Elite Support Providers Ltd

Quintessential Support Brokers

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

Summary of findings

Overall summary

About the service
Quintessential Support Brokers is a domiciliary care service registered to provide personal care to people in their own homes. At the time of this inspection they were supporting two people with personal care. One adult living in the community in their own home and one child, aged between 16 and 18, living in a shared house. Five people in total were being supported to live in the shared house, which is a domestic house, leased to the provider. Not everyone using Quintessential Support Brokers received a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care', which is help with tasks related to personal hygiene and eating. The local authority funded a 24-hour staff presence in the shared house. The care package for the adult living in the community was based on four personal care calls per day with two staff members allocated to each of the calls.

People's experience of using this service and what we found
The care and treatment of people was not always appropriate and did not always meet their needs. Care plans did not evidence that people were being involved to the maximum extent possible in their care or that their preferences were always being taken into account.

People were not always protected from the risk of abuse and improper treatment. Risks to people who use the service or staff were not always addressed to reduce or remove identified risks. People were at risk of potential harm because the registered person had failed to ensure the proper and safe management of medicines.

People were at risk of potential harm because the registered person had not ensured the staff providing the care had the qualifications, competence, skills or experience to do so safely. The registered person had not ensured staff were provided with appropriate support, training and supervision as was necessary for them to do their job safely and effectively.

The registered person had not made sure staff employed were of good character and that all required information and checks were carried out. This meant people were potentially at risk of staff being employed to work with them who were not suitable.

The registered person had failed to notify the Care Quality Commission without delay of incidents reported to, or investigated by, the police.

The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. They had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. The lack of robust quality assurance meant people were at risk of receiving poor quality care and, should a decline in standards occur, the provider's systems would potentially not pick up issues effectively.

Whilst the above concerns apply to any person using the service, the person living in their own home in the community was supported to have maximum choice and control of their lives, where possible, and staff supported them in the least restrictive way possible. Their relative was very happy with the support and care provided by the service to their family member. They were very complimentary of the small staff team of regular staff that provided their family member's care and support.

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

Rating at last inspection
At the last inspection the service was rated good (report published 6 January 2018).

Why we inspected
This inspection was prompted by information of concern we received.

Enforcement
We have identified breaches in relation to regulations 9, 12, 13, 17, 18, 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Care provided was not always person-centred; people did not always receive safe care and treatment and were not always protected from the risks of harm or abuse; staff recruitment, training, support and supervision were not adequate to ensure people were safe or that staff were competent and suitable for their roles; effective systems were not in place to ensure the service met the required fundamental standards of care.

We have issued requirement notices relating to the above breaches.

We also identified a breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009 at this inspection. The registered person had failed to notify us about important events which the service is required to tell us about by law.

We served a fixed penalty notice for this breach.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor intelligence we receive about the service and we will return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

Special Measures
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 not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For 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 effective.

Details are in our Effective findings below

Inadequate

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 responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Quintessential Support Brokers

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. This inspection was planned to check 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 Care Act 2014.

The inspection was prompted in part by an incident the Care Quality Commission (CQC) were made aware of. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of that incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk, staff recruitment, staff training, staffing levels and the safety of people who use the service. We examined those risks as part of the inspection.

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

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of the inspection the service was also supporting a child (16-18 years old) living in shared accommodation in a house which had been leased by the provider and one adult living in their own home in the community.

The service has a manager registered with CQC, who is also the nominated individual for the provider organisation. A nominated individual is a person who is responsible for supervising the management of the service on behalf of the provider. As well as the registered manager of the service also being the nominated

individual, they are also the only director of the provider organisation. This means they alone are legally responsible for how the service is run and for the quality and safety of the care provided. In this report, due to the person's multiple roles, we will refer to them as the registered person.

Notice of inspection
This inspection was unannounced. Inspection activity started on 18 April 2019 and ended on 3 May 2019. We visited the office location on 18 April 2019.

What we did before the inspection
We looked at all the information we had collected about the service. This included previous inspection reports, information received and information about important events the registered person and others had sent us. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered person and five staff members. We looked at the care plans for both people who use the service, monitoring records and medication sheets. We also looked at six staff recruitment files, staff training records and the staff supervision log. We reviewed a number of other documents relating to the management of the service. For example, the staff training matrix and a list of staff criminal record checks. We provided the registered person with a list of documents to be provided. Unfortunately, the registered person was not able to access or provide the majority of the documents during our visit. We gave the registered person 48 hours to send us copies of the missing documents.

After the inspection
We continued to seek clarification from the registered person to corroborate evidence found during our visit. We reviewed the additional information the registered person sent to us after the visit at our request and needed to seek clarification of some of that information. We emailed the registered person three times after the inspection visit because we had not been sent all the information we requested. Despite the repeat requests the registered person still did not provide all required information. We were not able to speak with the person who lives in their own home over the telephone so, with permission, we spoke with their relative. We met the child living in the shared house during the inspection, but they were not comfortable talking with us about their experience of the service. We sought feedback from two community professionals but had received no response at the time of writing this report.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
Inadequate: People were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems were not followed to safeguard people from abuse. Staff we spoke with said they were aware of the process to follow if they were concerned and had received training. However, not all staff had received training in safeguarding and other concerns, such as failing to check if all staff applicants were barred from working with children or vulnerable adults and failing to provide appropriate training to staff, put people at risk of abuse.
- Concerns raised by staff with the management were not always acted upon. This relates to concerns raised with the Care Quality Commission (CQC) by staff. Although staff told us the concerns had been raised with a manager, no actions had been taken and they felt they needed to raise the concerns externally in order for people who use the service to be safe.
- One person had been subjected to sanctions such as, no video games for a week, no activity for a week and having their weekly allowance withheld for a week, in response to a particular behaviour. We asked the registered person about this and were told those sorts of sanction were never used to manage behaviour that may challenge. However, we saw two recent documented incidents where this had been the case. The sanctions imposed had not been part of an assessed or agreed care plan and there was no rationale given for why staff had chosen and imposed those particular sanctions. This practice placed people at risk of improper treatment that was not in line with current best practise guidelines for positive behaviour support.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. People were not protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of people using the service.

Staffing and recruitment

- People were not protected by the recruitment practices at the service. Although the staff files we looked at contained some of the information required by the regulations, all files had some required information missing. For example, of the six staff files we saw only one had a full employment history with no gaps. Four had unexplained gaps ranging from three to nine years and another had an employment history but had given a reference from a previous employment from somewhere they had not said they worked and was not included in their list of previous employers.
- In staff files there were new starter forms, which detailed the start dates of the staff. We compared the start dates on those forms with dates on the staff members' criminal record checks. We found two members of staff had Disclosure and Barring Service (DBS) certificates which were dated after the recorded start dates. For one other member of staff the registered

person had not applied for a DBS check and had not checked to see if they were barred from working with vulnerable adults or children. This meant 50% of the staff whose recruitment we checked had started work prior to receipt of a satisfactory DBS check and prior to a check being completed to ensure they were not barred from working with vulnerable adults or children. In the Care Quality Commission guidance on DBS checks it states, "Where a new member of staff is to care for or support children in a regulated activity, a satisfactory enhanced and barred list check must be received before they begin to do so." The three staff identified above were all working with children at the service prior to their DBS and barred list checks being received. The registered person was not aware of any of the above discrepancies prior to us pointing them out at our inspection.

This was a breach of regulation 19 and Schedule 3 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure staff employed were of good character and that information specified in Schedule 3 was available for each person employed. This meant people were potentially at risk of staff being employed to work with them who were not suitable.

Using medicines safely

- People were not protected against the improper or unsafe management of medicines. Staff only administered medicines to one person who uses the service. We looked at the medicine administration record (MAR) sheets for that person. The latest best practice guidance was not being followed. For example:
  - There were two MAR sheets for two antibiotic courses. Neither MAR sheet detailed the duration of the course. Only the dose and how many times to be taken a day. There was also no record of how many tablets had been dispensed on either MAR sheet;
  - There were numerous gaps on these MAR sheets with no explanation as to why the gaps were there. This meant it was not possible for the registered person to be confident the medicines had been given as prescribed. This could result in inadequate treatment of a diagnosed infection;
  - Only one MAR sheet had the month and year on it, the other only had days from 13 to 25 with no month or year as required;
  - There was no specific care plan that detailed how medicines were to be handled for this person;
  - We checked the staff training matrix and found three of the staff who had signed to say they had administered the medicine had not had any training;
  - Ten different staff had signed the two MAR sheets to say they had administered medicines to this person. However, despite us asking the registered person to send evidence of staff medicines competency checks, four times since our inspection visit, the registered person failed to provide the evidence.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of harm because the registered person had failed to ensure the proper and safe management of medicines.

Learning lessons when things go wrong; Preventing and controlling infection

- There was no documented evidence that lessons had been learnt when things went wrong. For example, there was no analysis of at least two incidents of aggression to try to identify the cause and mitigate the risks to other people or staff.
- Not all staff had received training in infection control.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not done all that was reasonably possible to mitigate risks to people who use the service or staff.

Assessing risk, safety monitoring and management

- In the care plans for the two people receiving a service at the time of our inspection some risks not related to incidents, had been assessed. For example, risks associated with falls, choking, skin breakdown, moving and handling. Where those risks were present measures had been put in place to deal with those risks.
- However, a relative of the person receiving care in their own home told us they felt their family member was safe with the staff, adding, "Absolutely. They do exactly as they are supposed to and more." The relative also told us that staff had never missed a call.

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.
Inadequate: There were widespread and significant shortfalls in staff receiving appropriate training, supervision and support. There were significant risks of some people receiving poor outcomes and inappropriate and unsafe care.

Staff support: induction, training, skills and experience

- Staff were not adequately trained, and many did not have the skills, knowledge and competence that was required to provide support and care to the people using the service.
- Despite asking the registered person to provide details of the staff who were employed at the time of the inspection visit, the information we received was conflicting. The registered person provided four different lists, all of which were different. We looked at the staff training matrix on the day of the inspection. However, not all staff were included on that matrix. For example, two of the staff we met on the inspection visit were not included on the matrix. The registered person then sent another training matrix on 30 April 2019 but 11 of the 16 original staff names had been removed and four staff members added. Three staff members who we met, or were on current rotas to provide care to people, were not listed on either training matrix. On 30 April 2019 the registered person confirmed that the latest training matrix they had provided was up to date. This meant the three staff members (25% of the workforce) not included in the matrix were providing care even though they had received no training.
- We asked the registered person to identify staff who did not have previous experience working in care. This was so that we could ensure they had received an appropriate and thorough induction before being allowed to work unsupervised. The registered person identified only one of the staff team as having no previous care experience. However, when we reviewed staff files we found four of the six staff members, whose files we checked, had no previous experience working in care. We were also made aware that another new member of staff had no previous experience working in care. This meant at least five of the 12 staff members were inexperienced in providing support to people with complex needs such as those people living in the shared house. The rotas provided for the shared house showed two members of staff worked the day shift and two worked the night shift. However, the rotas also showed that there were numerous shifts each week where neither of the two members of staff working together in the shared house had completed their induction training and also had no previous care experience to draw on. This practice put people using the service at a high risk of receiving inappropriate and unsafe care.
- There was no evidence any staff had been assessed to ensure they were safe and competent to handle medicines. The only evidence of training was on-line training, and no training was evidenced for three of the ten staff who had signed the medicines administration sheets to say they had administered medicines.
- There was no evidence that any staff had received practical basic life support (cardio-

pulmonary resuscitation) for either children or adults.

- There was no evidence that any staff had received practical moving and handling training.
- The service was providing support to people with a range of needs and different diagnoses, such as, dementia, learning disabilities, autism, severe anxiety, risk of skin breakdown, risk of choking, epilepsy, behaviours that challenge and pathological demand avoidance (PDA).
- Taking the information relating to training completed at the time of our visit, 18 April 2019, the matrix showed that no staff had received training in supporting people with autism, or PDA. Only four of the 12 staff had done some training in learning disabilities, mental health and dementia.
- Only two of the 12 staff members had done online training in caring for people with anxiety. Only five of the 12 staff members had done training in dealing with behaviours that may challenge. No staff had received training in positive behaviour support, caring for people with epilepsy or caring for those at risk of choking or skin breakdown.
- Of the other training the registered person expected staff to complete, only two staff members had done training in the Mental Capacity Act 2005 (MCA). Only five were recorded as completing their fire safety training and only five had completed their food hygiene training.
- With reference to staff induction. The registered person told us all new staff had training in the Care Certificate. The Care Certificate was developed by Skills for Care and is a set of 15 standards that new health and social care workers need to complete during their induction period. Of the 12 staff we were aware of, only four had completed all 15 of the required standards. There was only evidence that one member of staff had been assessed as competent and that was in only nine of the 15 standards.
- We asked the registered provider to send us a log of staff one to one supervision meetings. We were sent the log which evidenced that only two members of staff had received any supervision. The logs stated that the two members of staff had received supervision on the first day of January, February and March 2019, each meeting was for one hour. However, in the column to be signed by the supervisor, each meeting date had been initialled by someone whose initials did not match anyone on any staff list, further evidencing that the staff lists provided by the registered person, were not accurate. There was no evidence that any other staff members had received formal supervision at all.
- We asked the registered person to provide evidence of 'spot checks' carried out on staff as they worked with people who use the service. We were sent evidence of three visits reporting on three members of staff working with the person living in their own home. The visits had been in December 2018, January 2019 and March 2019. On the notes for the visit in January 2019 it is recorded by the registered person that two of the staff should do the dementia training. There was no record that either staff member had done that training after their spot check. There was no evidence that spot checks had been carried out on any other staff to check the quality of their work and ensure they were working in a safe and appropriate way.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff working with people who use the service had not received appropriate support, training or supervision. This placed people at risk of harm or abuse and of receiving inappropriate and unsafe care.

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

- Care and support did not reflect current evidence-based guidance, standards and practice.

- With reference to the care provided to the child living in shared accommodation, we found their needs were assessed but care was not always delivered in line with best practice guidelines. For example, the use of punitive sanctions, in response to behaviour that challenged, was not in line with best practice positive behaviour support guidelines.
- In the "placement request documentation" for one person we saw that it was set out that care staff needed "Knowledge of Autism, management of PDA and [knowledge of] high levels of anxiety." There was no evidence that any staff had those required skills vital for the person's placement. There was no evidence the placing authority had been made aware by the registered person that staff employed at the service lacked the skills required to be able to deliver care in line with standards, guidance and the law. Staff providing the care to this person did not have the training or experience to do so.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of potential harm because the registered person had not ensured the staff providing the care had the qualifications, competence, skills or experience to do so safely.

- With reference to the person living in their own home and receiving care four times a day, we found their assessment and care planning met their needs and were in line with current best practice. Their relative was very positive regarding the care provided to their family member. When asked if they felt the staff had the training and skills they needed they answered, "Oh yes, definitely."

Supporting people to eat and drink enough to maintain a balanced diet;
- There were no concerns identified regarding people being supported with their diet or to stay hydrated.

Staff working with other agencies to provide consistent, effective, timely care
- At the time of this inspection the service was working with local authorities to assist with people moving on to new placements. While no feedback was received from professionals we approached, there were no complaints regarding the staff assisting external professionals in this process.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. Where people are deprived of their liberty in their own homes, applications must be made directly to the Court of Protection.
- We checked whether the service was working within the principles of the MCA. One of the people being supported had capacity to make the majority of their own decisions. There was evidence in the other person's care plans that decisions were being made in line with the MCA and were made in the person's best interests where they could not decide themselves. The relative we spoke with confirmed that staff always tried to give their family as much choice as possible and always involved them in decisions. The relative added, "They talk with

him, they're very good."

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.
Requires improvement: The service was not always caring. People were not always well-supported, cared for or involved as partners in their care.

Ensuring people are well treated and supported; Respecting and promoting people's privacy, dignity and independence

- The registered person had not made sure all staff had the training, skills or experience to ensure people were well treated and supported.
- The registered person had not carried out spot checks on staff working with the person living in the shared house to ensure they were well treated or that staff were following best practice guidelines.
- The registered person had not carried out spot checks on staff working with the person living in the shared house to ensure they were treated with respect or that their privacy, dignity and independence were promoted.
- Interventions set out in the care plan were not always appropriate or respectfully written. For example, in one area of a person's care plan it was stated that when the person looked shocked it meant they did not agree or like what the staff member had said. Rather than identifying actions for staff to take to find out what the problem was, someone had written (unsigned and undated) that staff should, "Tell me pulling this face will not change anything and remind me again what is expected of me." There was no record of when this intervention was used or if it had been effective or had resulted in causing more anxiety for the person.
- However, the relative of the person living in their own home in the community was very positive about the care their family member received. They said staff were always caring when they looked after their family member and added. "They are always laughing with [Name]. He seems to adore them." When asked if staff treated their family member wit respect and dignity the relative answered, "Absolutely."

Supporting people to express their views and be involved in making decisions about their care

- We asked the registered person to send us evidence of any quality assurance records, for example, surveys. However, these were not provided and there was no evidence that all people's views were being sought or that they were being involved in decisions about their day to day care or the drawing up of their care plans.
- However, the relative of the person living in their own home in the community said staff involved their family member in making decisions when they provided care and encouraged him to be as independent as possible.

Respecting equality and diversity;

- People's needs in relation to equality and diversity were assessed as part of the initial assessment and any needs found were incorporated into their care plans.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
Inadequate: Services were not always planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We saw care plans for both people who use the service at our visit on 18 April 2019.
- Care plans were not always kept up to date, meaning staff did not have accurate records to refer to. This also meant it was not possible to determine if people's needs were being met.
- The care plan staff were working to for the child living in the shared house had last been updated in November 2018. Staff told us the care plan did not reflect this person's current needs. A number of new staff had started after the care plan had last been updated. They were working with this person but had out of date information. This could lead to an increase in anxiety for the person where different staff were providing different care, or care in different ways. The registered person also told us the care plan was out of date and needed to be updated.
- After the inspection, the registered person sent us a new care plan on 29 April 2019, we were told this care plan had been updated and was current. It was recorded on the front cover as being updated on 1 January 2019.
- Although the care plan included details of the person's preferences and routines, it did not evidence that the person had been involved in developing their plan or that they agreed with the contents.
- The majority of the care plan was not dated or signed, meaning it was not possible to identify when the changes had taken place or which staff had made the entries.
- There were some notes relating to a medical issue with a note that antibiotics were taken. However, this entry was not dated and it was not possible to determine if the health issue had been effectively handled and was resolved.
- Poor record keeping meant it was not possible to case track that health issues were dealt with appropriately. For example, on the "Record of medical visits" form, we saw staff were incorrectly completing the columns. Under the heading of "Reason for visit" staff had entered "Doctor" or "Optician" rather than the reason for the visit, as instructed. Also, the record of visits was not accurate. For example, the note that the person had taken antibiotics did not have a record of a corresponding GPs visit or appointment.
- Not having continuous and clear recorded evidence to indicate people were supported appropriately meant that the registered person and staff did not have an overview of people's conditions and their wellbeing and staff would potentially not be able to respond and seek appropriate support when needed.
- There was little evidence that the person had been enabled and supported to make, or participate in making, decisions related to their care and treatment to the maximum extent possible. In the care plan there was a section headed as follows, "Young Person's Comments (Young people should be encouraged to contribute to all sections, and this

should be recorded in the relevant section. This is for their feedback and for them to write how they feel about the content of this plan)." The section was blank and there were no records anywhere in the care plan that showed the person had been involved or had been encouraged to contribute at all.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of people was not always appropriate, did not always meet their needs. Care plans did not evidence that people were being involved to the maximum extent possible or that their preferences were always being taken into account.

- The care plan for the person who lived in their own home in the community did demonstrate that they received personal care that was individualised to their personal needs. The person's relative said their family member received the care and support they needed, in the way they preferred. The relative added, "I don't think he would get it anywhere else [from another agency]."
- The daily notes demonstrated staff provided personal care to this person based on the way they liked things done.

Meeting people's communication needs
From August 2016 onwards all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service had not taken steps to comply with the AIS. Care plans did not evidence of how the AIS had been applied through identifying, recording and highlighting people's individual information and communication needs in their care plans.

This was also a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person was not enabling and supporting people to understand the care or treatment choices available to them.

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

- The care plan for the child living in the shared house contained very detailed information regarding family contact and how staff should support the person to maintain and develop family contact and relationships.
- Care plans contained details of different activities people were interested in. There was some evidence that staff had supported people to try new activities to see if they would like it. For example, one person had been supported to attend "taster sessions" at a local college to see if they would be interested in following a specific interest.
- People had access to activities that took into account their individual interests and links with different communities. Where possible, they were involved in the local community and visited local shops, cafes and other venues.

Improving care quality in response to complaints or concerns

- There were no recorded complaints from the people who received personal care. A relative told us they had never had reason to complain but that they would raise any concerns with

the management.

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. Inadequate: There were widespread and significant shortfalls in service leadership. The registered person 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

- Although there were quality assurance systems in place they were not effective in checking and ensuring the provider was meeting their legal obligations and the fundamental standards of care.
- During this inspection we identified areas, not identified by the registered person, where regulations were not being met and where action was needed to make sure people were protected and safe. Failure to identify and act on these issues potentially placed people at risk of harm or abuse.
  For example:
  - Not ensuring people were protected from harm or abuse.
  - Not ensuring staff recruitment was carried out to ensure staff employed were of good character.
  - Not ensuring staff had the training and skills they needed to meet individual people's needs
  - not ensuring the safe handling of medicines.
  - Not doing all that was reasonably possible to mitigate risks to people who use the service or staff.
  - Not ensuring that people were being involved in their care to the maximum extent possible or that their preferences were always being taken into account.
  - Not maintaining securely accurate, complete and contemporaneous records in respect of each person.
  - Not maintaining an accurate record of the care and treatment provided to the service user and of decisions taken in relation to that care and treatment.
  - Not maintaining securely records in relation to staff employed in the carrying on of the regulated activity.
  - Not seeking and acting on feedback from relevant persons and others on the services provided, for the purposes of continually evaluating and improving the service.
- Records were not always up to date, accurate, complete or available to the registered person.
- There was evidence that the data protection regulations were not always followed, and that confidential personal information was not always handled or stored securely. For example, the new operations manager told us that they stored and worked on staff rotas on their personal computer rather than on the secure work computer. In addition, the registered person stated that when the previous operations manager had left

the service recently, they had taken confidential information with them, including staff files.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively.

Statutory notifications
A statutory notification is information about important events which the service is required to tell us about by law.

- In the course of this inspection we discovered there had been six incidents which were reported to, or investigated by, the police. The registered person had failed to notify us of any of those incidents.

This was a breach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.The registered person had failed to notify the Care Quality Commission without delay of incidents reported to, or investigated by, the police.

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

- There had been no incidents that fit the remit of the Duty of Candour regulation, so we were unable to assess their compliance with this regulation.

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

- For the one person receiving care in their own home in the community we received positive feedback from the relative of this person regarding the care received and the staff team involved in that package of care.
- When asked if they thought the staff team that supported their family member had good relationships with each other the relative answered, "Yes, they work almost as one."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The care and treatment of people was not always appropriate, did not always meet their needs and their preferences were not always being taken into account. Service users were not being enabled and supported to be involved in their care and treatment to the maximum extent possible. Regulation 9(1)(3)(a-i)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not done all that was reasonably possible to mitigate risks to people who use the service or staff. The registered person had not ensured that staff providing the care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered person had failed to ensure the proper and safe management of medicines. Regulation 12(1)(2)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

Service users were not protected from abuse and improper treatment.
Systems and processes were not operated effectively to prevent abuse of service users
Regulation 13(1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

How the regulation was not being met:

The registered person had not established an effective system to enable them to ensure compliance with regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The registered person had not ensured systems were in place to enable them to:
-assess, monitor and improve the quality and safety of the service;
-assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others;
-maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to that care and treatment;
-maintain securely records in relation to persons employed in the carrying on of the regulated activity;
-seek and act on feedback from relevant persons and others on the services provided, for the purposes of continually evaluating and improving the service.
Regulation 17(1) (2)(a-f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

	The registered person had failed to ensure persons employed for the purposes of providing personal care were of good character and had failed to ensure information specified in Schedule 3 was available for each person employed. Regulation 19(1)(a)(3)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the requirements of the fundamental standards. The registered person had not ensured staff employed to provide personal care received such appropriate support, training and supervision as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1)(2)(a)

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The registered person had failed to notify the Care Quality Commission without delay of six incidents reported to, or investigated by, the police. Regulation 18(1)(2)(f)

The enforcement action we took:

We served a fixed penalty notice.