Assure HealthCare Group (South) Ltd

Willow Brook

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

Summary of findings

Overall summary

About the service
Willow Brook is a domiciliary service that provides care and support for people who may have mental health needs, a learning difficulty and physical care needs. The service provides personal care to people living in five 'supported living' houses where facilities are shared with people who do not have personal care needs. Staff provided support to people in each of the houses on a 24/7 basis. At the time of our inspection the service was supporting 11 people with personal care needs.

The service didn't consistently apply the principles and values of Registering the Right Support (RRS). Whilst the ethos of the service was in line with the principles to promote people's control, choice and independence, some processes were not consistently implemented to support this.

People's experience of using this service and what we found
The provider's quality assurance systems had not been effective in ensuring the delivery of safe, high quality care and support. We received conflicting views about the management of the service, which had been inconsistent following the departure of six senior managers in recent months.

We identified significant failings in the way people were safeguarded from the risk of abuse. Allegations of abuse were not always managed in accordance with established protocols.

We also identified significant failings in the way people's rights and freedom were protected. Current legislation and guidance was not being followed in relation to the use of restraint.

We received conflicting feedback about the way staff treated people. However, we observed positive interactions between people and staff during the inspection and staff protected people's privacy.

Arrangements were in place for obtaining, storing, administering and disposing of medicines in accordance with best practice guidance. However, we found this guidance was not always followed.

There was not an effective system in place to record and respond to complaints. Significant events had not been reported to CQC as required.

Enough staff were employed and there were clear recruitment procedures in place. However, full employment histories were not always obtained from applicants to check their suitability to work with the people they supported.

Staff supported people to achieve positive outcomes and enabled them to lead as full a life as possible. This reflected the principles and values of Registering the Right Support by promoting choice and independence. However, we received mixed views as to whether people's needs were met when they became distressed and agitated.

Risks to people's safety were assessed and monitored appropriately, including infection control risks.

People were supported to maintain a healthy, balanced diet and to access healthcare services when needed.

Staff expressed a commitment to delivering compassionate, dignified end of life care.

Staff had a good understanding of people's communication needs. They supported people to develop and maintain important relationships.

There was a duty of candour policy in place and the provider's previous rating was displayed on the premises and on their website.

Rating at last
The last rating for this service was good (published 19 April 2017).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding arrangements, medicines management and staff training. A decision was made for us to inspect and examine those risks as part of a comprehensive inspection.

We have found evidence that the provider needs to make improvements. Please see the key questions sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
At this inspection, we identified breaches of regulations in relation to safeguarding, the protection of people's rights and freedoms, the management of complaints, notifications of incidents to CQC and quality assurance systems.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Willow Brook

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 Care Act 2014.

Inspection team
The inspection was conducted by one inspector.

Service and service type
This service provides care and support to people living in five 'supported living' houses, so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection only looked at people's personal care and support.

The service did not have a manager registered with the Care Quality Commission. This means the provider is solely responsible, legally, for how the service is run and for the quality and safety of the care provided. However, a manager had applied to register with the Commission and their application was being processed.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We interacted with, and had limited conversations with, four people who used the service. However, most people using the service were not able to verbally express their views. We spoke with 10 care or support workers, three operational managers, the training manager, a consultant who was supporting the service, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care records and multiple medication records; six staff files in relation to recruitment and additional staff supervision records; safeguarding and incident records; and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
After the inspection, we continued to seek clarification from the provider to validate evidence found. We also received feedback about the service from four family members and six health or social care professionals who worked closely with the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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
• The provider had policies and procedures to protect people from the risk of abuse; however, these were not effective as they were not always followed by managers.
• We identified three allegations of abuse that had not been reported to the local safeguarding authority in accordance with established protocols. This meant there was no oversight of the internal investigations conducted by managers and no input by partnership agencies to the development of safeguarding plans to protect people from the risk of further abuse.
• For example, an allegation that a staff member had physically abused a person was not reported to the safeguarding authority. The internal investigation was not thorough and the limited remedial actions that were identified, such as extra training and supervision for staff, were not completed. When the safeguarding authority became aware of the incident, they directed that the investigation be re-opened.
• The provider did not have an effective system in place to collate, analyse and monitor allegations of abuse to ensure they were reported and investigated effectively, and that appropriate action was taken to protect people from further harm.
• This was confirmed by a safeguarding practitioner who told us, "Not all staff appear to be able to identify an incident as a safeguarding concern, or the process they should follow." They added, "I don't believe that all safeguarding concerns are logged through the correct process, nor in a timely manner. Responses to providing evidence requested for investigations/enquiries have not been robust or timely." Other safeguarding practitioners echoed these concerns.
• A family member, who had reported allegations of abuse relating to their relative, told us they had lost confidence in the ability of the service to undertake effective investigations.
• We discussed these concerns with the nominated individual who acknowledged that previous managers had not always acted appropriately or promptly in response to concerns.

The failure to operate effective systems to prevent abuse of and to conduct effective investigations was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Staff managed all the medicines of everyone who received the service. Arrangements were in place for obtaining, storing, administering and disposing of medicines in accordance with best practice guidance. However, we found this guidance was not always followed.
• Some medicines are subject to additional controls by law; these are called 'controlled drugs' (CDs). In one of the houses, we found staff did not follow the provider's recording procedures when a person went out and they took the person's CDs with them. This meant they were unable to account for where the medicines were at a given time, which put them at risk of going missing and not being available to the person in an

emergency.
• In another of the houses, the CD records were not accurate; they showed eight syringes of a CD were in stock, but we found 14 were present. This meant we could not be assured that the medicines stock was managed effectively and that people had received their medicines as prescribed.
• One person was prescribed a medicine to be taken 30 minutes before food, but records showed this was usually given with their breakfast. This meant it might not have been fully effective.
• Shortly before the inspection, staff had failed to give a person their evening dose of an epilepsy medicine. The person had a seizure the following day. The nominated individual acknowledged that the missed dose of medicine may have impacted on the person, although they made a full recovery.
• We discussed these concerns with the nominated individual who acknowledged this was an area for improvement. They later sent us copies of medicines audits conducted following the inspection, but did not provide any evidence to demonstrate that complete and effective audits were being completed prior to the inspection.

The failure to ensure medicines were managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Where medicines were prescribed to be administered on an 'as required' (PRN) basis, protocols to guide staff were detailed and personalised.

Staffing and recruitment
• There were clear recruitment procedures in place. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.
• However, we found full employment histories were not available for some staff. This meant the provider was unable to confirm whether further references should have been sought from previous employers that might have impacted on the staff member's suitability.
• We discussed this with the nominated individual who told us they had amended their recruitment processes to help ensure full employment histories were obtained from staff consistently in the future.
• People were supported by appropriate numbers of staff. These had been agreed at the start of people's contracts and were consistently met.
• Gaps in cover were filled by agency staff, most of whom had previously worked with the people they were supporting and knew them well.
• A process was in place to help ensure that agency staff had the necessary skills, knowledge and experience to support people effectively.

Assessing risk, safety monitoring and management
• Risks to people's safety and well-being were assessed and monitored. These were based on people's individual needs, including specific health conditions and behaviours that could pose risks to themselves and others.
• However, we found there was not a head injury protocol in place. There was no record to show that appropriate advice was sought, and monitoring undertaken, when a person fell and sustained a head injury. We raised this with one of the managers and by the end of the inspection an appropriate protocol had been put in place.
• Staff were knowledgeable about the risks associated with people's needs and could tell us how they promoted people's safety and ensured their needs were met. For example, they knew which people were at risk of choking and needed a modified diet or thickened fluids to reduce the risk.
• Positive risk taking was supported and encouraged in line with the principles of Registering the Right Support to help people learn new skills or enjoy experiences such as accessing community services.

Preventing and controlling infection
• There were appropriate systems in place to protect people from the risk of infection.
• Staff had completed infection control training. They had access to personal protective equipment (PPE), such as disposable aprons and gloves and described how they used these appropriately when providing care and support to people.

Learning lessons when things go wrong
• Weekly management meetings took place which enabled the management team to review incidents and identify any learning. Although this had not always been effective, as described above, we did identify examples of where it had been beneficial.
• For example, following a series of medicine administration errors, the provider had enhanced their staff competency assessments to make them more robust.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

• Staff told us they sought consent from people before providing care or support and acted in people's best interests. However, we found people's rights were not protected as staff were not following the MCA or it's Code of practice.
• All of the people using the service had profound learning disabilities or mental health needs, resulting in significant cognitive impairment. However, people's care records showed that no assessments of their capacity to make individual decisions about their care and support needs had been completed.
• Decisions staff had taken on behalf of people had not been recorded as part of the care planning process, in accordance with the MCA. These included decisions about the delivery of personal care, the management of people's medicines and the provision of modified diets.
• The provider was unable to confirm that people lacked the capacity to make the decisions for themselves and could not demonstrate that the decisions staff had taken were in the person's best interests and were the least restrictive option.
• Staff, including managers, had completed training in the MCA, but none had recognised the need to complete MCA assessments and record best interests decisions to demonstrate that people's rights were being protected.
• The relatives of some people had been invited to sign consent forms to allow staff to manage their medicines; however, the relatives did not have the power in law to do this. This demonstrated a further lack of understanding of the MCA by staff.
• Following the inspection, the provider completed MCA assessments and best interests decision forms for some decisions for some people. They told us they would complete all others that were required as soon as possible.

The failure to ensure people were cared for with the consent of the relevant person and in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 support in their own homes, an application must be made by the local authority 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found staff were not following current legislation and guidance, and were not working within the principles of the MCA.

• All the people receiving regulated support from the service had restrictions in place to prevent them going out independently. One or two staff members were always present when people left their homes. Also, some people's movements inside their homes were monitored on a 24/7 basis, either by staff being physically present, or via listening devices in their rooms. The need for restrictions to people's liberty was documented in their support plans. However, no MCA assessments or best interests' decisions had been completed to determine the person's capacity to consent to, or justify the need for, such restrictions.
• Some staff believed that authorisations from the Court of Protection were in place to permit them to prevent people leaving their home, but this was not the case. The provider had contacted the local authority who have the responsibility for making the application to deprive a person of their liberty, but no deprivation of liberty authorisations were in place. This meant people were being deprived of their liberty unlawfully.
• The provider's records showed that staff had used physical intervention to restrain people on 196 occasions in the 12 months prior to the inspection. The need for physical intervention to prevent people causing harm to themselves or others was usually documented in people's support plans. However, these had not always been developed with the involvement of the person and those close to the person to ensure that such interventions were necessary, were in the person's best interests and were the least restrictive option. This was contrary to the MCA, the MCA Code of practice and the provider's policy on the use of restraint.
• There was insufficient scrutiny and oversight of the use of restraint by the provider to ensure that where restraint was used, it was a proportionate response to the likelihood of harm and the minimum amount of force was used for the minimum length of time.
• Although the training manager told us they reviewed each incident of restraint and showed us examples of where they had done this, we identified incidents of restraint that had not been recorded or reviewed.
• There was also no evidence of a restrictive intervention reduction programme, as recommended by Department of Health guidance on the use of restraint. This meant there was a risk that people would continue to be experience high levels of physical intervention. For example, following one intervention, where an older person sustained bruising while being restrained, an investigation identified the need for further guidance to be given to staff; however, this was not done until we raised the issue during the inspection.

The failure to use restraint without taking account of the person's capacity to consent to such treatment and the failure to ensure people were not deprived of their liberty, for the purposes of receiving care or treatment, without lawful authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• New staff completed a programme of induction. In addition, staff who had not worked in care before were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.

• Staff refreshed and updated their training regularly to help ensure their knowledge remained up to date. Most staff also completed a range of training to enable them to deliver effective care and support to people living with a learning disability, such as autism awareness, epilepsy management, positive behaviour support and communication training. A family member told us, "[My relative] is looked after very well. Staff seem well trained and go on [relevant] courses."
• However, although training was provided, some staff did not consistently act in accordance with professional standards, for example in relation to the application of the MCA, safeguarding, medicines management and respectful care. This showed that staff did not always recognise poor practice. You can find more information about this in the Safe and Caring sections of this report.
• Staff told us they felt supported in their roles. They received regular one-to-one sessions of supervision and annual appraisals to assess their performance and identify any training needs. Comments from staff included: "I feel very appreciated. We get a lot of thanks and [the manager] looks after us" and "Managers are really supportive here and there's an open-door policy".
• The provider supported staff to access an independent psychological therapy service. This encouraged staff to use reflective practice techniques to cope with the day to day pressures of their role and understand the perspective of the people they supported.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were assessed before they started using the service and regularly thereafter. Detailed support plans were then developed from this information. A social care professional told us, "Assure have worked with a number of complex people very well and supported discharges from mental health hospitals."
• Care and support was planned and delivered in line with people's individual assessments and support plans. Staff had a good understanding of people's support needs and how to meet them.
• Feedback from relatives and social care professionals showed staff had achieved positive outcomes for some people whose previous placements had broken down and who had been reluctant to accept care and support in the past.
• For example, one person who had previously always been unkempt had been supported to accept personal care from staff. When we met the person, they appeared clean and well groomed, and staff told us they even visited the hairdresser regularly, something they had never done previously. Another person who had rarely gone out previously was being supported to visit shops and cafes regularly.
• A further person who had a severe adverse reaction to weather events had been supported to use a "safe room" to reduce their level of anxiety. Staff described how they had supported the person effectively to better cope with such events and this had resulted in the person rarely needing to use the safe room any more.
• Technology was used to help manage people's health conditions. For example, an epilepsy sensor was placed under the mattress for one person to alert staff if the person experienced a seizure while in bed; this meant they could be supported promptly if needed.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to maintain a healthy, balanced diet. One person was being supported to attend a slimming club to help them manage their weight. A health care professional told us, "[Named staff member] has also noticed how often [the person] opts for [fast food] and fish and chips and is working with him to ensure he has a balanced diet."
• Staff knew people's food preferences and people received the food of their choice. Where people had specific dietary needs, these were known by staff and planned for.
• Staff followed guidance from professionals regarding people's eating and drinking needs and this guidance was recorded in care plans for staff to follow.
• Where people were at risk of not eating or drinking enough, their intake was monitored closely and

referrals made to doctors where needed.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care
• The service worked with other agencies to achieve positive outcomes for people and people were supported to access healthcare services appropriately. A healthcare professional told us, "[Named staff member] follows up any recommendations and tries his best with [named person], particularly with managing health needs which is very difficult."
• People's health needs were clearly recorded in their support plans and contained information from a range of health care professionals, including doctors, nurses, speech and language therapists, and learning disability specialists.
• When people were admitted to hospital, staff provided written information about them to the medical team, using a 'hospital passport', to help ensure the person's needs were known and met. A family member told us that when their relative was admitted to hospital, staff "visited" and "stayed with them all day and at night".

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as good. At this inspection the rating has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• We received conflicting feedback about the way staff treated people, depending on which of the houses they lived at. One person told us, "[Named staff member] argued with me yesterday, shouting, 'I've got to get back to my kids'." They explained this was when an activity finished unexpectedly early, without explanation. The person was living with a form of autism and unexpected changes in routine were known to cause them distress.
• A healthcare professional told us they had raised concerns after they "overheard a member of staff speak inappropriately to [a person], shouting at them to be quiet".
• Records showed staff had not always treated people with care and compassion when they used physical intervention, including on two occasions when staff had reported rough handling of people.
• However, we also received positive feedback about staff. For example, a family member told us, "[My relative] gets on well with staff. He has a good relationship with them. There is quite a lot of laughter there."
• A social care professional told us, "Some of the support workers are superb. [Named staff member] is one of the most passionate, caring and person-cantered support workers I have ever come across and she has significantly improved the quality of life of [name person]." Another social care professional told us, "When [named person] becomes unwell they [staff] desperately want to look after her. They really care."
• During the inspection, we observed positive interactions between people and staff. People appeared relaxed and comfortable in the presence of staff.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. Their diverse needs were detailed in their care plans which included their needs in relation to culture, religion, diet, and gender preferences for staff support.
• Staff knew what was important to people in relation to their equality needs and the support they might need to maintain them. Staff assured us that all people were treated fairly regardless of any protected characteristics they had.
• Each person had a 'pen picture' detailing their background, history and interests. This included details of people's families and their circle of support. Contact with and by families was welcomed and was recorded in the person's care plan.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to express their views and make decisions about their care.
• Records confirmed that people, and where appropriate family members, were involved in meetings to review their care plans. A family member told us, "We get to see [my relative's care plan and they [staff] go through everything with us. They are very open about everything."

• Comprehensive information provided clear guidance to staff about how each person communicated. For some people who could not express themselves verbally, there were guides which included details of what they might do and what this usually meant. Staff had a good understanding of the different ways people communicated their needs.
• Where people did not have close family members, they were supported to access advocacy services. An advocate is an independent person who builds a rapport with someone to help them express their views.

Respecting and promoting people's privacy, dignity and independence
• Care and support were provided in a way that respected people's privacy. Staff provided examples of how they protected people's privacy during personal care, for example by closing doors and curtains and keeping the person covered as much as possible.
• Staff talked about people respectfully and often with fondness. They also used touch, appropriately, to reassure people and help them remain calm.
• One staff member told us, "The culture here is caring. We all want to do the best we can for [the people we support]. For example, on their birthdays, we want to make sure they have celebrations and give them the best birthday they can have."
• Staff understood the need to promote independence. Support plans included information about what people could do for themselves. For example, one said, "[The person] can wash their hands and face when encouraged." A staff member told us, "We're not here to do things for [people], we're here to support them to do it."
• One person had been given a one-cup kettle, which enabled them to make a hot drink with minimum support and without the risks posed by a full-sized kettle. This helped the person retain a level of independence.
• To support another person to maintain their continence, staff followed an individual routine that worked for the person, including when they returned to the home from an activity. The person understood this routine and it had helped maintain their dignity and a level of independence.
• Care files and confidential information about people were stored securely. They were only accessible by authorised staff, in accordance with data protection legislation.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
• A complaints procedure was in place. However, this was not available in a format that was accessible to people using the service and there was no evidence to demonstrate that the provider had taken steps to explain it to people in a way they could understand.
• The nominated individual told us no complaints had been recorded. However, a family member told us they had raised "a list of concerns" with a senior manager, but no action had been taken. These included complaints about missing property and staff committing motoring offences while driving people's Motability cars.
• Neither the senior manager, nor the nominated individual were able to provide a record of these complaints. They were also unable to demonstrate that the complaints had been responded to or addressed appropriately.
• Another family member told us they had raised concerns about the way their relative was being supported. A record had not been made of their concerns or any action taken to address them.

The failure to operate effective systems to identify, record and respond to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• We received conflicting feedback as to whether people's needs were met, depending on which of the houses they lived at. Some family members told us their relatives' needs were not being fully met, for example when they became distressed and agitated. This was supported by health and social care professionals, who were taking steps to find alternative placements for some people.
• A family member told us they felt some staff were not able to de-escalate situations when their relative became agitated in the community and this had resulted in unnecessary police intervention on three occasions.
• However, other family members told us their relatives needs were being met well and this was confirmed by other health and social care professionals who worked with those people. For example, a family member told us, "They [staff] understand when [my relative] has his 'moments' and can often divert him. They have learnt the things that will trigger him. On the whole the know how to deal with him."
• A social care professional told us another person had "settled in well and their behaviours have reduced considerably". They added: "During [a multi-agency review meeting] everyone was happy with the care [the person] was receiving and commented on how much happier he is".
• People's likes, dislikes and what was important to the person were recorded in person centred care plans. Staff were knowledgeable about people's preferences and could explain how they supported people in line

with this information.
• Care records showed that people's care plans had been followed. For example, they confirmed that staff had followed a person's epilepsy plan when they experienced a seizure, together with a period of post-seizure monitoring, as specified.
• For people who were unable to express pain, we saw there were individual pain profiles in place to help staff identify when the person might need pain relief. Records showed the profile had been followed when a person showed indications of pain and was given paracetamol.
• Our observations showed staff were responsive to people's needs. For example, one person could have rapidly changing moods and quickly became upset. We saw staff respond promptly when this occurred and used positive support and reassurance to help the person calm again.
• Staff understood the potential triggers that caused people to behave in a way that put themselves or others at risk and took steps to avoid them at all times. One person had an obsession that caused them to become anxious and staff had developed a script to use when the person started talking about this. All staff were aware of the script, which meant the person received consistent messages to help them overcome the obsession.
• People were supported to achieve identified goals. Personal goals were monitored and reviewed to ensure they were achieved where possible. For example, staff were working with one person to reduce their anxiety about travelling in cars.
• People were empowered to make as many choices as possible. For example, staff described how they supported a person chose a new car. During the inspection, we heard people being given a variety of choices of what they would like to do and where they would like to spend their time. A staff member told us, "If [a person] refuses personal care, we would try to encourage, but if that failed, we'd accept their decision."

End of life care and support
• The nature of the service meant that it did not usually support people at the end of their lives.
• One person had been diagnosed with a terminal illness, and a social care professional told us, "They [staff] have been really, really good about discussing [the person's end of life plan]." However, we found an end of life plan had not been completed, so we could not be assured that the person's end of life wishes and preferences would be met.
• We discussed this with a consultant who was supporting the service and by the end of the inspection an end of life plan, in an accessible format, had been completed for the person.
• Staff expressed a commitment to supporting the person to experience a comfortable, dignified, pain-free death. They had developed links with external healthcare professionals to enable them to achieve this.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• The provider was working within the AIS. People's communication needs had been assessed and people had a communication support plan which detailed the support they required to communicate effectively. For some people, this included the use of a traffic light system to help them express their mood. Staff had a good understanding of people's differing communication needs.
• People were provided with some information in a way they could understand which helped them make decisions about their care. For example, some information, including care plans, were provided in an easy read format.
• Staff also supported people using Makaton, PECS and social stories. Makaton is a communication system that uses symbols, signs and speech; PECS (Picture Exchange Communication System) uses pictures to help develop communication skills; and social stories are prompts or scripts used to help people on the autism

spectrum understand and behave appropriately in certain situations.
• For example, a social story had been used to support one person to visit the dentist; this enabled the person to understand where they were going and what would happen there. The person communicated this to us with a smile on their face, showing they were relaxed about the planned visit.
• 'Key workers' were allocated for each person. This is a named staff member who takes a particular interest in a person and acts as a point of contact with the family and professionals.
• A healthcare professional told us, "Allocating key workers works well; they appear responsible for following up with [people's] needs, for example appointments, recommendations, care plan updates. They are also a good point of contact for updates." They added, "It's great when support workers use their own initiative, for example making social stories to increase someone's understanding."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were encouraged to maintain relationships with their friends and families and were supported to do so by staff. For example, they updated one family member three times a day, to reassure them that their loved one was being cared for.
• Another family member told us, "They [staff] take [the person] to [another relative] for tea sometimes which is nice. They would also bring him home to us a few times and that works well."
• Staff also supported people to keep in touch with friends and family members using video conferencing applications on a computer.
• People were provided with opportunities to participate in a range of activities of their choice, both within the houses and in the local community.
• Activities included horse riding, shopping and meals out. Where the person had chosen not to go out, staff supported them to engage in something they would enjoy. For example, during the inspection, one person was encouraged to interact with a balloon, which judging from their laughter, they clearly enjoyed greatly.
• Birthdays and special occasions were celebrated within each house and shared with everyone living there.
• The provider also operated a day centre where people from each of the houses, and the local community, could visit to interact with others and take part in a wide range of activities, such as craft work, music and dance.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• To comply with regulatory responsibilities, providers are required to notify CQC of significant events that occur while people are receiving the service. However, we found the provider had not notified CQC of eight such events, including allegations of abuse and incidents reported to, or investigated by, the police. The nominated individual told us they had delegated this task to individual managers, but we found there was not a process in place to check that notifications were made when needed.

• Following the inspection, the provider submitted retrospective notifications for some, but not all, of these incidents.

The failure to notify CQC of all significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• The provider's quality assurance systems had not been effective in ensuring the delivery of safe, high quality care and this had resulted in six breaches of regulations.

• The systems had not identified that some safeguarding incidents had not been reported to the local authority or to CQC, as required; they had not identified the lack of full employment histories in staff files; they had not identified recording issues relating to controlled drugs. You can find more information about this in the Safe section of this report.

• The tool used by staff to audit people's care plans was not effective as it did not include checks that the Mental Capacity Act (MCA) had been followed; as a result, the audits had not identified the absence of MCA assessments across the service. In addition, the process to review the use of restraint, to ensure it was used appropriately, was not robust. You can find more information about this in the Effective section of this report.

• There was not an effective system in place to ensure that complaints were recorded, managed appropriately and used to identify learning. You can find more information about this in the Responsive section of this report.

• The nominated individual told us senior staff in each of the houses completed weekly and monthly audits. In addition, the nominated individual met with senior staff every week to discuss emerging issues and concerns. However, these processes had not identified any of the concerns we found during the inspection, so had not been effective.

• The tool being used for the monthly audits was out of date as it was based on previous CQC regulations. The provider was unable to confirm improvement actions identified in these audits had been addressed.

The nominated individual told us it was down to the manager of each of the houses to "tick them off" but there was not an effective process in place to check this had been done.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service did not have a manager registered with the Care Quality Commission. However, one of the new managers had applied to register with the Commission and their application was being processed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We received conflicting views about the culture and management of the service. A social care professional told us, "Leadership is poor. So many changes and no one knows who is doing what. Since the previous care director has gone things have deteriorated significantly." They added, "[There are] so many promises of what they will do, but these things never seem to happen."
• A family member echoed these concerns and added, "I wouldn't recommend the service. If any improvement is promised, it only lasts a couple of days and then it's back to square one."
• Some professionals reported difficulties contacting managers and having to "chase them for information". One social care professional told us, "It's not easy to get hold of someone or get someone to call you back", although another social care professionals told us, "[One of the managers] responded promptly to my emails and answered calls to their mobile, if no one was answering the landline."
• A family member was more positive about the management and told us, "We have had contact with the managers, for example, we had a barbeque for [my relative's] birthday and all the managers came. We have good relations with them."
• The nominated individual and a current manager acknowledged that "things had slipped" due to a lack of consistency with the management team. In the six months before the inspection, four senior managers had resigned, followed by the recruitment and resignation of a further two senior managers.
• The provider was recruiting new managers to fill vacant posts; two had already started work and another was due to start shortly after the inspection. In the interim, the provider was being supported by an independent consultant who had reviewed service provision at one of the five houses and implemented an action plan to address areas for improvement at that house.
• New areas of management responsibility had been drawn up, together with clear lines of accountability. Further recruitment was planned to provide deputy managers in each of the five houses. However, the structure clearly needed more time to become fully established and embedded in practice.
• Staff told us they felt supported by the current management team. Comments included: "Things are really good here. There's a really good culture, we really do care and have really good relationships with [people]", "The culture here is caring. I can't fault the one-to-one support [people receive]" and "I've been really well supported by my line manager. It's a really good team and I was welcomed into it [when I started]".

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 had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. A review of incidents showed that none had reached the threshold for action. The nominated individual described how they would follow the policy if an incident reached the threshold.
• The provider had been open by displaying the previous rating for the service on the registered premises and on their website.

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

• Systems were in place for gathering the views of people who used the service, those acting on their behalf and professionals. These included annual quality assurance surveys. Responses from the latest survey were being collated and the nominated individual described how they would analyse them to identify areas for improvement.
• Staff said they were able to raise issues and make suggestions about the way the service was provided, in one-to-one meetings and staff meetings. They told us they felt engaged in the way the service was run and described managers as "approachable" and "accessible".
• The service engaged with multiple health and social care professionals to help ensure people received effective, joined up care. Records demonstrated multi-agency support had positively impacted on people's lives.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission without delay of significant incidents, including incidents of abuse or allegations of abuse, and incidents reported to the police. Regulation 18(1) & (2)(e)&(f).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people were cared for with the consent of the relevant person and in accordance with the Mental Capacity Act 2005. Regulation 11(1), (2) & (3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines. Regulation 12(1) & (2)(g).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to operate effective systems to identify, record and respond to complaints. Regulation 16(1) & (2).

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from the risk of abuse and improper treatment. The provider had also failed to ensure restraint was used appropriately and that people were not deprived of their liberty unlawfully. Regulation 13(1) & (5).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service. Regulation 17(1) & (2)(a).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements.