David Adeolu Adekola

Wurel House

Inspection report

135 London Road
Sittingbourne
Kent
ME10 1NR

Tel: 07879648163

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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

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

About the service
Wurel House is a small four bedroom supported living service providing personal care to people with a learning disability. The service also provides domiciliary care to older people living in their own houses and flats in the Swale area of Kent. At the time of our inspection there was one person living at the supported living service and nine people receiving domiciliary care in the community. All nine receiving a domiciliary care package received support with personal care. This is help with tasks related to personal hygiene and eating. We also considered any wider social care provided.

People's experience of using this service and what we found
Relatives expressed frustration and concerns in relation to the frequency, length and duration of community care visits. Comments relating to this included, "Time wise they should be there for one hour for morning, same at night. 30 minutes at lunch and dinner times. A total of three hours a day. They roughly stay for 15 to 20 minutes each time, I'm pretty sure they don't stay that long." And "On Monday [staff member] suggested not to come in for the lunchtime as she came late morning." They went on to explain this left their elderly parent to carry out care. They said, "They can't plan for anything and feel anxious waiting as the [person] wants to get up out of bed. [Spouse] had to help him get on the commode yesterday."

Most relatives gave us positive feedback about their loved one's care and support from the care staff. They told us, "She is so comfortable after they have been, they talk to her as a person and not a patient. They do everything for her." "We are 100% pleased with the girls, they are angels." "She really likes them, they proper get her cheerful, jolly and make her laugh." And "[Loved one] seems very happy. Staff are good with her. They have conquered communication with her."

The management team were not aware of Right support, right care and right culture. Based on our review of safe, effective and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support
Staff did not support people with their medicines in a way that promoted their independence and achieved the best possible health outcome. People could not be sure their prescribed medicines were always managed in a safe way. Staff supported people to complete personal care tasks and activities. However, these assessed needs were not set out in the care plans for people with learning disabilities and other people receiving support in the community. Care plans for people with a learning disability and or autism

were not structured to support people to achieve their goals and aspirations. Staff enabled people living at Wurel House to access specialist health and social care support in the community.

Right Care
The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Staff had not received training on how to recognise and report abuse. People received kind and compassionate care. Staff protected and respected people's privacy and dignity. People's care, treatment and support plans did not reflect their range of needs to promote their wellbeing and enjoyment of life. Individual risks were not always assessed and managed to keep people safe. Care plans and risk assessments were inconsistent and did not always detail the relevant information staff would need to meet people's assessed care and health needs. People could not be assured new staff were adequately checked to ensure they were suitable to work with people to keep them safe. We found no evidence that people had been harmed however, systems were either not robust enough to demonstrate staff recruitment was effectively managed.

Right culture
Within Wurel House supported living service, people and those important to them, were involved in planning their care. Staff were able to communicate well with the person living at Wurel house supported living service, despite staff not receiving Makaton training to help them communicate. The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. Registered persons had failed to notify CQC of incidents and events such as abuse and serious injuries.

Wurel House supported living service was not clean, people were at risk from the spread of infection. Government COVID-19 guidance in relation to testing people and staff and the use of PPE (personal protective equipment) had not always been followed. The provider's infection control policy was not up to date or robust.

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 supported this practice.

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

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

Rating at last inspection
The last rating for this service was good (published 13 December 2019)

Why we inspected
The inspection was prompted in part due to concerns received about person centred care, staffing levels, medicines management and recruitment of staff. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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

We have identified breaches in relation to risk management, medicines management, infection control, recruitment and deployment of staff, safeguarding people from abuse, capacity and consent, staff training, assessment of care, records, complaints, reporting of notifiable events and effective systems to monitor and improve the service at this inspection.

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.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Wurel House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The provider of the service was also the manager of the service.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 March 2022 and ended on 09 April 2022. We visited the service on 28 March and 30 March 2022. We carried out telephone calls with staff between 04 and 09 April 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gained feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. The local

authority told us they had visited the service within the last month.

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 used all this information to plan our inspection.

During the inspection
We spoke with one person who lived at the supported living service and their relative about their experience of the care provided. We also spoke with nine relatives of people who received personal care from the service in their own homes. We spoke with seven members of staff including the provider, care coordinator and support workers.

We observed staff interactions with one person at the supported living property and observed care and support in communal areas.

We reviewed a range of records. This included six people's care records and two medicines records. We looked at four staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service, including checks and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance, training records, rotas and healthcare records.

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

Systems and processes to safeguard people from the risk of abuse.

- People were not kept safe from avoidable harm. The provider did not have effective systems to protect people from the risk of abuse. Staff had not received safeguarding training, some staff we spoke with did not feel confident concerns of abuse would be appropriately dealt with and some did not know how to report outside of the organisation. Although this was a risk to people, no actual harm had occurred. We provided information to staff to ensure they knew how to report concerns of abuse outside of the organisation.
- The provider's safeguarding policy was out of date and did not provide staff with the information they needed to recognise abuse, report abuse and escalate concerns outside of the organisation. The provider's safeguarding policy stated that staff had access to the local authority safeguarding policy and the provider's safeguarding policy at the supported living premises at Wurel House. The policy was not on site when we visited and staff did not have copies.
- People and those who mattered to them did not have safeguarding information in a format they could use, to enable them to know how and when to raise a safeguarding concern.

The provider had failed to protect service users from abuse and improper treatment. This placed people at risk. 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) Regulations 2014.

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

- People did not live safely and free from unwarranted restrictions because the service had not assessed, monitored and managed safety well. Risks relating to people's care and environment had not been well managed. There were no risk assessments in place in relation to people's care, support, physical health needs, safety, moving and handling, COVID-19, environment, oxygen use and catheters. Risks to people had not been identified and mitigated.
- The provider had not followed their health and safety policy and had not followed health and safety legislation, as they had failed to assess risks to people and staff. Risks to staff working in the community had not been assessed. At Wurel House, risks in relation to building work, risks of falling from windows and fire safety had not been considered to keep the person safe. We reported fire safety concerns to Kent Fire Service.
- The provider had not assessed the risks of people falling out of windows, windows did not have window restrictors. The provider had recorded in their health and safety check which had been completed on 2 February 2022 that window restrictors were not in place. Although this was a risk to the person, no actual harm had occurred.
- The provider had a policy which stated a first aid box was available. The only first aid box seen contained out of date first aid supplies. When we checked the contents of the first aid box with staff, there were many

missing items and antiseptic wipes had expired in June 2017, bandages had expired July 2017. This meant if there had have been an emergency requiring first aid, suitable equipment was not available. Staff were unaware of another box containing other supplies. After the inspection the provider told us they had placed a first aid poster up to detail where the first aid box was situated and who the first aid trained staff were.
● Staff told us there had been no accidents or incidents to report at Wurel House supported living service. One incident form had been completed for an incident that occurred in the domiciliary service. Action had been taken as a result of the incident and the package of care was terminated to protect staff members. However, the completed incident referred to previous incidents of aggression that had occurred. We checked with the provider and these had not been recorded. Incidents relating to people had not been managed safely to reduce the risk of harm.

The provider had failed to protect people from risks related to fire and the environment. Risks related to people's physical health needs had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been recorded and reviewed. This placed people at risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff working with the person at Wurel House supported living could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe.

Staffing and recruitment
● Prior to the inspection and during inspection we received concerns regarding staff recruitment. Staff were not always recruited safely because the provider did not have a robust recruitment system. This meant employment histories, DBS checks and employment references were either not completed or held unclear information.' The provider could not be assured that all staff were suitable for their roles.

A robust approach to recruitment was not taken to ensure only suitable staff were employed to provide care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider sent us evidence to show that new DBS checks had been undertaken.

● Prior to the inspection and during inspection we received concerns regarding staff deployment. The deployment of staff in Wurel House domiciliary care was not adequate to ensure people's needs were met. The staffing rota did not have start times, call times and length of calls listed. Feedback received from people and relatives evidenced staff were cancelling calls to people. This had not always been reported to management team. People had experienced one staff member turning up to provide care when they needed two staff to provide care and support.
● Relatives reported to us that their loved ones had experienced delays in receiving support to get up, washed, dressed, eat, drink and support with continence care. People's care records evidenced this. This evidences not enough staff had been deployed at the right time to meet people's assessed needs. People experienced staff rushing their care and not staying the full amount of time.
● Comments from relatives included, "The only bones of contention I have is they normally come at 8.30am but it has been 10.30am which has happened very regularly. I've normally cleaned [loved one] up before 9.00 am as they aren't here. Today was 12pm for breakfast so we agreed to miss lunchtime and come out at teatime. It's not unusual for them to come three times a day or twice a day when it should be four times" and "They have not come in yet [11:05am], normally its 8.30am. Mum normally does his breakfast once he's

in his chair but had to have it in bed today. One [staff member] came in last night it was a one off, it's normally two but the other one had to go somewhere else. She only stayed 15 minutes."

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was no systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● The service had enough staff at Wurel House supported living service, including for one-to-one support for people to take part in activities and visits how and when they wanted.

Using medicines safely

● Prior to the inspection and during inspection we received concerns regarding medicines practice. People were not supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely. The provider did not have effective systems in place to manage medicines effectively, this put people at risk of harm. Medicines had not always been administered following prescriber instructions. One person had been prescribed antibiotics; they had missed two doses of the medicine. Medicine administration records (MAR) showed other gaps in records. It was not possible to determine whether the medicines had been given or not. There was no process in place to account for medicines in stock and counting was not taking place.

● MAR charts did not include all medicines people were taking. Medicines records were not in place for people prescribed creams and emollients, despite them being prescribed these. Medicines were not adequately recorded on people's care plans. This meant that people were at risk of not receiving their prescribed creams. This could impact their health.

● Medicines and medical equipment had not been returned to the pharmacy for disposal following the provider's policy. Full sharps boxes were located in Wurel House that had not been returned to the pharmacy along with medical equipment prescribed for a person who had left the service more than two years ago.

The failure to manage medicines safely demonstrates a breach of Regulation 12 (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was meeting shielding and social distancing rules.

● We were not assured that the provider was admitting people safely to the service.

● We were not assured that the provider was using PPE (personal protective equipment) effectively and safely. We observed staff and the provider not wearing masks on the first day of our inspection. We challenged this practice and masks were worn, the provider required prompts and reminders throughout the inspection to wear their mask over their nose and mouth.

● We were not assured that the provider was accessing testing for people using the service and staff. The provider had failed to follow government guidance on testing in health and social care settings. After the inspection, the provider arranged for tests to be delivered to the service.

● The service did not use effective infection, prevention and control measures to keep people safe. The service did not have good arrangements for keep premises clean and hygienic. We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service were dirty and had not been cleaned effectively. Cleaning schedules were not completed, cleaning

had not included cleaning of high touch areas and any additional cleaning to maintain robust cleaning standards. On day two of the inspection the provider had introduced a cleaning schedule.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were not assured that the provider's infection prevention and control policy was up to date.

● Staff had not completed food hygiene training and had not followed correct procedures for preparing and storing food. Food found in the fridge at Wurel House supported living had not always been labelled when opened by staff and discarded when use by dates had expired. This was a potential risk of harm to people.

This demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Wurel House also provided people living in the community with domiciliary care. Relatives and staff told us that staff wore PPE when they entered people's homes. A relative told us, "They have all the gear. They are safe that way."

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

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

- People's needs were not always assessed. Prior to people receiving a service from Wurel house domiciliary care their needs were not thoroughly assessed. However, prior to people receiving a service at Wurel House supported living their needs (including their communication needs) were assessed. These assessments were used to develop the person's care plans. In both the supported living and domiciliary service, the care plans were not clear or robust and did not clearly detail what people's assessed needs were.
- People's equality and diversity needs, end of life care needs, oral care, capacity and health needs were not included in the information obtained before packages started to enable staff to provide safe, person-centred care and support.
- Information about people had not been assessed or recorded. For example, information about allergies and whether they had a DNACPR order (do not attempt resuscitation) in place. This meant that staff did not have all the information they needed to provide safe care and support.
- The assessments and re assessments of people's needs had not led to goals and action plans being set to support people with learning disabilities to develop and improve their skills and maintain certain levels of independence, this meant there were no clear pathways to future goals and aspirations, including skills teaching in people's support plans.

The failure to provide care and treatment to meet people's assessed needs is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience

- People were supported by staff who had not received relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions.
- Staff had not received training to meet people's assessed needs. Videos had been sent to staff over a group chat application. Staff reported these videos were not effective. Staff had not received physical training to use some equipment which left people at risk of harm. The provider did not check staff competency to ensure they understood and applied best practice.
- One person's risk assessment showed that they communicated using some Makaton sign language and had difficulty expressing themselves. The risk assessment showed that all staff should receive basic Makaton training. Staff had not received Makaton training to help them communicate more effectively. We did not observe any negative impact of this on the person.

● Some staff employed to work in the community had not received any induction and had not shadowed experienced care staff to develop their skills and knowledge of the service and the people they supported. One staff member said, "I would not recommend Wurel House as an employer for someone with no care experience. We do not even shadow when we start. Literally just start and straight into care calls."
● Staff told us, "I have not had any training since working for Wurel house. We are in the process of arranging moving and handling training"; "[Care coordinator] sends us videos to watch" and "The only training we receive is a link to a video to watch through WhatsApp, no actual training, no assessment. I don't think that is right. I have not done any moving and handling training with this company; I do feel we need to be refreshed and practice using equipment as we do have some people who use equipment." A relative told us they had moving and handling concerns related to the use of slide sheets. They detailed staff had not been using the slide sheets appropriately.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff employed to work in the community told us had not received any induction and had not shadowed experienced care staff to develop their skills and knowledge of the service and the people they supported. One staff member said, "I would not recommend Wurel House as an employer for someone with no care experience. We do not even shadow when we start. Literally just start and straight into care calls."

Supporting people to eat and drink enough to maintain a balanced diet
● The person living at Wurel House supported living service was not supported appropriately to prepare and cook meals to maintain good health and have a balanced diet. This put the person at risk of harm. The oven at Wurel House was broken and was not in use. This meant the only foods the person ate were meals cooked in the microwave.
● We observed the person being offered choice as to which microwave meal they would like to eat. Once they had selected the meal the staff member then cooked the meal in the microwave, rather than supporting the person to follow the instructions for cooking and setting the correct time on the microwave.
● People in receipt of domiciliary care from Wurel House were at risk of malnutrition and dehydration because of the impact of erratic care visit times. Relatives were concerned about the impact of inconsistent and erratic care visit times on their loved ones. Some people had long periods of times between meals and drinks because of long periods of time between care visits or because of cancelled care visits. One relative told us, "They come at different times like today I spoke to Mum just after 12:00 and the girls [staff] were there then. This was the breakfast slot. She was still in her nightie. Mum had been waiting all morning for her breakfast but managed to do something to eat herself. She told me I'd love a cup of tea. She had not had anything to drink since 19:00pm last night." A staff member said, "Last week on 6 April [staff members] were working together on morning and lunch calls. They eventually finished lunches at 16:00pm. They had missed two people out. I did the tea calls and got there at 16:00pm, two people had not been given lunch calls. The person thought I had come to do lunch and I explained I was there to do tea, they had not had a lunch call. The person was not able to make their own food and drink, luckily the daughter had visited and was there between 12.00 and 16:00pm and confirmed she had given mum food when the lunch call did not take place. The morning and lunch staff did not know she was there."

The failure to assess the risks to the health and safety of people to ensure people received safe care and treatment is a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The person living at Wurel House supported living could have a drink or snack at any time.

● Not everyone who received domiciliary care needed support with eating and drinking. Where they did, people and relatives said they were happy with the support they received. One relative said, "They know my mums likes and dislikes and she has a choice of meals, it's normally what I make for her."

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

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

● We checked whether the service was working within the principles of the MCA. Records relating to mental capacity were poor. People's care plans contained no information about their mental capacity. For example, in the domiciliary service the care plan section for mental capacity stated 'none' for their assessed needs and none for support.
● The care plan for the person living at Wurel House supported living did not mention mental capacity at all. There was no evidence that staff had worked with the person to assess whether they had capacity to make specific decisions. The person living at Wurel House had attended a medical appointment in March 2022 and were unable to answer the doctor's questions. Records relating to the appointment evidenced that the person lacked capacity to provide medical information and consent needed to be obtained via the provider or next of kin. There was no evidence to show that the provider had followed the MCA. There was no record that a capacity assessment or best interest discussion had taken place.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff gave examples of how they supported people to make their own decisions. For example, offering a choice of two items to wear and offering different items for their foods.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Where people needed support to access healthcare this was in place. Staff called an ambulance, accessed medical support via 111 and referred people to the GP as needed. Staff were clear about the action they would take when a person presents as unwell. There were clear records when actions had been taken, referrals had been made on to healthcare specialists when required. However, records relating to the outcomes of appointments and referrals were not always clear. This is an area for improvement.
● People living at Wurel House supported living did not have health actions plans/ health passports in place which could be used by health and social care professionals to support them in the way they needed. This is an area for improvement.
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives.
● The service worked with others to ensure people were appropriately supported. There was clear and

regular communication between the service and social workers and commissioners to keep relevant people informed of changes and concerns.

● During the inspection, one person was supported by the provider and a staff member to attend a hospital appointment. Staff worked with the person to help them understand what was going to happen, when it was going to happen and reassured them. A relative said, "They phone me regarding hospital appointments."

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Governance processes were not effective and did not help to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up shortfalls in practices in relation to health and safety. No other audits had taken place, the provider was unaware of the concerns and issues highlighted during our inspection relating to risk assessment, safeguarding, medicines management, staff recruitment, staff deployment, infection control, training, care planning, assessment, nutrition and hydration, capacity and consent, recording and notifications of events.
- The provider lacked oversight of the supported living service and the domiciliary care service. The provider lacked understanding of current regulations, good practice and this had an impact on the care and support people received and the guidance staff received. The provider had not registered the service as an organisation to enable staff to access COVID-19 testing and was unaware of this process until the inspection. During the inspection the provider registered the service to enable staff to gain COVID-19 tests. The provider had not been completing the NHS community capacity tracker and was unaware of this process until the inspection.
- Records were not returned to the office frequently enough to enable the management team to monitor and check care and support had been delivered to meet people's assessed needs. No audits of care records had been completed. This meant the management team were not aware of the concerns in relation to recording until the inspection identified the issue.
- Records in the service were poor. The staff list the provider gave CQC was not complete. The list of people receiving the regulated activity of personal care in the community was not complete. Daily records lacked detail of what support and care had been given in the community. For example, daily records stated personal care given, but did not detail whether this was a wash, bath, shower, shave or teeth cleaning. Daily records lacked detail about how long the visit was for.
- The provider had failed to make interim arrangements for staff to access policies and other documents whist building work was taking place at Wurel House. It was not possible to know how long this work had been going on; staff and the provider reported differing timescales of between four and seven weeks. The documents were being stored at the provider's home. This meant staff did not have access to policies and procedures to inform them of how to provide safe care and treatment.

The provider had failed to operate a robust quality assurance process to continually understand the quality

of the service and ensure any shortfalls were addressed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. CQC had not received any notifications from the service in a 12-month period. The provider told us they understood their role and responsibilities, however, they had not notified CQC about all important events that had occurred. Regulatory requirements had not been met, serious injuries and deaths had not been reported to CQC without delay.

The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 16 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● The provider's complaints policy was not adequate. The policy was out of date and referred to old Health and Social Care Act regulations and standards. It did not provide people information about who to complain to if they were not satisfied with the response and was not in an easy to understand format. The complaints procedure was not available at Wurel House supported living, and people in the community were not provided with this. The provider told us that there had not been any complaints about the service. However, relatives informed us they had complained to the service. These complaints had not been recorded and had not been dealt with appropriately, the issues and concerns were still occurring when we inspected. For example, care visits were at erratic times, care visits were being cancelled by staff and people were not receiving the care and support they had been assessed to receive.

● The provider had not met with any people or relatives following complaints or when something had gone wrong. Relatives told us, "We haven't heard from them [provider] at all." And "We have only seen [senior staff member] once, she came a month ago to help out."

The failure to acknowledge, investigate and take action in response to complaints is a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about the service can be informed of our judgements. The provider had displayed a copy of their rating on their website.

Working in partnership with others

● The provider had not worked in partnership with others. The provider had not kept up to date with local and national developments within health and social care. There were no learning opportunities to update their skills and knowledge to benefit the experience of people using the service.

● The provider was unaware of Right Support, Right Care, Right Culture and was not able to demonstrate through practice and through records to form part of the ethos of the service.

● The provider had not attended any local or national events or forums to make sure the practices they were following were current and best practice. They were not signed up to well known, reputable websites to find advice and guidance such as Skills for Care. Skills for Care supports adult social care employers to deliver what the people they support need and what commissioners and regulators expect.

The provider had failed to evaluate and improve their practice to continually assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We received mixed feedback from staff in relation to the support they received from the provider and senior care staff. Some staff felt the management team were not approachable. Some staff working in the domiciliary service felt undervalued and felt there was a poor culture within the service. Staff told us that there had been concerns about staff conduct which had which had been reported to the provider. The issues had not been dealt with and this was affecting staff morale. Comments included, "Staff do not feel appreciated, morale is dead"; "If you text [provider] he reads it, sometimes doesn't reply, he is not there at all, he is not supportive. We see him once in a blue moon. [Senior care staff] is contactable 9.00 to 17:00 Monday to Friday. If you message outside of that you don't get a response. There is no support, we get shouted down when making suggestions" and "Communication is good, we are like a little family, we keep abreast with what is going on. I am very happy."

● Staff working at Wurel House supported living felt communication and culture was good and they got good support. One staff member said, "I have messaged [provider] after hours to ask questions and I always get a message back within an hour."

● Relatives were positive about the care and support from care staff. Comments included, "We are so grateful for all that they do"; "All good vibes"; "Can you tell the girls how good they are"; "They are kind to [loved one], very upbeat and cheerful with her"; "I'm very happy with them, and so is mum"; "I can't fault them in any way, they are so lovely"; "I can't give the girls enough praise"; "The girls are good with her, they engage with her"; "All very kind and approachable, they should take their time and be more gentle" and "They look after him totally, It's like it's their Dad."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Management were visible in the supported living service, approachable and took a genuine interest in what people and staff had to say. We observed the person living at Wurel House supported living service knew the provider well. The person engaged with the provider and staff and appeared happy; they were smiling, chatting and initiated contact and conversation.

● People receiving a service had not yet been asked for feedback about their care and support by the provider through surveys or through telephone contact. The service had only been back in operation again since late 2021 following a two-year gap in providing personal care.

● Staff meetings had not taken place. The management team used group chat messages to ensure effective communication and to ensure all staff got information at the same time. Staff felt this was not always effective.

● Compliments had been received. One received in February 2022 read, 'I would just like to thank you and your staff for the love and care, they showed my dad in his final weeks. Particularly [staff members], who were also a tower of strength to my mum, going above and beyond. We cannot thank them enough. Please pass onto them our sincere gratitude.'

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify CQC in a timely manner about deaths that had occurred. Regulation 16

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC in a timely manner about incidents that had occurred. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect service users from abuse and improper treatment. Regulation 13 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to acknowledge, investigate and take action in response to complaints. Regulation 16 (1)(2)

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate a robust approach to recruitment to make sure only suitable staff were employed to provide care. Regulation 19 (1)(2)(3)

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 had failed to provide care and treatment to meet people's assessed needs. Regulation 9 (1)(3)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by 31 May 2022

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people from risks related to fire and the environment. Risks related to people's physical health, catheters, choking and epilepsy had not been assessed and care had not been planned to keep people safe. Accidents and incidents had not always been recorded and reviewed. The provider had failed to manage medicines safely. The provider had failed to ensure effective infection control measures were in place to keep people and staff safe. Regulation 12 (1)(2)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by 31 May 2022

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had failed to evaluate and improve their practice to continually assess, monitor and improve the quality of the service. Regulation 17 (1)(2)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by 30 June 2022

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy staff sufficiently and failed to ensure staff had the appropriate training to ensure people's needs were met. Regulation 18 (1)(2)

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulation by 31 May 2022