Voyage 1 Limited

Kent and Medway Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Kent and Medway Domiciliary Care Agency is a supported living service registered to provide personal care. The service provides support to people with a learning disability and/or autism living in supported living settings, so that they can live in their own home as independently as possible. At the time of the inspection they were providing support to 13 people who were in receipt of the regulated activity personal care. 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.

People lived in their own flats and had access to their own facilities such as bathrooms and kitchen. There were a number of different locations across Kent where the service was providing support to people.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Not all staff supported people to play an active role in maintaining their own health and wellbeing. One person wanted to be weighed regularly so they could manage their diet, but this was not happening. Staff did not always support people to achieve their aspirations and goals. One person told us they would like to set some goals, but staff had not supported them with this.

Right Care
People were not protected from harm or abuse. Staff had used unlawful restraint on a person, and this had not been reported. People's individual health risks were not always well managed to ensure they received to care and support needed. Staff were not always respectful when talking about people they supported. For example, one staff member referred to someone as a 'spoilt brat'. Not all staff understood how to protect people from poor care and abuse. People were not always supported by staff who had the skills and knowledge needed to meet their needs. People's care plans did not always reflect their range of needs. For example, one person had been prescribed a medicine to help when they felt anxious, this was not included in their support plan, and there was no guidance on when and how to use it.

Right Culture
Staff had failed to ensure risks of a closed culture were minimised, they had not ensured people received

support that was based on transparency, respect and inclusivity. Daily notes did not reflect the negative support provided, that staff told us about. People did not always lead inclusive and empowered lives. Some staff were not always supporting people to be as independent as possible. Staff told us they did not always feel supported by senior management at the service. Staff told us they had raised concerns which were not always acted upon.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 16 November 2020)

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 the provider remained in breach of regulation and we identified further breaches of regulation.

Why we inspected
We undertook this comprehensive inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safeguarding and allegations of abuse. A decision was made for us to inspect and examine those risks

Enforcement
We have identified breaches in relation to safe care and treatment, assessing people's health needs, dignity and respect, person centred care and management oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Kent and Medway Domiciliary Care Agency

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.

Inspection team
The inspection team was made up of two inspectors.

Service and service type
This service provides care and support to people living in eleven '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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. However, we gave short notice when visiting people's home to ensure we had their consent.

Inspection activity started on 19 January 2023 and ended on 30 January 2023. We visited the location's office on 19 January 2023 and 25 January 2023.

What we did before the 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. 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.

During the inspection
We spoke with 5 people who used the service and 5 relatives about their experience of care provided. We spoke with 12 members of staff including the registered manager, deputy manager and support staff. We reviewed a range of records including 4 people's care plans. We reviewed medication records and looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from avoidable harm or abuse. One person did not always feel safe living in one of the services. Staff told us that 1 person was scared of another person who lived there. Staff told us they would have to 'stand guard' by the door for them to be able to leave their room.
- Staff failed to recognise and act when a person began to neglect themselves and their environment. Staff had failed to identify a decline in the persons mental health and seek support form health care professionals.
- Staff had completed safeguarding training however this had not ensured people were kept safe from abuse. For example, a Staff member told us that a person was forced to sit on the toilet after they communicated with staff that they didn't want to and had capacity to make that choice themselves. The staff member told us this was for staff convenience. We reported this to senior management within the service and reported it as a safeguarding concern to the local authority.
- People were subject to unlawful restraint. One person's care plan detailed verbal de-escalation techniques to support them if they became anxious or distressed. Staff told us that on more than one occasion they needed to 'pin down' the person as a form of restraint. The persons care plan detailed that no physical interventions should be used to support them.

The provider had failed to ensure systems and processes were in place to safeguard people from the risk of abuse. This is a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- The provider had failed to ensure risks to people's health and the environment were assessed and well managed.
- People who lived with epilepsy did not have support plans in place. Staff did not have guidance to follow if the person should have a seizures and what action they should take. When we spoke to staff they were not clear at what point during the seizure they would need to seek medical intervention.
- People who were at risk of malnutrition were not always supported by staff to mitigate that risk. One person had been prescribed a nutritional supplement to help maintain a healthy weight. Staff told us they had stopped giving the supplement to this person as they sometimes refused it. Staff had failed to seek professional support prior to stopping the supplement, they also failed to record and document when they stopped giving the supplement. This person also needed their weight recorded, as recommended by the speech and language team (SALT) to monitor their weight. This person had not been weighed since July 2021. The registered manager could not be assured that the person received the nutritional input they needed and were not aware if the person had lost weight, requiring further input from healthcare

professionals.
● People's personal behaviour support (PBS) plans did not consistently reflect people's most up to date needs. One person had been prescribed an 'as required' medicine to support them as a last resort when they were anxious or distressed. This had not been included in their PBS plan to inform staff when the person may need this medicine to help them.
● Staff had failed to consistently identify and report hazards in a person's bedroom. Broken plug sockets were found underneath a sink causing a risk of fire and electrocution.

The provider had failed to ensure people's health needs were well managed and mitigated. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
● Medicines were not managed safely. Staff had failed to ensure people always had their medication in stock. One person's medication administration record (MAR) was blank for the last entry and we observed there to be none of this medication in stock. When we asked a staff member where the medication was. They confirmed the person did not have this medicine in stock when the patch was required to be changed. Another person had been prescribed a medicine to support them if they became constipated, however this was not available should the person need it.
● Medication administration records were not always accurate and up to date. Staff had not consistently recorded when medicines had been administered and there were gaps in the MAR sheets. During our medicine count we found one person had 8 tablets missing with no explanation as to what happened to these tablets.
● Medicines were not always stored safely. Some liquid medicines did not have an open date on the bottles to ensure the medicines were discarded after a certain time period in line with manufacturer guidelines. Using medicines that are out of date can reduce the effectiveness of the medicine.

The provider had failed to ensure people's medicines were well managed. This is a breach of Regulation 12(2)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong
● The registered manager did not have an effective system in place learning lessons from incidents and accidents. Incident forms detailed a debrief had taken place after incidents, however staff told us this was not always the case and they felt unsupported with certain situations, such as supporting people who were anxious or distressed.
● Staff told us there was no learning from incidents regarding supporting people when they were anxious or distressed. Staff told us the incidents reoccurred and were again reported to their line manager.
● Some incidents and accidents were not recorded or reported. Incidents of unlawful restraint were not recorded. The registered manager could not be assured that learning from these incidents could be implemented to reduce the likelihood of reoccurrence. The registered manager could not be assured the person was receiving the required input to support their changing needs from other healthcare professionals.

The provider had failed to ensure incidents and accidents were always recorded and reported. This is a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● People were not always supported to maintain a clean and hygienic living environment. One room we observed there to be no toilet seat on the persons toilet. Other rooms we visited were visibly unclean and odorous. This was an area for improvement.

● People were supported to access vaccinations to help reduce the risk and spread of infection.

● The provider ensured there was enough personal protective equipment (PPE) available for people and staff.

Staffing and recruitment

● The service had enough staff to support people in line with their care and support plans. The registered manager had an effective system in place to ensure shifts were allocated and covered. For example, if a staff member was sick, it would flag up on the system so they could ensure this was covered and the person was informed.

● There were enough staff to support people with their 1-1 support hours. If a staff member was on annual leave or phoned in sick, another staff member would pick this up, this included office staff such as the deputy or registered manager.

● The provider ensured pre-employment checks were completed in line with their policies. This included an up to date DBS, employment history and references from previous employment.

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 requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or consistent care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans were not always updated when their needs had changed. Staff told us they would be asked to complete people's care plan reviews, but this was not always possible when they needed to support people with their care needs. One person's care and support plan had not been reviewed since August 2021.
- Care and support plans did not always reflect people's needs. One person's care plan outlined they needed support with maintaining their mobility by completing exercises. There was no support plan in place or guidance for staff to show what these exercises where and when and how often they needed to be completed.
- People's care and support were not always delivered in line with standards and guidance. For example, recognised tools such as MUST were not used effectively to monitor weight loss or weight gain for people that needed it.
- Care plans reflected a good understanding of people's communication needs. For example, one person did not communicate verbally but by hand gestures. A communication profile was in place to inform staff how to support people to make choices.

Staff support: induction, training, skills and experience

- The skills of staff did not always match the needs of the people using the service. Staff told us they had not completed face to face MAPPA training. MAPPA training is a form of, last resort, safety intervention training for staff to support the person safely when they are anxious and/or distressed. One staff member also told us they had not had any training regarding this, they were just shown what to do by another staff member. When we spoke to the registered manager, they told us the training had not taken place due to COVID19.
- Staff had not always received training to enable them to deliver safe care responsive to people's needs. We could not be assured that all staff who worked with people who lived with epilepsy, had training to support them. One staff member also told us that they had not received epilepsy training and they didn't know if the person who lived with epilepsy had any medicines for this.
- Staff told us they did not feel like they had enough training in certain areas. Staff told us they needed more training regarding supporting Autistic people. One staff member said they would like more training regarding autism because a lot of the people they support are autistic people and the generic training didn't give them enough information to support people.
- The registered manager carried out competency assessments for staff to ensure they understood and applied their training. However, these were not always effective when highlighting the lack of support staff felt.

The provider had failed to ensure Sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were not always supported to access healthcare services and support to ensure they live healthier lives.
- People were not always supported to attend annual health checks, screening and primary care services. For example, one person visited the opticians in May 2019 which highlighted they needed a yearly review. This person had not been supported to visit the opticians since this date. Staff told us it was because of access issues, however they had not sought out an alternative optician.
- Staff worked with other agencies to support people living in their services. People with specific heal needs were supported to see their specialist. For example, one person saw a specialist nurse regarding their stoma.

- People had health passports in place which gave an overview of essential information that other health professionals would need to best support that person. Staff also ensured people were able to access emergency healthcare when it was needed.

Supporting people to eat and drink enough to maintain a balanced diet

- People with complex needs received support to eat and drink in a way that met their personal preferences as far as possible. For example, one person needed a modified diet and they were supported to buy food that was prepared in the correct texture and then these meals were delivered to their door.
- People were also supported to go out and do their food shopping. Relatives told us staff supported their family members to do shopping on a weekly basis and ensured they had nutritious food available in their home.
- Some people had guidance in their care and support plan regarding what type of meals they would like to eat and what they need support with. For example, one care plan detailed the person would like encouragement not to drink as many fizzy drinks and support to find alternative drinks.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We found the service was not always working within the principles of the MCA. Although appropriate legal authorisations were in place to deprive a person of their liberty, people were not always supported to give

consent, for example people were subjected to unlawful restraint as reported on in the safe section of this report.

●People who lacked the capacity to make complex decisions, for example regarding their medicines, had been involved in best interest meetings to ensure the appropriate support was given.

● The service ensured that people who had a power of Attorney (POA) that they were involved in the decisions making process.

Requires Improvement

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 did not inspect this key question. However, this key question was last inspected 06 December 2019 and rated outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Some people did not always receive kind and compassionate care, not all staff used positive or respectful language. For example, one staff member told us they didn't like supporting certain people and referred to them as 'manipulative' and a 'spoilt brat'.
- Another staff member used inappropriate language when referring to a person they support, they said 'they just want attention 24/7'. This showed a lack of understanding of the persons support needs and how to refer to people respectfully.
- We observed one staff member telling a person they would not be able to do an activity they wanted to do, if they did not 'behave' as a form of punishment.
- Some staff completed daily records using degrading and negative words. For example, daily notes for some people included, '[person] woke up with an attitude', '[person] put on the seizure' and [person's] room smelt of shit and wee'.
- Some staff had told us they had previously raised concerns to the senior supervisors regarding how staff speak to people they support in a negative way. They told me that they had witnessed other staff had been very rude to a person they support in the past. They told us they were unaware of what happened as a result of them raising this concern.

The provider failed to ensure service users were always treated with dignity and respect. This is a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Some people were not always supported to make decisions regarding their home environment. For example, daily notes outline one person was 'given a list of chores to complete'. There was no evidence that the staff member had spoken with the person about what chores they wanted to start with and what support they needed for this.
- Some people were not always supported to be as independent as possible, for example we observed a staff member making a person some food and drink and although they asked the person what they wanted, they did not ask or encourage the person to help and be more independent.
- Staff supported people to maintain links with people that were important to them. For example, we observed people going into each other's flats where they enjoyed each-others company.
- We observed some positive interactions with staff giving time to people when making decisions about

what they were doing. We observed some staff to be attentive and supportive.

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 did not inspect this key question. However, this key question was last inspected 06 December 2019 and rated outstanding. At this inspection the rating has changed to requires improvement. 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; 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

- People did not always receive person-centred care to meet their needs and preferences.
- Some people were not always supported by staff to participate in their chosen social and leisure interests of a regular basis. One person needed the support of a staff member who could drive. There was not always a suitable member of staff on shift to ensure the person could go out. One staff member told us "There is always a lack of drivers on shift". A relative also told us, "[person] gets upset when there isn't a driver to taken [person] out".
- Care plans were not always person centred. Some care plans lacked information around empowering people to set goals. One person told us they would like to set some goals but were unsure where to start and had not been supported by staff to do so.
- Staff did not always support people to achieve their health and wellbeing goals. For example, one person's care and support plan outlined they would like to be weighed regularly so they can manage their diet and what food they eat. Staff could not demonstrate they had supported this person to be weighed. They had not been weighed since being supported by this provider.
- Some people were supported to maintain relationships. People were supported to attend day centres and college. Staff supported people to make sure they were ready for the day, sometimes just using verbal prompts as support.
- Relatives and people were supported to maintain relationships. Relatives told us they were always able to see their loved one.

The provider had failed to ensure people consistently received person-centred care. This is breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints and concerns were not always dealt with thoroughly by the service and the outcome or actions taken was not always documented.
- The registered manager told us there had been no complaints made to the service and if a complaint was raised it would be looked into and dealt with in line with their policy. However, one relative told us of a complaint they had made but were unaware of the outcome. The service had investigated the complaint but had failed to fully convey and involve the relatives with the outcome of the complaint.
- Staff had told us of occasions when they had raised concerns to senior staff members, however there were

no records to show when the concerns were raised or what action was taken. For example, staff told us that during a sleep night they would find the wake night staff member not supporting people who needed it, however the documentation for this could not be found when we asked for it.

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.

● People's care and support plans detailed how people preferred to communicate. For example, one person's support plan outlined they liked to be shown pictures and are able to communicate with a yes or no.
● Staff were able to tell us how they supported people who used different communication methods.

End of life care and support
● Not everybody had a support plan in place regarding their end of life care. People's care and support plans did outline when people were asked if they wanted to discuss this part of their care. It was documented if people did not want to discuss this and their wishes were respected.
● The registered manager told us they were not currently supporting anyone who was end of life care but had systems in place should they support someone at the end of their life.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Robust governance systems and processes were not in place to identify issues and ensure there was a system of continuous learning and improving with the care provided.
- Governance processes were not consistently effective to keep people safe and provide good quality care and support. For example, the provider had a central system to have oversight of accidents and incidents. However, the registered manager had not ensured that all accidents and incidents were recorded and reported by staff. There was no identification of learning from these incidents to reduce the risk of reoccurrence.
- The registered manager had failed to ensure staff kept accurate and complete records in relation to each person. For example, daily records did not corroborate what staff had told us or reflect people's current needs.
- Quality assurance audits were not always effective at identifying issues or errors. The registered manager and senior team leaders carried out audits in areas such as medicines. The most recent medicine audits had not highlighted the errors we found during inspection, including 'as required' medicines not being available for people who had been prescribed them.
- The registered manager had failed to ensure there was an effective system in place to identify additional training that were needed. It was not clear what training staff had completed and whether they had the necessary training to be able to support people, including supported people who could become anxious or distressed.
- The registered manager had failed to ensure effective systems were in place to identify and assess risks to the health, safety and welfare of people who use the service. For example, the registered manager had not ensured people who lived with epilepsy had support plans in place and people who were at risk of malnutrition were being supported as per their guidelines.
- The provider had failed to improve on their requires improvement rating from the last inspection.

The provider had failed to ensure effective and robust governance systems were in place to ensure the health and wellbeing of people who use the service. This is a breach of regulation 17 (governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a person centred culture in the service. The provider and registered manager failed to

identify a poor culture within the service. Neither the provider or registered manager had a robust system in place to identify the concerns we found during inspection. For example, they had failed to identify some staff were not supporting people in a positive, person-centred way. This included how staff were referring to people in documentation and how they spoke about people they support. The registered manager had also failed to pick up on the abuse that people had been subjected to within the service.

● The registered manager had not ensured there was an open and honest culture amongst staff to ensure people received good quality care and support. Poor practice amongst some staff had not been reported or highlighted to ensure people were not subjected to any harm or abuse.

● The registered manager had failed to consistently ensure people felt empowered. The senior management team failed to ensure supportive and positive role models were regularly visible in the service to ensure they were modelling the correct standards of care. Staff told us they did not always feel supported by management.

The provider failed to ensure people received care that was person centred, open and empowering. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager had not ensured people, relatives and staff were fully engaged with the service. Not everyone was supported to attend or organise their health care appointments that they needed. We saw evidence that some people were being regularly supported but this was not consistent across the whole service.

● The provider had not always acted on feedback from staff. For example, staff told us they had asked on numerous occasions for additional training to support them in their role.

● The provider had sought feedback from people's relatives. Some relatives had completed surveys with their thoughts about the service. For example, one relative felt their communication with the office and managers could be better. An action to address this was to ensure they have everyone's details correct and up to date.

● People were supported by staff to have conversations around the everyday living of their homes and each house did this differently. For example, one house would sit and discuss what their plans are for that week and domestic tasks that needed completing.

● Some people were engaged in the local community. For example, some people were independent when going out so they could make their own decisions regarding how they spent their time.

● The provider worked in partnership with others. The provider had engaged in local forums to work with other organisations to improve care and support for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their legal duty regarding duty of candour. Where incidents had been reported, people's relatives were informed.

● The duty of candour requires providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.