Kisimul Group Limited

An Darach Care - Cambridgeshire

Inspection report

2 Peterborough Road
Farcet
Peterborough
PE7 3BH

Tel: 01733241722
Website: www.kisimul.co.uk

Date of inspection visit:
27 June 2023
29 June 2023
04 July 2023
15 August 2023

Date of publication:
17 January 2024

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

An Darach Care - Cambridgeshire is a domiciliary care agency providing personal care and support to younger adults with a learning disability. At the time of our inspection the service was supporting 18 adults in 4 supported living houses and 2 single occupancy annexes. The service can support up to 20 people in total. The registered manager works from a separate office located on the same site as 1 of the houses close to Peterborough.

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:
Care was not always provided in a dignified manner which had the potential to compromise people's human rights. Staff were trained in restrictive practices, and we found people's records mostly, not all, had guidance in place for staff to follow when using control and restraint. 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 supported this practice.

Right Care:
Care was not always provided in a person-centred way which promoted people's dignity, independence or human rights. There were not always staff with suitable skills deployed to meet the needs of people. There were some gaps in staff training, and we were not assured staff had the skills and knowledge to fill the requirements of their role. Medicines were not always safely managed, and medicine records were not always completed accurately.

Right Culture:
The service lacked effective oversight and leadership. The provider's systems for monitoring and improving the quality of the service had not been effective. Learning from events was not always shared with the staff team. This placed people at potential risk of harm.

The failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate placing people at risk of potential harm.

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 good (published 14 July 2021).

Why we inspected
The inspection was prompted in part by notification of an incident following an allegation of abuse. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the safeguarding procedures and the culture within the service. This inspection examined those risks.

As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for An Darach Care - Cambridgeshire on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

An Darach Care - Cambridgeshire

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 was carried out by 3 inspectors (1 of whom specialised in medicines), a specialist advisor (an external professional with a specialism in learning disabilities and autism) and an Expert by Experience. 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 4 'supported living' settings, based on 2 sites, so 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
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 27 June 2023 and ended on 15 August 2023. We visited the location's office on 27 June 2023. We visited people in their homes on the 29 June 2023 and 04 Jul 2023.

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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed support plans and associated records for 9 people. We reviewed medicine administration and associated records for 12 people. We spoke with 4 people who used the service and observed staff delivering support to people in 4 houses. We spoke with 15 staff including the registered manager, service manager, deputy managers, senior support staff, support staff, quality business partner, service development practitioner, head of adults' service and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection we received further documentation electronically, such as governance audits, recruitment files, supervisions, and minutes of meetings. We spoke with 7 relatives, a social worker and 2 social care professionals from the local authority. We continued to liaise with the local authority about our concerns following the inspection.

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 requires improvement. At this inspection the rating remains 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

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- This inspection was prompted following a serious safeguarding incident involving a person using the service and members of the staff team. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. We are currently waiting for the provider to conclude the internal investigation. As a result, this inspection did not examine the circumstances of the incident.
- The Commission is however aware that staff witnesses did not report the incident to the provider, local authority or CQC. This raises concerns regarding staff understanding that safeguarding people is the responsibility of everyone.
- Not all incidents of potential abuse had been managed appropriately. For example, the provider could not provide a record of an internal serious incident review when we requested this and failed to protect people from the risk of further abuse.
- People had care plans which contained information on how staff could manage different presenting risks. These included risks associated to people's health and the environment. Not all documents we reviewed contained the same information.
- People had changes made to their medicines by health professionals, however this information had not been reflected in the person's care plan, even though we could see the care plan had been reviewed the day before our visit.
- People had a positive behaviour plan (PBS) in place. This is a document created to help staff understand and support people who display behaviour that others may find challenging. This document should include all forms of control and restraint which had been prescribed and agreed by professionals involved in a person's care. On review of a PBS plan, we found not all forms of restraint currently being used were recorded in the person's plan, although had been recorded in other documents. Other documents we did review however directs staff to follow the agreed interventions set out in the PBS plan.

Using medicines safely

- Staff did not always follow effective processes to assess and provide the support people needed to take their medicines safely.
- During the inspection we found an expired medicine. Records showed staff had administered this medicine on 8 occasions, this meant the medicine may not have been effective. Staff did not follow processes to ensure medicines were checked so they were safe to use. Following our visit staff requested a new prescription from the GP, however in the interim period this person did not have access to this medicine should they need it. This placed the person at risk of harm if de-escalation techniques were unsuccessful.

● Medicines were stored securely. However, staff did not always follow the provider's policy when completing records for controlled drugs (medicines requiring additional controls due to their potential for misuse) accurately. Liquid medicines also did not have the date opened labelled, and therefore the service could not be assured they were still safe to use.
● Two people who required rescue medicines if they had an epileptic seizure did not have a protocol in place to support staff on how to administer this medicine safely.
● Care plans were regularly updated, however, some contained inaccurate information. For example, some referred to the persons STOMP care plans (stopping over-medication of people with a learning disability, autism or both), however these specific care plan documents were not in place as stated.
● Medicine audits did not always take place in accordance with the provider's medicine policy. Medicine audits that had taken place had not identified the shortfalls we identified during the inspection.
● Staff understood how to report medicine related incidents however, there was no mechanism in place to share learning with staff. This was confirmed by the manager on site.

In relation to the above shortfalls we found that systems were either not in place or robust enough to demonstrate risk was effectively managed. This placed people at risk of harm. This demonstrated a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Care plans contained person-centred information about de-escalation techniques to use to support people.
● Staff we spoke to understood the principles of STOMP and ensured people's medicines were reviewed by prescribers in line with these principles.
● People could take their medicines in private when appropriate and safe and staff understood how people liked to take their medicines.
● Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.
● We informed the registered manager of our findings during our visit. We received evidential assurance the following day that all of these oversights had been amended. We have also received assurance from the nominated individual that a further audit of all documents was being planned to pick up any similar shortfalls in care plans which we did not review.

Staffing and recruitment
● At the time of our inspection we observed a high number of staff on site. All people using the service were allocated a minimum of 1 staff member. Depending on people's support needs and the activity they were participating in, this may increase.
● There was a high number of temporary staff working at this service. Permanent staff we spoke with shared positive comments about some of these staff and their skills at engaging with certain people who had complex needs.
● Relatives we spoke with gave mixed views on whether there were enough staff. A relative told us, "I'm not always convinced there is no, I know everyone's staffing ratio and sometimes when I go there is no way near enough. I know they use agency staff a lot which concerns me as they [people using the service] need routine. I went in recently and didn't recognise anybody."
● People using the service required staff to be always with them. We were told on our visit by staff that a local policy had recently been implemented for staff shifts to be arranged so people were not supported by the same staff member for a whole shift period. This was implemented for the well-being of both the person being supported and the staff member. Staff told us this was not always the case and dependant on which

staff planned the shift.
● Staff were recruited safely.

Learning lessons when things go wrong
● We found that most serious incidents were reviewed by the registered manager and senior managers. These reviews intended to include an analysis of what caused the incident and learning and actions were identified following the incident. If appropriate the learning from these events were shared amongst the wider staff teams. We could not be confident that this happened after every serious incident as evidence we requested following a serious incident review could not be provided.
● Behaviour of concern, identified by staff as 'lower level' were recorded on a different system. These incidents were not analysed or reviewed by the registered manager. We spoke with staff who informed us briefings and learning from these incidents did not happen. We also reviewed an audit which had identified learning and analysis was needed to follow these reports, however this action had not been rectified.

Preventing and controlling infection
● Systems were in place to minimise the spread of infection.
● Staff were using personal protective equipment (PPE) effectively and safely.
● The provider's infection prevention and control policy was up to date.

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 good. 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.

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

- People needs were assessed and used to inform care plans. Some care plans had sections missing or had been completed as 'not applicable at this time'. For example, a care plan had the section on sexuality and relationships completed as 'not applicable at this time'. The other care plans we reviewed had this section removed. Sexuality and relationships are important to people, leaving this information out of care plans indicates the provider had failed to identify the importance of this for the people they supported.
- We reviewed an audit completed by a member of the management team who had highlighted that care plans had sections missing, however at the time of our inspection this had not been rectified.
- People had care plans which contained a lot of information regarding their behaviour and how best to support them. We observed staff delivering care in line with that person's care plan. The staff we observed knew people well.

Staff support: induction, training, skills and experience

- The provider did not ensure staff had the correct skills and training to be able to support people with learning disabilities and autism. We reviewed daily care records which included how a person was 'sent to their bedroom' and told to 'stop whining'. We reviewed behaviour of concern forms which described a person was 'beginning to kick off'. The use of this language did not demonstrate staff have the appropriate understanding and knowledge.
- Staff told us they completed a 2-week training programme at the beginning of their induction prior to working with people using the service. Staff were mostly positive about the training offered from the provider. The training matrix showed some gaps where staff had not completed training in some subjects relevant to their role. This placed people at risk of harm as staff may not have the skills required to support people with highly complex needs.
- Relatives we spoke with gave us mixed feedback about whether staff received the appropriate training in order to be able to support people effectively. A relative said. "I don't think they've got the right training, not for [family member's] challenging behaviour. They [staff] come and go so much they can't get to know [family member] well enough either. [Staff] do shadowing when they start." Another relative said, "I can only presume they have; I think new starters could have more in-depth shadowing and person-centred training."
- The provider assured us following the inspection that all staff were being supported to update any training required.

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

- People were included in the planning and preparation of their meals and menu planners were displayed

in the kitchen in their homes. People were supported to buy the food they liked and were able to access their own food at any time.

● People who needed support to eat and drink safely had input from speech and language therapists (SALT) and / or dieticians. During our visit we observed staff following guidelines to provide a modified diet for a person they were supporting. The person had been involved in choosing their meal first.

● People were supported to maintain healthy diets. We spoke with a person who had attended a slimming world class the previous evening. Staff told us they had attended this group for a number of years and liked attending it within their local community.

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

● Relatives all told us people were supported to access healthcare appointments appropriately, including the GP and dentist. Relatives were kept informed of appointments and had the opportunity to accompany people. A relative told us, "I think the doctor gets called to the house so [family member] doesn't have to go."

● A social care professional told us, "The [deputy manager and senior support staff] ensure that they are on top of health appointments and always seem to have a good understanding on the current situation."

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

● Appropriate deprivation of liberty applications had been made to the Court of Protection for authorisation, however a number of these had not yet been processed. This was due to a processing delay. We spoke with a social worker who confirmed this delay in their local authority.

● People had a positive behaviour plan (PBS) which included the different forms of control and restraint which could be used to support the person when needed. These had been agreed by professionals. Different control and restraints were included in the PBS and staff were trained to use the least restrictive method possible. We did however identify a PBS plan which had omitted information relating to a form of restraint being used.

●The provider had a bespoke training programme in place which trained staff in the use of restrictive practice.

● Best interests decisions took place, and where appropriate the service had involved an advocacy service to support people with their decision making. Advocacy services support people to be involved in the decisions that affect their lives.

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 good. 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.

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

- People's records contained negative language which rather than being informative and fact based, were judgemental and implied fault on the individual. For example, in a document describing an incident, explained a member of staff from a neighbouring house came over 'to ask [person] to stop as they were setting other tenants off next door'.
- Records used language which infantilised people, treating adults as children in their own home, for example, '[Person] was sent to their room and told to stop whining.'
- The registered manager informed us these documents, including those which contained language such as 'kick off' were reviewed by either managers or senior staff on site. Staff had not been challenged or redirected for further training until we raised our concern during the inspection. This indicated the language was accepted and normalised across the service and allowed to continue. This raises a concern over the culture and oversight of the service.
- Staff did not always follow instructions put in place by management. Staff made decisions about how to organise shifts which went against what had been advised by their line manager. This placed more importance on the staff wishes disregarding management instruction and the needs of the people using the service.

The provider had failed to identify and address shortfalls in the culture of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised our concerns regarding the culture of the service with the nominated individual and the head of adult services during our inspection. They were responsive to our concerns and put an action plan in place immediately which included their intention to commission a full culture review of the service.
- The care and support we observed during our inspection was positive and people appeared to like the staff who were supporting them. However we remained concerned that records did not always reflect this

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

- Audits had been completed to monitor the quality of the service, but these had not identified and resolved

the shortfalls we found during our inspection. Therefore, the systems in place to monitor and assess the service provided was not effective.

● Behaviours of concern and daily records did not have robust management oversight. Staff and people using the service did not have the opportunity to debrief following the incidents recorded as a behaviour of concern. This meant there was no analysis or opportunity to learn, identify potential triggers and avoid a reoccurrence of a similar incident.

● Documents relating to people's care and support contained incorrect information. For example, we reviewed an MCA (mental capacity assessment) for a person which referred to another person. This document had been reviewed by a senior member of staff and not identified as an issue within the review.

● The training matrix used by managers to assess staff training needs were not accurate. Therefore, managers did not have an effective overview of the training requirements.

● The provider and registered manager had failed to develop systems to share learning with staff following other incidents and near misses, including medicine errors to reduce the risks of them happening again.

● The provider and registered manager had failed to ensure concerns regarding staff conduct were effectively followed up and addressed. Therefore, the governance systems in place were not robust enough.

● The provider had notified CQC of important events they were required to tell us about. Additional information the commission requested following these notifications was not always provided. Therefore, we were not assured the provider and registered manager understood their responsibilities in providing the required information about the service provision.

● The registered manager did not have effective oversight of all aspects of the care and support being delivered to people using the service. This was also evident as professionals who were asked for feedback did not know who the registered manager was.

The provider has failed to ensure systems established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Assurance was given to us by the nominated individual that mandatory training (assessed by the provider as necessary to the role) had been prioritised for staff to complete. Managers were supporting staff teams to complete this as soon as possible.

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

● People were given the opportunity to meet with staff or managers. We observed a person deciding which of the management team they wanted to meet with that day. Staff told us that each day during the week this person meets with a manager of their choice.

● All relatives informed us they had recently received communication from the provider requesting feedback.

● Staff informed us that they were given the opportunity to speak to managers. Staff received supervision on a 1.1 basis and team meetings were held. Staff told us that they could raise concerns and share ideas.

● The provider had worked closely with the local authority, social workers and learning disability teams who were involved in people's care.

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 Medicines had not been administered in line with how the prescriber intended, these medicines were past their expiration date. Medicine policy processes were not followed in line with the providers medicine policy and procedures. Documents containing information of risk were not always correct, information was missing or had not been updated. Safeguarding processes had not been followed as expected.

The enforcement action we took:

The provider is required to submit a report to the Care Quality Commission every 28 days containing details of quality assurance audits which have been completed, and any subsequent actions identified.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not robust and had therefore not been effective. Issues regarding poor practice had not been identified and or addressed.

The enforcement action we took:

The provider is required to submit a report to the Care Quality Commission every 28 days containing details of quality assurance audits which have been completed, and any subsequent actions identified.