to an agreed multi-disciplinary plan and communicated well throughout this process.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to consistently ensure safe use of medicines, take timely and adequate measures to ensure prevention and control of infection and monitor and manage risks to people effectively. 12 (1) (2) (a) (b)(g) (h)
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure consistent and effective management and governance of the service. 17 (1) (2) (a) (b) (c)