Pathway For Care Limited

Pathway for Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pathway for Care is a supported living service providing personal care to people with a learning disability and/or autism. Support was provided across 5 different supported living settings where people had their own flats or rooms. As part of our inspection we visited 2 of the supported living settings. 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 15 people were receiving a regulated activity.

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.

People's experience of using this service and what we found
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. People were not being protected from abuse as systems were not in place to ensure staff responded to incidents appropriately. The risks associated with people's care were not reviewed and updated to reflect the most up to date information. The management of medicines and infection control were not always being managed in a safe way. There were sufficient staff to support people with their care.

Right Care
Health care support was not always being sought for people and where it was, staff were not always following the guidance provided. The provider was taking on packages of care for people where it was not always appropriate or safe to do so. Staff had not always received appropriate training and supervision to support people effectively and safely. People were encouraged to eat and drink and staff were encouraging people to make healthy choices.

Right Culture
There was a lack of robust oversight of care by the provider. Where audits were undertaken, these were not always identifying existing shortfalls. Relatives and external professionals fed back concerns about the lack of actions and communication from the leadership team. Where feedback was sought, actions were not always taken to make the improvements. Staff fed back they did not always feel listened to or supported.

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 September 2022). 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 regulations.

Why we inspected
The inspection was prompted in part due to concerns received about people not being protected from abuse and unsafe care. A decision was made for us to inspect and examine those risks.

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.

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.

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

Enforcement and Recommendations
At this inspection we have identified breaches in relation to people not being protected from the risk of abuse, people not being protected from risks and unsafe care, the management of medicines and poor infection control. We also identified breaches in relation to the failure to ensure the principles of the Mental Capacity Act were consistently followed, staff not being appropriately trained and supervised, and people not being supported appropriately with their health care needs. We also identified a breach relating to the lack of robust oversight by the provider.

We took immediate action to keep people safe.
Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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.

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

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 effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pathway for Care

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 4 inspectors.

Service and service type
This service provides care and support to people living in four '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 not a registered manager in post although an application had been submitted. We were supported on the inspection by the providers regional team and one the local service managers referred to as 'manager'.

Notice of inspection
This inspection was unannounced.

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 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 3 people and 4 relatives about their experience. We received feedback from 9 health and social care professionals. We spoke with 13 members of staff including care staff, the manager, operations manager, regional director, the chief operations officer and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including 6 people's care plans, daily care notes, medication records, safeguarding records and incidents. We reviewed a variety of records relating to the management of the service including supervisions, training and recruitment files.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection in June and July 2022 the provider had failed to ensure risks to people's safety were robustly assessed and accidents and incidents effectively monitored that related to one of the four settings we visited. This was a breach of regulation 12 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.

- Risks associated with people's care was not always managed in a safe way. Prior to the inspection, health care professionals raised concerns with us about the unsafe environment at two of the settings that posed risks to people. We found at one setting window restrictors were broken and two windows were unable to close. This posed a risk to people that had a history of climbing out of windows. The provider had planned for this to be fixed and although the provider was not responsible for making the repairs, they had not taken immediate steps to mitigate the risks to people.
- At both settings there were risks of people leaving their homes without staff despite being assessed as requiring this support. The provider had not taken robust safety measures to reduce this risk. We saw numerous incident forms for both settings where people had been able to leave their homes, and access public areas including busy roads which put them at risk of harm.
- Assessments were not reviewed regularly to ensure they included up to date information around the risks to people. For example, one person had diabetes and their eating habits had changed. Their risk assessments had not been updated with guidance for staff on how best to support them. The manager told us, "There is no time frame [to review them], I still might look at them." They said if something changed, they will update the risk assessment. However, we found this was not happening.
- There were occasions where other risks to people had been identified which was noted in their care plans. However, risk assessments had not been undertaken in relation to this including one person who was at risk of ingesting non-food items and another person that had reduced vision. This meant there was a risk staff would not provide the most appropriate care. We have fed this back to the provider who has now updated these risk assessments.
- There remained a lack of robust management around accidents and to minimise risks to people's safety. The provider told us all incident and accidents were reported to them, analysed and discussed as part of a multi-disciplinary team process. However, there were numerous incidents recorded on incident forms, behaviour charts and daily notes that had not been reported to the provider. This meant there was a risk that any learning required may not be recognised and acted upon as noted from the previous inspection.

The failure to ensure risks to people's safety were robustly assessed and accidents and incidents effectively monitored was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At one of the settings there were staff who had a good understanding of the risks associated with people's care and how best to support them with this. They told us they reviewed risk assessments and would update their manager if there were any changes to the person's needs.

Using medicines safely

At our last inspection in June and July 2022 the provider had failed to ensure robust medicines management. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst there had been some improvement at this inspection the provider was still in breach of regulation 12.

● At one setting, staff were not always following the guidance on the 'when required medicines' (PRN) protocols before offering the person the medicine. One person's protocols stated the medicine should be offered in 'extreme anxiety'. We noted on numerous occasions staff were recording they had administered the PRN for anxiety or hyperactive behaviour which was not in line with the protocol. There was also an occasion where the person was given a larger dose of medication than was safe to do so. We have reported this concern to the local authority safeguarding team.
● When amendments to medication administration records (MAR) charts were handwritten, they didn't always contain all the information needed to support staff to administer the medicine in line with the prescriber's intentions. This meant medicines may not be given appropriately.

The failure to ensure robust and safe medicines management was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● PRN protocols were in place for most medicines prescribed to be given 'as and when. These offered a detailed explanation of what a medicine was to be used for and what the outcome should be. When a PRN medicine was administered staff recorded the reason for use and outcome.
● At the other setting medicines were administered at set times of the day using a paper-based system which supported staff to follow the prescriber's intentions. Medicines care plans were person-centred. They explained how staff could best support people with their medicines and included additional risk assessments where needed for specific treatments.

Systems and processes to safeguard people from the risk of abuse
● The provider had not protected people from abuse and neglect. Prior to the inspection we were made aware of an incident of inappropriate restraint that had taken place at one setting. Whilst the provider took immediate action, we identified further instances of people at a heightened state of anxiety, where staff were not equipped to respond to this. This put the person, other people and staff at risk. Although the provider had consulted the trainer who provided the current restraint training and the trainer had objected to having staff trained in two types of restraint, they could have made a decision sooner to provider the more intense restraint training.
● Relatives fed back they did not always feel their loved ones were safe. Comments included, "We have grave concerns over the safety of [person]" and "We want [person] to thrive and be safe. We are scared [for person]."

● Although staff had received safeguarding training, they were not always recognising safeguarding incidents or reporting alleged abuse. We asked one member of staff for examples of potential abuse with them responding, "This doesn't happen here." However, on review of incidents and accidents we saw incidents of alleged abuse, harm, actual abuse and verbal abuse. Another member of staff told us, "Mostly the tenants will become aggressive and try to attack others." Although they said they would complete an incident form, the manager and provider were not always reporting these externally as a safeguarding incident.
● We spoke with the local authority after the inspection who confirmed many of these incidents should have been reported to them. One health care professional told us, "[Person] ran out last weekend and parents flagged it rather than the service." Another told us, "Some safeguarding concerns are raised by [one of the settings], but others have not been appropriately."

Failure to investigate and report instances of alleged abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff at one of settings had a good knowledge of what they would do if they suspected abuse and how they would escalate this if they had concerns. One told us, "If I see it I say it (report to the manager), if they don't respond then I will escalate it to the local authority."

Preventing and controlling infection
● People were not always supported to ensure good infection prevention and control. On day one of the inspection we found dried vomit outside of a window and there was dried faeces in a communal toilet. We reported this to the manager who put a sign up on the bathroom to say this was out of use. However, when we returned 11 days later the vomit had not been cleaned up.
● We also observed the communal laundry room used by people and staff had thick dust covering one of the meshes on the window. Staff were also storing rinsed mop heads (colour coded used for designated workspace areas) on top of the washing machine rather than hanging the mops in well-ventilated area such as a clothesline.
● On the second day of the inspection we arrived at a setting to find a large amount of rubbish bags piled in front of the bin, one of which had been ripped open with the contents spilled across the drive. It was only after we arrived, we heard the manager ask a member of staff to pick the rubbish up.

The failure to ensure good infection prevention control is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● At both settings, there were the correct numbers of staff based on how each person was funded. In addition, there was a member of staff to support other staff when they needed to take their break. One relative told us, "Currently I am pleased with the level of staff [person] has got."
● During the inspection we saw that where people needed support with tasks this was provided by staff straight away. Staff said that they were enough staff to support people. Comments included, "Here there are enough staff" and "For now there are enough staff."
● Staff recruitment and induction systems promoted safety, including those for agency staff. Prior to being employed, a range of checks were completed to help ensure staff were suitable for their roles. These included an interview, a review of previous employment and references, health screening and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

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. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection in June and July 2022 the provider had failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there had not been improvement at this inspection and the provider was still in breach of regulation 11.

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.

- Where decisions were being made for people, there was not always evidence their capacity had been assessed. For example, all of the people at one of the settings were under constant supervision from either one or two members of staff. There was no assessment of the person's capacity to agree to this restriction to determine this was in the person's best interests' or whether less restrictive measures had been considered.
- Where people may have to be safely restrained when they were in a heightened state of anxiety, there were no capacity assessments or best interests' decision records relating to this.
- Another person had an audio monitor outside of their room. There was no assessment of their capacity to determine whether they were able to consent to this. After the inspection the provider sent us a signed

consent form for the person however there was no evidence their capacity had been assessed in relation to this despite the provider confirming with us the person lacked capacity around other decisions being made and restrictions being placed on them.
● Other people were making unhealthy decisions in relation to their nutrition and hydration which was affecting their health. There were no capacity assessments undertaken to determine whether they understood the risks associated with this.
● There were capacity assessments relating to people not being able to go out without a member of staff. However, the records relating to the best interests' discussion were not fully completed, nor signed and dated by the manager undertaking the assessments.
● Staff at one of the settings were not able to explain the main principle of the MCA and were not able to tell us how and when the MCA should be put into practice to ensure restrictions to people's freedom were monitored. One staff member told us, "I don't know what it is." Staff at the other setting were able to explain the principles of MCA.

The failure to ensure the principles of the Mental Capacity Act 2005 were consistently followed was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other instances, we found the service worked alongside relevant local authorities to discuss applications to the Court of Protection to deprive someone of their liberties. These applications were reviewed to ensure that should conditions be imposed; theses would be monitored.

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

At our last inspection in June and July 2022 the provider had failed to ensure people's health care needs were effectively monitored. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst there had been some improvements the provider was still in breach of regulation 9.

● Where people attended appointments or received healthcare treatment, this was not always fully recorded to ensure this could be monitored. The manager at one setting told us they were waiting for a consultant appointment for one person. However, the person's care plan had a letter from the attended consultant appointment in November 2022. The manager was not aware of this and had not implemented the guidance from the consultant.
● The same person had a diagnosis of dysphasia which affects how you speak and understand language. However, it had been wrongly recorded as dysphagia in their care plan. This is a difficulty with swallowing. Yet there was no follow up of this with a speech and language therapist or guidance around this and the current guidance in the care related to the wrong diagnosis.
● There was a note in another person's care plan in December 2022 from a health clinic. It stated the person was to have an electrocardiogram (ECG) after two weeks of starting a medicine. There was no evidence in their care this had taken place and the manager was unable to confirm if this had taken place. After the inspection the provider confirmed the ECG had taken place however the person's health action plan had not been updated to reflect this.
● A health care professional fed back to us one person at another setting had sustained an injury to their mouth and lost two teeth. The person's health action plan had not been updated to reflect how this impacted the person but just stated an appointment with a dentist needed to be booked. Whilst an initial

referral was made in November 2022 and chased on 30 January 2023 no further action had been taken.
● Health care professionals fed back to us their concerns about the lack of consultation with them from the provider in relation to support for people. One told us, "We frequently receive no response to our offer of appointment times." Another said, "We have bi-weekly teams call for [person] due to the complexity of their needs. Some of my health colleagues have struggled to get responses."

The failure to ensure people's health care needs were effectively monitored was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At one of the settings relatives fed back there had been some improvements with their loved ones being supported with health appointments. One relative told us, "[Manager] kept me in the loop, [person] has been to the opticians, been to dentist which they hadn't sorted before."
● We saw instances where people had health reviews with the GP and multi-disciplinary meetings were held in relation to other people's heath care

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Packages of care had been taken on by the provider before the provider and staff had time to fully assess individual people's needs. Each person living at one setting was known to having periods of high levels of anxiety. We noted from one person's pre-assessment one of their triggers was high level of noise from other people. Despite knowing this, the provider had still agreed to support this person, knowing there were other people whose own behaviours would trigger anxiety for this person.
● There were frequent instances of heightened anxiety displayed by people that according to the records were triggered by other people at the setting. We did not see any records relating to people at one setting being consulted about other people moving in despite the fact they were going to be sharing communal areas with them.
● Relatives fed back there was not an appropriate compatibility assessment of people sharing the communal areas at one of the settings and that this impacted on their loved ones. Comments included, "Too many acceptances of clients that are not suitable" and "The people are not a good mix there, the compatibility we were promised has fallen short."
● Health care professionals fed back their concerns about the compatibility of people at one of the settings. One told us, "[Provider] are now taking increasingly complex people which they are then unable to support." Despite this being raised to the provider, they continued to progress a further package of care for a person that may not have been suitable based on the needs a health care professional made us aware of.

As the provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately this was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had failed to ensure suitably qualified and skilled staff were deployed to meet people's needs. One person we spoke with felt staff were not appropriately trained to support them. They told us, "They need training in autism again, they are better at understanding but could do with a bit more. They don't understand my [condition]."
● Relatives also had concerns about the effectiveness of the training provided at one of the settings. One relative told us, "Staff not being trained properly which is causing us anxiety." Another said, "There is an apparent lack of appropriate training in managing challenging behaviours."
● All people had a learning disability and autism. At one of the settings a person was frequently being

supported by consistent agency staff. However, of the 5 agency staff, according to the information provided, only 1 had training in learning disability and only two had received autism training. The lack of this training meant they may not provide the most appropriate support to the person.

● Staff at one of the settings had received training to positively support people in distress without the use of restraint. However, the training they had received in relation to safely restraining a person was not robust which left people and staff vulnerable. Although the provider had consulted the trainer who provided the current restraint training and the trainer had objected to having staff trained in two types of restraint, they could have made a decision sooner January 2023 to provide the more intense restraint training.

● Staff fed back they still did not feel confident around providing the most appropriate support. One member of staff told us, "It won't [training] work. I have raised my concerns about it, I said we need even more [training] so we know what to do if these situations happen."

● During our inspection we found shortfalls in the practices of staff and the provider including assessing people's capacity, infection control and safeguarding.

● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. At one of the settings the regular agency staff had not had any supervisions.

● Other staff at the setting had only had one supervision since November 2022 with 1 member of staff not having had any supervision. At the other setting staff were receiving group supervisions which staff fed back was not appropriate. Comments from them included, "Supervisions should be one to one so you can have a confidential conversation with manager and employee" and "We have group supervisions. I don't think this is right. I like to share things, personal things and other things." The manager for one setting told us, "I do group supervisions because they are much better. I wasn't meeting my targets so now I do them in a group they're looking much better."

The provider failed to ensure there was adequate training, knowledge and competency checks which was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider told us one to one supervisions would now be taking place with all staff. One member of staff told us, "We have been told by the manager these (supervisions) will be starting." The provider was also undertaking recorded reviews with staff on their understanding of the more robust restraint training to determine whether they felt more confident."

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

● Staff encouraged people to maintain a healthy diet whilst respecting people's choices. We observed one person had bought themselves snacks. Staff encouraged the person to spread the snacks out through the day.

● People's care plans contained information in relation to their food preferences and these were known to staff. We saw from daily notes that people were supported with meal preparation around these preferences.

● People chose when they wanted to eat. Staff supported people to cook when they chose to eat and to fit around their schedules.

Inadequate

Is the service well-led?

Our findings

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

At our last inspection the provider had failed to consistently ensure effective communication and to assess, monitor and mitigate the risks relating to people's health, safety and welfare. 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.

● Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively. Relatives told us they had concerns about the provider and management oversight of care at one of the settings. Comments included, "There is extremely poor communication from care provider and management to resident's family", "I felt like I was banging my head against a brick wall. I have made countless calls to senior staff and felt like I was getting nowhere", and "The management is poor, [The manager] is propped up by the regional managers."
● External professionals fed back increasing concerns about the leadership and culture at the settings we visited. Comments included, "I'm not confident in the running of a service for people with complex needs. It feels like it's starting to snowball a bit", "The communication between the service and external agencies is very poor" and "The communication between myself and home is very poor."
● There were no adequate systems in place to robustly check the quality of care. At one of the settings the manager told us they had not identified some of the concerns with the environment that put people at risk including windows that were unable to close. This was despite staff telling us this had been shared with the manager several weeks prior to the inspection. However, we saw the manager had reported this to the Landlords in November 2023, but no further action had been taken to chase this." The provider's team were also not picking up on these shortfalls including infection control despite telling us they frequently visited this setting.
● Staff at one of the settings told us they did not always feel listened to in relation to their concerns. Comments included, "I don't always feel safe, we always have the fear with us. Inside I feel nervous", "When we go to [manager] with a concern, they listen but nothing changes" and "I am very stressed at the moment."
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We identified through incident and accidents reports there were incidents of abuse. Not all of these at the time had not been notified to us by the provider.

The failure to ensure robust and effective quality assurance systems were in place was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff at the other setting told us they felt supported by the management. Comments included, "I do very much feel supported" and "The manager comes here and checks we are ok."
● The provider confirmed steps were being taken to undertaken one to one meetings with staff and ensuring staff had opportunities to raise their concerns through regular staff meetings and handovers.
● The provider confirmed they are taking steps to improve the communication between them and external professionals to include asking professionals to include the senior management team in email correspondence

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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; Continuous learning and improving care
● The provider did not always use formal feedback to influence positive changes. In a relative's survey completed between June and October 2022 relatives fed back concerns about the lack of meaningful activities. We found this concern remained with one person telling us, "I tell [manager] I am really bored but nothing changes." Comments from relatives included, "They are not doing outside activities, they are just babysitting [person]" and "There is not enough going on with [person]. [Person] would love to go out more." We saw from daily notes people were seldomly being supported to take part in meaningful activities outside of their homes. An external professional told us, "[People] are rarely supported in the community without parents checking and encouraging staff continually."
● Relatives fed back about the lack of transparency around what improvements were being made to the service since the previous inspection in June and July 2022. One relative told us, "We never saw an action plan, parents were promised this by [provider]. It's their untransparent attitude. Very difficult to communicate." Another said, "As a company they didn't send us any action plan after the CQC report." They said the provider should have acknowledged the shortfalls.
● Some staff told us they didn't always feel supported by management to fulfil their responsibilities. Although staff meetings were taking place this was not used an opportunity to listen to their views and act on this. Minutes from the meetings showed how at times work was affecting staff overall well-being and mental health. There were no actions on minutes to show what the provider had undertaken to address this. One member of staff told us, "I feel a little bit low. I feel isolated."
● The provider advised us they implemented a daily 'senior operations daily check' that included a review off accidents and incidents for review and learning. However, this was not robust. For example, we saw incidents forms for a person that occurred on the 4 and 6 February 2023. The daily checks for those days stated that no incidents had occurred in relation to the person.
● The provider had not always ensured they had shared information externally or with relatives regarding neglect, unsafe care and people being harmed whilst receiving support. One professional told us, "We hear about incidents from service users and their families that staff have not told us about."

The provider failed to ensure the service performance was evaluated and improved is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were people that did access the community to take part in activities they enjoyed including one person that went swimming and another person that whose family had arranged for the person to attend an educational setting.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's health care needs were effectively monitored and failed to ensure an assessment of the needs and preferences for care and treatment of people was adequate.

The enforcement action we took:

We imposed a condition to the providers registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed

The enforcement action we took:

We imposed a condition to the providers registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's safety were robustly assessed, accidents and incidents were effectively monitored, the management of medicines was safe and infection control was adhered to.

The enforcement action we took:

We imposed a condition to the providers registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were

protected from the risk of abuse

The enforcement action we took:

We imposed a condition to the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there was robust oversight of care at the service and failed to ensure the service performance was evaluated and improved

The enforcement action we took:

We imposed a condition to the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there was adequate training, knowledge and competency checks for staff

The enforcement action we took:

We imposed a condition to the providers registration