Poppy Cottage Limited

Poppy Cottage Limited

Inspection report

Poppy Cottage
Denham Green Lane, Denham
Uxbridge
Middlesex
UB9 5LG

Tel: 01895832199
Website: www.poppycottagelimited.com

Date of inspection visit:
25 January 2022
26 January 2022
31 January 2022

Date of publication:
19 May 2022

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Poppy Cottage Limited is a supported living service. The service provides personal care to people living in five supported living settings, so that they can live as independently as possible. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection 18 people used the service and 12 people received support with personal care. The service was set-up to provide support to adults under and over 65 years, living with dementia, learning disabilities, mental health conditions, physical disabilities and sensory impairments.

Poppy Cottage Limited is also a domiciliary care service. The service informed us they had provided domiciliary care to people in their own homes in the community in the past, but were not doing so at the time of our inspection.

People's experience of using this service and what we found
People's risks were not always assessed appropriately to identify or effectively reduce risk in areas such as fire safety, health, finances and safety of chemicals. Governance systems did not manage risks to people well, or ensure records were well managed.

People's care and support was provided in a safe and clean environment. Systems were followed to ensure people were protected from abuse and poor care. The provider reviewed incidents but this did not include themes or outcomes. We have made a recommendation about this. People and relatives told us they felt the service was safe and that staffing levels had improved. Medicines systems had generally improved, however we have made a recommendation about the management of medicines records and audits. Staff recruitment checks were completed before they started supporting people. We have made a recommendation about the recruitment records.

The service did not effectively meet two people's hydration needs to maintain their health and wellbeing. Other people received effective support to monitor their nutrition.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not consistently support this this practice. We have made a recommendation about this.

People's care, treatment and support plans were holistic. However, they did not always include enough information about identified needs or how to provide support. We have made a recommendation about this.

People were supported to be independent, pursue their interests and achieve their own goals. Staff protected and respected people's privacy and dignity. People told us they staff were caring and treated them well. We have made a recommendation about how people prefer to be addressed.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: The service supported people to have the maximum possible choice, control and independence. This was not consistently supported by recorded best interest decisions.
Right care: Staff provided person-centred care and promoted people's dignity and privacy. This was not consistently supported by documentation, which did not always demonstrate how people's human rights were considered and upheld.
Right culture: People were at increased risk of harm because the provider did not manage risk well to protect people. There was a transparent and open and honest culture between people, those important to them, staff and leaders.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 22 September 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made. The provider remained in breach of two of the regulations and we found a new breach of regulation. It was no longer in breach of other regulations.

This service has been in Special Measures since 8 September 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures. The service is now rated requires improvement.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches of regulation in relation to risk assessment, good governance and meeting people's hydration needs.

We issued a notice of decision to impose conditions upon the providers registration. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Poppy Cottage Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors visited the office location and people's homes on 25 and 26 January 2022. A medicines inspector visited the office location 25 January 2022. An Expert by Experience made telephone calls to gain people's feedback about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in five 'supported living' settings, so that they can live 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.

This service is also a domiciliary care agency. At the time of our inspection the service had not started to provide personal care to people living in their own homes. Therefore, we did not inspect this type of service delivery.

Notice of inspection
We gave a short period notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us 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 eight people who used the service and five relatives about their experience of the care provided. We received written feedback from one relative. Some people used different ways of communicating including Makaton (a type of sign language), photos, pictures and their body language. We observed people's care to help us understand the experience of people who could not talk with us. We spoke with 16 staff members including care worker, heads of care, administrative staff, manager, development manager, operations manager and registered manager, who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received written responses to our questionnaires from nine staff members, including night-time and casual care workers.

After the inspection
We sought more information about fire safety, people's risk assessments, staff training and policies and procedures. We spoke with a local authority fire officer and received feedback from social workers involved in people's care.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Fire risk assessments, emergency evacuation procedures and fire drills did not effectively identify or mitigate hazards and did not account for reduced staffing levels at night. The management team told us they could not demonstrate safe evacuation for people who were dependent upon staff support to evacuate at night. This meant people were at increased risk of harm.
• One person's emergency evacuation plan stated if staff could not support them to exit the premises, then they would stay put in their bedroom with the door locked to wait for the fire service to rescue them. This was not a safe evacuation plan and did not consider national fire safety guidance.
• The provider did not consistently or effectively mitigate other risks to people. For example, risks to two people's health in relation to hydration were not identified or mitigated. One person experienced urinary tract infections and had acute kidney injury stage one; their care plan stated staff should encourage fluids and a water bottle was purchased to measure this, however, a daily fluid target was not identified and there was no guidance about when or how staff supporting the person should report concerns about the person's fluid intake to prevent their health deteriorating.
• We found shortfalls in the same person's risk assessments for choking, pressure and moisture ulcers. Two other people's moving and handling risk assessments did not include enough information about their mobility equipment, or how many staff were required for different moving tasks. This meant staff who were not familiar with the person's needs did not have access to all the information required to mitigate risks.
• Risk assessments were not recorded in relation to people's financial needs. This meant staff did not have access to enough information about specific risks to people or how to support people to reduce the risk. The service could not demonstrate how they had considered a person's mental capacity in relation to the risk of having a bank card and PIN.
• The service had not consistently documented people's individual risk assessment for the control of substances hazardous to health (COSHH). The service provided one person's risk assessment, however, this was incomplete as it did not identify why the person was at increased risk. Information about COSHH products was not available to ensure staff and people knew the risks and how to respond in cases of misuse, or accidental spillages on to people's skin.

• The service had made some progress by introducing risk likelihood, severity and classification as part of their assessment process. However, this was not applied effectively to identify whether levels of risk were mitigated to an acceptable level. This meant the provider did not know whether further actions were required to address risk.

Care and treatment was not always provided in a safe way. The provider did not effectively assess or mitigate the risks to the health and safety of service users. This placed people at increased risk of harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider took action to mitigate these risks. They sought advice from the fire service and introduced additional staffing at night the week after our inspection. An action plan was implemented to review and update all fire risk assessments and emergency evacuation plans. This included the completion of regular fire drills to simulate differing staffing levels and people's needs, to demonstrate evacuation plans were effective and remained so. An action plan was implemented to address other risks to people and we saw evidence this was being progressed.
• Staff we spoke with were knowledgeable about risks to people and how to keep people safe. For example, staff knew about a person's risk of choking and accurately talked through their agreed plan of care for eating and drinking.
• In practice, staff followed procedures to account for people's financial transactions and regular checks were made by the provider to reduce the risk of financial abuse.
• During our inspection we found COSHH products were consistently stored safely in locked cupboards to reduce risk. Staff were knowledgeable about people's ability in relation to using cleaning products, including positive risk taking. We also saw examples where people's involvement in managing risk was considered and documented.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our last inspection the provider had failed to establish or operate effective systems to protect people from abuse. Appropriate action had not been taken to obtain legal authority to deprive people of their liberty to keep them safe. This was a breach of regulation 13(2), (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

• The provider had improved systems to identify and report concerns of neglect and abuse. A safeguarding lead was appointed, who understood requirements and ensured concerns were reported to the local safeguarding authority. They maintained an audit trail to demonstrate outcomes and actions taken to reduce the risk of abuse.
• We found one instance where a staff member had not completed the correct record for an unexplained injury, which meant this was not escalated appropriately. We raised this with the management team, who acted to follow-up the person's wellbeing and reported this to the local safeguarding authority.
• Records showed new staff had completed the minimum level of safeguarding training. We found numerous gaps for existing staff and the provider produced an action plan to address this.
• Staff feedback indicated they understood safeguarding procedures, "Staff know how to report concerns and heads of care at each property check with staff. Things are now reported properly", "We have had a few safeguarding issues and the management team have stepped in and responded quickly and have always had the person's safety and care at the forefront. We have risk assessments and I have done online training to help me identify any abuse or risks" and "I have no issues following whistle-blowing as it would be in the

best interest of staff or a service user".
• Safeguarding information was accessible to people and staff, such as who to raise concerns with and contact details for the local safeguarding authority.
• The provider had taken action to liaise with the local authority, who were responsible for seeking the legal authority to deprive people of their liberty, to keep them safe. For example, two people required continuous staff supervision and we saw this was authorised by the Court of Protection.
• The service had reviewed people's positive behaviour plans to prevent the use of restrictive interventions such as seclusion. A staff member told us, "I have never used any of these restrictive methods on any of our service users…they are the last resort to use and even that must be less restrictive as much as possible."
• Systems were in place to review accidents and incidents and share lessons learnt with staff through team meetings and the electronic communication system. However, this was not always robust. For example, insufficient action was taken in response to a person's hospital treatment for presumed urinary tract infection (UTI) and acute kidney injury to ensure appropriate monitoring systems were agreed and put in place. Outcomes and themes were not clearly recorded to demonstrate what action was taken. The development manager told us there were not any particular themes across the service, but referred to themes in one person's distress which led to a review of their care plan. Records showed there had been a decrease since September 2021 and staff we spoke with confirmed this.
• We looked at a sample of investigations and found these to be thorough and outcomes and actions addressed risk and were clearly recorded.

We recommend the provider ensures analysis of accident and reviews is robust and includes themes, outcomes and actions taken as part of lesson learnt.

Staffing and recruitment
At the previous inspection the provider was in breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not always obtain the required checks to make sure staff were of good character prior to employment.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

• Recruitment practices had improved. Potential candidates attended for interview and completed assessments as part of the interview process. A recent photo was on file and references were obtained.
• For one staff member, a reference did not relate to their employment history and for another a character reference was obtained instead of an employment reference. The provider submitted evidence after the inspection this was because other referees had not responded and agreed to update the staff file to reflect this. Other staff members employment records were updated to accurately reflect their work history.
• Disclosure and barring service checks (DBS) were carried out for all new staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. In two staff files viewed, the date of their DBS was after their start date. However, the provider gave us evidence after the inspection that staff were on induction during this time and a risk assessment was in place to support their decision.
• The service obtained and checked agency staff profiles prior to them supporting people including DBS updates online. The provider confirmed they had no system in place to undertake spot checks of the agency to ensure right to work requirements were met.
• The provider had a recruitment policy in place which was not updated to reflect the change in management. The policy made reference to guidance documents on DBS, volunteers and EU settlement, which were taken from the government website but was not incorporated into the content of the recruitment policy.

We recommend the provider works to best practice to further develop their recruitment policy and practices, with records available on files to demonstrate actions taken.

Using medicines safely
At our last inspection the provider failed to ensure medicines were managed and administered to people safely. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to medicines management.

• Medicines systems and completed medicines administration records (MARs) showed improvements had been made to ensure people received their regular medicines as prescribed.
• We found a person's care plan was not updated with a change to dosage of the medicine and there was no confirmation of who prescribed the change of dosage. However, during the inspection when accessing the same care record on a different computer, we saw that that the information was in the care plan. We could not be assured that all staff who managed people's medicines had access to the information they needed to administer medicines safely. The management team took immediate action to address this.
• The service did not identify where medicines were homely remedies rather than prescribed 'when required' (PRN) medicine. PRN protocols were not always in place and where they were, these were not always person specific to ensure effective, consistent administration of medicines.
• The provider's medicines policy stated administered PRN medicine should be recorded on MARs. However, we found staff sometimes recorded on different documents, which increased the risk of staff administering repeated doses of PRN medicines. The management team took immediate action to review PRN and homely remedy protocols.
• The service carried out regular medicine's audits. However, these were not always effective as they had not identified the areas we found during the inspection.
• People who used the service were assessed to see if they could safely manage aspects of self-administration.
• The storage of people's medicines and records had improved to address safety and ensure people's privacy.

We recommend the provider takes action to ensure medicines audits are robust and medicines records are up-to-date and appropriate.

At the previous inspection the provider was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure there were sufficient numbers of suitably skilled and experienced staff to meet people's needs.

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

• People using the service, their relatives and staff consistently told us staffing levels and continuity of care had improved. For example, people told us, "Staffing has improved and there are more regular staff, which means I get to go out more" and "The biggest improvement I can see is the staffing and this means there are now opportunities to go out regularly".
• We have reported upon staffing levels at night under the key question about assessing risk and safety management. In response to our concerns the service took action and implemented additional staff at night. They also started to review people's care packages with local authority commissioners to ensure

people's needs at night were met.
• We observed people received one to one staff support in accordance with their agreed plan of care and support hours. Rotas showed enough staff were planned and electronic systems that recorded staff actual start and finish times were checked by the provider. We crossed referenced a sample of the electronic data with rotas in January 2022 and found actual staff start and finish times showed enough staff were on shift to support people.
• The provider had significantly reduced its use of agency staff. Where agency staff were occasionally needed to cover absences and vacancies, the service made arrangements to book the same staff. People and staff told us agency staff members knew people well.

Preventing and controlling infection
At our last inspection the provider had not taken effective action to detect or prevent the risk of infections. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. During the inspection we saw soiled laundry was brought through the kitchen into the laundry room. The risks around this had not been considered or mitigated. The supported living services were generally clean with cleaning schedules in place to support this, however, we found a microwave was unclean and rusty which was immediately removed by staff and action taken to replace it. These shortfalls were addressed by the provider after the inspection. High touch areas were regularly cleaned although records did not outline the frequency. The service informed us and records showed in the event of a COVID-19 positive case, increased infection control checks were implemented, which included frequent cleaning of high touch areas. These shortfalls were addressed by the provider after the inspection.
• We were assured the provider was meeting shielding and social distancing rules and was admitting people safely to the service. Staff used PPE effectively and safely. Donning and doffing information was on display and available to staff. PPE stations were available at each supported living service and bins were provided to dispose of used PPE. Staff wore masks throughout the inspection, although occasionally some staff wore the mask off their nose and needed reminding to put it on correctly.
• We were assured staff followed effective procedures to prevent visitors from catching and spreading infections. Lateral flow test results were checked and temperatures were taken of visitors on arrival at the office and each of the supported living services. Systems were place for people and staff to be regularly tested and the frequency of testing increased in response to an outbreak.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The service had responded appropriately to a recent COVID-19 positive cases and prevented the spread of infection. Staff were trained in infection control and competency assessment were carried out on staff to assess their learning and practices.
• Food storage was clean and hygienic. Fridges and freezers were organized and opened food was labelled and dated to ensure it was not eaten past expiry dates.

Visiting
• The provider's policy and procedure for visiting aligned with government guidance. The service enabled people to receive visitors safely and people were supported to visit their family and friends in the community, as well as overnight stays at their family members' homes. We have reported upon a separate visiting concern, unrelated to COVID-19 under the well-led section of this report.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection we recommended the provider took action to ensure staff followed people's nutritional and hydrations needs. Not enough improvement had been made at this inspection and the provider was now in breach of regulation 14.

• One person experienced regular urinary tract infections (UTI) and had a diagnosis of acute kidney injury stage one. They had recently been admitted to hospital due to their confused state and treated for presumed UTI. In response to the paramedic's advice, the service had purchased a measuring fluid bottle and instructed staff to encourage the person to drink. However, no action was taken to identify an appropriate fluid target to maintain the person's health and wellbeing. Staff had sometimes noted the person's fluid intake in their daily notes, however this was inconsistent. Some days no fluid was recorded and other days a small amount was recorded. There was no monitoring system to ensure appropriate action was taken if the person was not drinking enough."
• Another person's care plan stated they required full support to eat and drink and may refuse food and fluid. Written guidance said staff needed to be patient with the person, however, there was no further explanation about how staff should monitor, record and report concerns about food and fluid intake, or what the person's daily fluid target was. Records showed the person's fluid intake was sometimes very low, without any record of further actions taken.

The service did not consistently meet the hydration needs of service users to sustain good health. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to review people's hydration needs and sought advice from their GP.

• Staff supported people to eat and drink using adapted equipment as identified in their care plans.
• Records showed people received modified diets and supplements in accordance with dietitian and Speech and Language Therapy (SaLT)guidance for swallowing risks.
• Staff supported people to create and follow their individual menu plans in accordance with their needs and preferences.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection the provider had failed to carry out assessments of people's holistic needs and preferences in collaboration with relevant others. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• The service had made progress in assessing people's holistic needs. Assessments included information about emotional, physical and health and wellbeing needs. However, the content of some assessments did not always result in a clear understanding of people's level of need or outcomes. For example, there was no correlation between the level of need and how frequently a person needed support to reposition to prevent pressure areas. Staff we spoke with were able to describe the person's needs and support required to enhance comfort and prevent pressure areas. However, there remained a risk that new staff may not have access to enough information meet the person's needs.
• Standard national assessment tools were used to identify people at risk of malnutrition. We saw one person's weight was closely monitored with instructions to refer to the GP if this decreased. However, weight records showed a positive increase.
• Staff we spoke with understood and followed a Speech and Language Therapist's (SaLT) care plan for a person's eating and drinking swallowing difficulties.
• Positive behaviour plans were in place in response to emotional and psychological needs and contained detailed information about how to support the person proactively. However, records did not always include who was involved in developing the plan, such as positive behaviours specialists. The manager told us they would take action to ensure this information was included.
• The service completed standard NHS 'health passports' which captured people's needs. We found that rather than completing the health action plan at the end of this document, the service created their own health action plan. This additional document duplicated information in the 'health passport' and did not list agreed actions as this was recorded elsewhere in the electronic recording system. We were concerned the system could be confusing for staff and there was a risk key information would be missed.
• People told us and records confirmed that staff supported people to access a range of health services such as, physiotherapy, optician and the dentist. We saw two people had been supported to access health services to upgrade their mobility equipment, in response to changes in need.

We recommend the service follows best practice guidance and implements standard national tools to ensure the content of all assessments is appropriate and sufficient.

Staff support: induction, training, skills and experience
At our last inspection the provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The provider had a training policy in place which outlined staff induction and training programmes. Since the previous inspection existing staff had completed the care certificate training and new staff were progressing with workplace evidence to demonstrate their learning in practice. The provider had also identified staff to put forward for National Vocational Qualification training.
• We found there were still gaps in training for existing staff across all areas. The current training matrix did not always account for staff initial training or include details about the expected frequency of ongoing

training, this meant we could not be assured training was in date for all staff. We saw evidence the provider had made efforts to follow-up with staff to complete mandatory training. In response to our feedback the service produced an action plan with specific time frames and support required for individual staff to achieve this.
• New staff told us they were inducted into the service and provided us with evidence of the induction booklet they were working through. They confirmed they worked alongside other staff in getting to know people and the role. Staff consistently told us the training had improved in that there was more face to face training and less reliance on online training. Staff commented "Better quality training which includes external trainers", "Managers are working alongside us in implementing the training such as communication training, which will improve people's lives" and "Training has gone back to basics which has been invaluable".
• Agency staff profiles included an outline of training they had completed which was routinely checked by the service. The service ensured agency staff inductions were completed and records confirmed this.
• The provider had a supervision policy in place which outlined supervision would take place four times a year alongside workplace competency observations. The policy indicated staff were subject to annual appraisals and the training policy indicated new staff were subject to probationary reviews. The provider had identified supervisions, reviews and appraisals were not happening at the frequency outlined in their policy. However, this was being addressed and a supervision, probationary review and appraisal matrix was in use which showed supervision, probationary reviews and appraisals had commenced and others were scheduled.
• Staff told us they felt better supported and that one to one supervision had commenced. They also confirmed staff meetings were taking place more regularly which had improved communication and teamwork. Staff commented, "I feel better supported and clear about what is expected from me," and "The support to staff and the services have definitely improved".

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider failed to ensure care was provided with people's consent or with the required legal authority. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

• We found staff knowledge about MCA legislation and their responsibility to gain people's consent had

improved. For example, staff told us, "I verbally ask for consent or use visuals to contain consent, also read the person's support plan and care plan to advise how the induvial gives consent" and "I always ask for permission". The service had made some progress in staff MCA training and had started to implement MCA workbooks to assess staff competency in this area.

• The service used MCA assessment templates which followed the principles of the MCA code of practice. However, we found the decisions being assessed were not always specific and the best interest decision had not been recorded. For example, one assessment stated the decision was about COVID-19 without further explanation about this. We saw examples of other decisions that were specific and provided a summary of best interest decisions and who was involved.

• A member of staff described to us in detail how they had worked closely with the person's community health team to assess their mental capacity. A best interest decision was made in consideration of the person's safety and potential distress by pursuing a particular medical intervention. The service was supporting the person with the least restrictive interventions and a plan was in place to review the success of this and agree on next steps in the person's best interest.

• The service had liaised with people's funding authorities to apply to the Court of Protection (CoP) where people's liberty was deprived to keep them safe. Where the CoP had authorised this for two people, this was recorded in people's care plans. However, detail was lacking about the conditions, such as the requirement to review with the CoP if the person's needs changed. This meant staff may not have access to information they need to comply with the decision.

We recommend the provider takes action to consistently record relevant information about how they apply the principles of MCA and DoLS legislation in practice.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question was requires improvement. At this inspection the rating has changed to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Supporting people to express their views and be involved in making decisions about their care
At our last inspection the provider was not always delivering care in a compassionate or supportive way to promote people's dignity and respect. This was a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

• Staff we spoke with referred to people respectfully and empathetically. We noted that staff frequently used terms of endearment towards people, without consideration for how people wished to be addressed and the impact this may have on some people. We raised this with the management team who said they would take action to address this with staff. Where people preferred to be called by 'nicknames' this was recorded in their care plan and respected by staff.
• People told us, "Staff here are lovely" and "I have a great relationship with [named staff member], we like the same things and go out and do things that I enjoy together." One relative we spoke with felt that in the past some staff had not been caring but said now "things are brilliant" with new staff and new management arrangements.
• We found in general care records had improved to ensure people's emotional and psychological needs were reflected through respectful language and terminology. In one case a person's age was referred to as a reason for not learning a new skill. We raised this with management who agreed to review how this was recorded, in order that the person's choice and ability was reflected rather than based on their age.
• We observed staff interaction with people was warm and friendly and people appeared relaxed in the company of staff.
• In general, we saw staff took time to communicate with people and listened to their views. At one setting we saw information was displayed about how staff should support a person with their communication aids, although this was not used by staff in our presence. Management told us the service was working to embed everyone's communication tools through training, role modelling, supervisions and team meetings. We saw some staff had attended communication training and others were due to attend training by the end of January 2022.
• At other settings we saw staff using people's preferred methods of communication, such as Makaton, photos and pictures to support people to express their views, feelings and choices about their care and

support.
• Staff consistently told us communication training had improved and demonstrated enthusiasm for ensuring people were supported to understand information and express their choices and decisions.
• We observed staff supported people to maintain and develop independent living skills. For instance, people were supported to prepare their own menu plans, shopping lists and cook their meals, with staff guidance and support according to people's abilities.
• The service had improved the way people's communal areas were used to promote people's rights, comfort and privacy. For example, people's records were stored discreetly and securely. The position of staff computers and phones were considered to minimise the impact of noise in people's living areas.

We recommend the provider reviews people's wishes about how they would like to be addressed and ensures this is recorded in their care plan.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

At our last inspection the service did not consistently provide personalised care or ensure reasonable adjustments were made to support people with communication. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• Staff we spoke with demonstrated they were knowledgeable about people's needs and preferences and described how they supported people to reach their goals. However, we found recorded care plans did not always provide clear information about people's specific needs or support requirements. For example, in some care plans the statement 'full support with personal care' was used without explanation about how staff should meet people's needs.
• Care plans were written in the first person without explanation about whether this was the person's own words or gathered from other people who knew the person the well. This meant it was not always clear what was the person's voice or and what was agreed in their best interests.
• People were supported with their religious and ethnic identity. For instance, staff had researched and supported one person to worship at key times in their home.
• Staff understood what was important to people and staffing was allocated to enable people to pursue their own interests and goals.
• A relative told us, "The manager understands my daughter really well, she listens to suggestions and understands her needs, things are followed through such as a long-term dentist appointment".
• People had individual communication plans, however, these did not always contain accurate information about their preferred communication methods or how staff should meet people's needs. For example, one person's care plan did not include the use of pictures, shorter words or videos that were referred to in their communication risk assessment. The same person's health passport (for sharing with health care professionals) identified facial gestures and short words, but did not identify the use of pictures or videos
• In practice, staff had good awareness, skills and understanding of individual communication needs, they

knew how to facilitate communication and when people were trying to tell them something.
• We saw people had access to information in formats they could understand. There were tailored visual structures, including pictures, photographs, use of gestures, symbols and Makaton signing, to support people's understanding. This helped people to plan their day and know who would be supporting them.

We recommend the provider takes action to ensure people's care plans contain accurate information about identified needs and preferences and how staff should meet people's needs.

Improving care quality in response to complaints or concerns
At our last inspection we recommended the service develops a system to monitor complaints in order to respond to trends and areas of risk. Enough improvement was made in this area.

• There was an appropriate complaints policy and procedure which also signposted people and those important to them to advocacy services if support with a complaint was needed.
• Since our last inspection the service complaints log recorded one concern which the service resolved quickly and multiple complaints from one source. The service investigated and provided responses, which included their findings and what action the service had taken to address issues raised. We found a further response from a service director acknowledged feedback from the complainant but did not provide information about how the director intended to act. The service signposted the complainants to the local government ombudsman to review their complaint as appropriate.
• People who used the service were supported to raise concerns and complaints easily and staff supported them to do so.
• There was an 'easy read' compliments and complaints guide and other accessible information about how to raise concerns. For example, one setting had implemented a 'grumble' folder for people to tell or write about lower level concerns for staff to help resolve or escalate to the management team for support with this.
• We looked at compliments received since our last inspection from five different people's family members. Compliments included feedback about specific staff members' care and the positive impact upon people's quality of life, recognition that people were well supported during the pandemic, and acknowledgement about general improvements to the service.

We recommend the provider seeks advice and guidance from a reputable source to ensure recorded responses to complainants are consistently robust.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
At our last inspection the provider failed to ensure people received tailored support to meet people's social and leisure needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• People were supported to participate in their chosen social and leisure interests on a regular basis. Staff enabled people to broaden their horizons and develop new interests and friends.
• People told us there was more opportunity for activities. One of the people who used the service told us they were the service user champion and they took responsibility for organising a Halloween party.
• Staff were motivated to look for places of interest for people to visit. People told us they recently went out for lunch and on a trip to Windsor. During the inspection some people went to a farm, another person was

planning to participate in a football match as part of a team at the weekend.

End of life care and support
• The service was not supporting people at the end of their life.
• One person had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form in place which was contained appropriate information about the decision and who was involved. A DNACPR form is used where a decision has been reached that if the person's heart or breathing stop, cardiopulmonary resuscitation (CPR) should not be attempted. In response to this the manager had recorded starting discussions about end of life care and the person's wishes as part of their care plan.
• Staff end of life training was arranged in February 2022, to ensure staff had the skills to support people.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had not established or effectively operated systems and processes to ensure compliance with regulations. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider failed to implement robust monitoring to identify risk or assure itself that risk was reduced to an acceptable level.
• The provider had implemented a schedule of checks and audits, which identified and acted upon some gaps. However, they had not identified concerns we found in relation to risk management such as fire safety, people's mobility and health, finances, control of substances hazardous to health, or the management of records.
• Since our last inspection the service failed to demonstrate how they had considered underpinning human rights in relation to an isolated visiting restriction placed on a person and their family. This was reviewed when we raised the concern. The service kept this under review and the decision was later reversed. However, we were concerned the service did not always understand its responsibilities to demonstrate how it has considered the impact on people's rights, as part of risk management.
• We found information in people's care records were not always accurate, contemporaneous or complete. Information in different documents were not accurately cross referenced. The use of different templates, electronic and paper records led to duplication, as well as relevant information being left out in key records. We were concerned this was confusing and there was a risk staff would not know which document was current and correct to follow.
• The provider's medicines policy and procedure did not consider homely remedies. We found in practice the service had not taken action to check whether some 'when required' medicines were prescribed or being administered as a homely remedy.
• There was no approval system by a competent staff member to authorise the content of risk assessments, care plans and other records to ensure standards were met. We saw and heard the board of directors were involved in the service. However, board meetings, decisions and support from external experts (which was good practice) were not always recorded to show how this fed-into continuous improvement, to support proactive rather than reactive development of the service.

• The service had not identified an ongoing training pathway proportionate to the level of responsibility and knowledge required of leaders. This is important to ensure leaders are up-to-date with relevant standards and good practice guidance.
• The service had not adequately displayed its previous inspection rating on its new website in accordance with requirements. The development manager took immediate action during our inspection to ensure this was updated and easily accessible to the public.

Systems or processes were not established and operated effectively to effectively assess, monitor and improve the quality and safety of the services. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team were responsive during our inspection and put an immediate action plan in place to address the concerns raised.

At the last inspection the provider failed to consistently notify CQC of events where required. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

• Since our last inspection the provider consistently notified CQC in relation to identified safeguarding referrals, deprivation of liberty authorisations and other events, as required.
• Where we identified a potential safeguarding concern during our inspection, the service made a referral to the local safeguarding authority and completed a retrospective notification.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At our last inspection the provider failed to implement a positive, open culture which resulted in poor staff morale and inconsistent person-centred care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 in relation to the culture of the service and staff morale.

• The provider and leadership team worked hard to instil a culture of openness. They spent time with staff and people discussing values and created an atmosphere where people felt valued.
• Staff felt able to raise concerns with managers without fear of what might happen as a result. For instance, staff members said, "I feel confident to inform management of concerns. Management are supportive, always engaging and will come see me if I need help with anything" and "They are excellent with that. All our concerns are addressed immediately without any hesitation at all".
• Staff were able to explain their role in respect of individual people without having to refer to documentation.
• Staff consistently told us there has been many positive changes since the previous inspection and told us this enabled them to deliver personalised care to people. Staff comments included, "It's so nice to have a good moral, the residents say they are a lot happier now that they have regular faces. They go out a lot more, even their families say how happier they are to. Nothing is too much for anyone", "We are provided with the tools to do the job, communication is better and there are more team meetings", "It feels like we are all working on the same page" and "I am very happy working here. Worked here for some time and this is the best it has been" and "Great place to work, feel valued and encouraged to develop".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
At our last inspection the provider did not always seek and act on feedback from relevant persons and other persons to continually evaluate and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the service was no longer in breach of regulation 17 in relation to engaging with relevant others in the development of the service.

• The provider sought feedback from people and those important to them and used the feedback to develop the service.
• We saw examples of 'you said', 'we did' responses to address feedback from surveys in September 2021. The service had recently sent follow-up questionnaires to relatives in January 2022 and expected to evaluate these by the end of February 2022.
• Records showed the leadership team kept people and their relatives up-to-date with changes at the service, and encouraged them to get in touch if they had any queries or ideas to develop the service.
• The service worked closely with health and social care professionals to review people's needs and outcomes, including commissioning authorities in relation to the service improvement plan within given timeframes.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
At our last inspection we recommended the service takes action to develop and sustains a positive, open culture to uphold people's welfare and to underpin its duty of candour responsibilities. The provider had made improvements.

• The service understood the underpinning principles of the duty of candour and had an appropriate policy and procedure in place.
• Staff gave honest information and suitable support, and knew how to apply duty of candour where appropriate.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not consistently meet the hydration needs of service users to sustain good health.

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 Care and treatment was not always provided in a safe way. The provider did not effectively assess or mitigate the risks to the health and safety of service users.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services.

The enforcement action we took:

We imposed a condition on the provider registration.