Positive Community Care Limited

Positive Community Care Recovery Services

Inspection report

Kingsmead Business Park
Frederick Place
High Wycombe
HP11 1JU

Date of inspection visit:
26 September 2019
01 October 2019
02 October 2019
08 October 2019

Date of publication:
06 February 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Positive Community Care Recovery Services is a 'supported living' service. The service provides personal care to people with a range of needs including learning disabilities, autistic spectrum disorder, physical and sensory disabilities, mental health conditions and older people who may be living with dementia.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the service supported 78 people but only nine people received personal care.

The service was not fully developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
We found the service had not always taken appropriate measures to protect people from the risk of avoidable harm. Risk assessments did not consistently identify hazards or safe measures in response to people's specific needs.

Robust recruitment practices were not always followed to make sure staff were suitable. The service had a safeguarding policy and procedure, but this was not in line with current national legislation. This meant the service did not always follow the proper procedures to protect people or alert statutory agencies. Planned and actual rotas did not always accurately reflect the level of staff required or the identity of all staff. There was no system in place to show how agreed levels of staff support were transferred to staff rotas to meet people's needs.

The storage of people's medicines was well managed and records indicated people received their medicines as prescribed. However, we found written guidance did not always provide enough detail about 'when required' medicine for staff to follow.

There was a lack of comprehensive and robust oversight by the registered manager and provider. Shortfalls had been missed and action was not taken to prevent the service from falling below an acceptable standard. People's care planning documentation and management records were not always complete, accurate or contemporaneous.

People were not always supported to have maximum choice and control of their lives and staff did not

always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We have made a recommendation that the provider works to the principles of mental capacity legislation.

The service did not always (consistently) apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support due to limited inclusion. For example, care plans and key working records did not consistently demonstrate how people were involved in decisions about their care.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.
As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people.

The service did not always support people effectively in line with positive behaviour support (PBS) principles. Staff did not always receive suitable training to support people in accordance with their PBS plans. Restrictive intervention practices were not always clearly understood by staff or identified in people's positive behaviour support plans.

People were supported to access healthcare services and staff co-ordinated effectively with health care practitioners to promote people's health. The service had recently improved staff communication systems to make sure people received continuity of care.

Relatives and people told us they were happy with the care and support they received from staff, with comments such as; "I am a very happy parent. The new team leader is 10 out of 10. My [family member] enjoys his company and their face tell me they are happy" and "[Staff] are very caring and look after [family member's] needs. The staff go beyond the call of duty."

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

Rating at last inspection
This service was registered with us on 17 April 2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of scalding. We also received concerns in relation to allegations of inadequate staffing levels and lack of management response to safeguarding concerns to protect people from the risk of avoidable harm. This inspection examined those risks.

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

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

Since our inspection the provider has taken action to mitigate the risk or scalding and are progressing with their action plan to address other concerns highlighted.

Enforcement
At this inspection we have identified breaches in relation to, safe care and treatment, safeguarding people from abuse and improper treatment, good governance, staffing levels, suitable staff and informing the Commission of incidents.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 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 always effective.

Details are in our effective findings below.

Requires Improvement

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

Positive Community Care Recovery Services

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 carried out by four inspectors. One inspector visited the provider's offices and three inspectors visited people in five supported living settings.

Service and service type
This service provides care and support to people living in 20 'supported living' settings, so that they can live as independently as possible. At the time of our inspection 78 people were supported but only nine people received support with personal care. 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 26 September 2019 and ended on 11 November 2019. We visited the office location on 30 September 2019 and 8 October 2019.

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

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with eleven members of staff including senior care workers, agency workers, care workers, the training and compliance manager and the registered manager who was also 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 five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, training data, staff recruitment and induction records. We spoke with four professionals who regularly visit 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.

This is the first inspection for this newly registered service. This key question has been rated 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 did not have robust systems to protect people from the risk of abuse. The provider's safeguarding policy and procedure did not reference current relevant legislation and the definition of abuse was not up to date.
• The safeguarding policy and procedure advised staff to report 'evidence' of safeguarding concerns. This is not in accordance with national legislation; it is the provider's responsibility to report any allegations or suspicion that a person may be at risk of abuse. The service had not always reported incidents that met the safeguarding threshold to the safeguarding local authority. This meant people were at potential risk of ongoing harm from abuse.
• The registered manager did not keep a log of safeguarding referrals; they could not demonstrate when they reported safeguarding concerns to the local authority or whether another agency had made the referral.
• The registered manager could not provide evidence of their investigations following safeguarding concerns. For example, anonymous information of concern about staff practice which potentially put people at risk of harm was raised with the registered manager in July 2019. They did not document their investigation to evidence their method, findings to justify their conclusion, lessons learnt, or actions taken to prevent the risk of abuse.
• Processes were in place to protect people from financial abuse, however, these were not always followed by staff. We found a person's finance record to be inaccurate; some receipts were missing and calculations were incorrect week commencing 9 September 2019. This had not been identified by management at the time of our visit. The team leader completed an audit and investigation which found staff had put £10 of the person's money separately in the safe due to wrong calculations, however this was not reported or recorded anywhere by staff at the time. This was not in accordance with the provider's finance policy and procedure.

The provider failed to establish and operate effective systems to prevent the abuse of service users or to effectively investigate allegations of abuse. This was a breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Financial discrepancies were investigated and staff were reminded of the correct procedure.

• All staff received safeguarding training. Staff we spoke with said they would report concerns about the safety or wellbeing of people who used the service to management.
• The provider had identified areas for improvement and had developed an internal safeguarding board who were responsible to regularly review and monitor all incidents. The aim of this was to make sure appropriate responses to safeguarding concerns were consistent, as well as for learning to feed-into the development of

policies and procedures. An investigation template and process were also planned to improve the analysis of information. This framework was not yet embedded at the time of our inspection, so we could not assess its impact.

Assessing risk, safety monitoring and management; Using medicines safely
• The service did not always effectively risk assess people's needs to protect them from avoidable harm. People's risk assessments did not include the risk of scalding hot water. This was despite the registered manager instructing staff to do so in writing in September 2019.
• One person's risk assessment identified they were at 'high risk' in relation to an egg allergy. However, it did not contain sufficient information for staff to follow to keep the person safe. There was no information about the potential impact upon the person's health, safe measures to avoid contact with eggs, or when to seek medical attention. The registered manager checked this information and clarified this was not an allergy, rather a cultural choice. One member of staff we spoke with was aware this was not an allergy but a cultural choice. There was no negative impact upon the person, however, their initial assessment was inaccurate and had not been followed-up to make sure the person was not at risk.
• Another person had left the service unsupervised at night through a gap in the window despite there being window restrictors in place. The window was situated in a spare bedroom but the door was not kept locked. The service user leaving unsupervised at night was documented as a known 'high risk' but the only recorded safe measure was; "1-1 support in the community and at home except when resting in [person's] bedroom." There was no recorded environmental consideration to reduce the risk or how staff should monitor the person's during the night when there was only one member of staff on duty. A front door sensor alarm was already in place but this was not documented in the person's care plan or risk assessment. The registered manager told us in response to the latest incident staff checks had been implemented to make sure doors and windows were secure, but they could not evidence this. A bedroom sensor alarm was arranged to alert night staff of the person's whereabouts in the home to reduce the risk of reoccurrence.
• Missing person plans did not always provide appropriate guidance. People's missing person's risk assessments did not always respond to their level of need or dependency on staff to keep them safe when accessing the community. Staff told us they would always report people missing immediately, however there was a risk that staff who were not familiar with this would follow the risk assessment and wait longer than was safe before reporting.
• Medicine administration records we looked at indicated people received their medicine as prescribed. However, we found some areas of the management of people's medicines needed improvement.
• One person was prescribed medicine 'when required' for their anxiety. The recorded protocol in place for this medicine did not contain enough information for staff to follow safely. It stated the medicine should be given to settle the person's mood but did not provide details about what actual signs of anxiety would require medicine administration. The protocol did not refer to the name or dose of the medicine or the maximum dose in 24 hrs to prevent over dose. No potential side effects were recorded or whether monitoring of the person's health was required by staff after medicines administration. There was no evidence the person had come to harm or were administered the medicine when it was not appropriate. However, the lack of detailed information meant the person was at potential risk of harm through not receiving medicine as prescribed.
• We found a medicines stock discrepancy; the running count recorded 61 tablets but upon counting there were only 60. Staff could not account for the discrepancy. The registered manager told us they would investigate what could have gone wrong to avoid it from reoccurring.
• There was some medicine stock at one setting which was not in use. We discussed with staff that these needed to be returned to the pharmacy.

The provider failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider responded during and after our inspection. A timely action plan was put in place to make sure risk assessments were updated and people's medicines protocols were reviewed.

• The provider implemented and embedded a 'safe bathing temperatures and frequency' protocol for staff to monitor water temperatures. Staff were aware of hazards and followed safe measures to reduce the risk of harm. We checked records at five settings which confirmed temperatures were within the safe range to prevent the risk of scalding and legionella.
• Personal emergency evacuation plans (PEEPs) were in place for each person detailing the level of staff support required to evacuate safely.
• A risk assessment for fire safety was completed June 2019. Some areas for development and improvement were noted but were not assessed as high risk. The area team leader said they were going to have a meeting and put all actions in place as a priority.
• Medicines were stored securely. Medicines requiring refrigeration were kept in a designated medicines fridge at the correct temperature which was recorded. Controlled drugs were stored in a separate controlled drugs cabinet.
• Staff received training in medicines administration and assessments to check their competency before they were authorised to administer medicine. Staff we spoke with demonstrated they were aware of the policies and procedures and their responsibilities in relation to this.
• The service kept a log of staff who were authorised to give medicines and specimen of their signatures.

Staffing and recruitment
• People were not always supported by staff who received robust recruitment checks to make sure they were suitable. We found recruitment documentation did not always include staff's full employment history; employment gaps and reasons for leaving previous employment were not consistently explored or recorded by the provider as required.
• One member of staff had received an enhanced Disclosure and Barring Service (DBS) check of criminal convictions for the time they had been in the UK since December 2017. However, the service failed to check with the relevant foreign office for any criminal records from their country of origin before 2017. The registered manager was unable to provide us with evidence of any risk assessment for this situation.
• Staff recruitment information held by the service was not always accurate. For example, the actual start date for one employee was a month later than their original contract started. The provider sent us evidence after the inspection to show the person's actual start date was after their DBS and references were received. We were informed there was an administrative error when the person was asked to sign the correct version of their contract.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff recruitment procedures were effectively managed. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider assured us that their system for recruitment checks had been reviewed and tightened for future recruitment checks. The registered manager said they would follow-up with the agency to make sure agency staff were suitable.

• The provider's rotas were not effectively planned or kept up-to-date to reflect actual staff deployment. There were several gaps for night staff and day staff where there should have been at least two staff to meet people's one to one needs. Agency staff were not identified on the rota. The registered manager told us the

software system would not allow this and there was no other record in place.
• At two settings people were regularly supported by a team of agency staff and no permanent staff. The registered manager told us an area manager based themselves in this address from 3pm although this was not documented on the rota. Regular agency staff did not receive supervision from management; there was no system to support them to carry out the duties they were employed to perform or to make sure they provided people with support consistent with their agreed care plans.
• A suitable system for reviewing people's dependency needs and calculating safe staff deployment was not documented. We asked the registered manager to show us how staff deployment was calculated. They provided a spread sheet, untitled, which showed the number of one to one staff support hours people received per day and per week. This did not include how the service calculated total staff hours required to meet people's needs at each setting and there was no recorded rationale about minimum safe staffing levels.

Systems were not in place to show sufficient numbers of suitable staff were planned and deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider said they would make sure agency staff received supervision and took action to make sure rotas were kept up-to-date. The registered manager said they would review a system to document and review people's needs and staffing levels to show clearly on staffing rotas.

• Other checks such as staff employment references, right to work and identification were checked by the provider. We found that staff interviews were robust and person-centred.
• The provider was able to show they had adapted the staffing in the morning at one setting in response to a change in a person's needs in accordance with agreed actions to safeguard the person and others.
• Staff and relatives told us there were enough staff to meet people's needs. Relatives told us their family members received support from regular permanent staff most of the time. Where agency staff were used they were regular to promote continuity of care.

Learning lessons when things go wrong
• Incidents and accidents were recorded in the central system. However, appropriate actions were not always taken or recorded. For example, in response to an incident of physical aggression in August 2019 there was no outcome recorded on the incident report and the author had entered 'No' in answer to whether the person's care plan had been reviewed. The registered manager was able to show us other evidence that staff had met with the person's social worker and agreed outcomes were actioned.
• Staff told us, "We have a team meeting to discuss incidents and accidents and discuss ways of preventing reoccurrence."

Preventing and controlling infection
• Staff followed procedures to protect people from the risk of infection during the provision of their care.
• Each person who used the service had their own fridge/freezer. We saw staff recorded the temperatures of these every day which were within safe range.
• Care workers had completed training in infection control practice.
• Personal protective equipment (PPE) items such as disposable gloves and aprons were available and used by staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Behavioural needs assessments did not always effectively identify or meet people's needs or follow relevant national guidance.
• One person was prescribed medicine 'when required' to sedate them for the purpose of controlling behaviours that challenged. Medicine that is used to change a person's mood is a form of 'chemical restraint' and needs to be included in the person's positive behaviour support plan. This is to make sure staff have a clear understanding when to use medicine as a last report when other less restrictive, therapeutic strategies have not worked. The registered manager was not aware of the term 'chemical restraint' or that it needed to be considered as a form of restrictive practice that limited the person's freedom. In practice, records showed the person was administered this medicine infrequently for specific reasons; there was no indication this was administered excessively or inappropriately.
• Another person's PBS plan stated they needed two staff to use "approved physical interventions, such as guiding" as a last resort. However, it did not detail what type of specific physical intervention staff should use to protect the person and others from harm. Staff we spoke with were not aware that any type of physical intervention was authorised and had not received training. Staff told us less restrictive strategies worked most of the time to avoid the person's level of distress escalating.

The service did not effectively assess people's behavioural needs or deliver care by staff who were trained in physical intervention in line with the person's care plan. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took action during and after our inspection. They reviewed documentation for 'chemical restraint' and told us they would seek advice from a positive behaviour specialist to review a person's PBS plan.

• Staff were knowledgeable about other aspects of the person's PBS plan. Staff understood and followed the person's routine and consistently gave the same account that the person's behaviours that challenged were rare. We saw where incidents occurred these led to a review of the person's support hours with their social worker to reduce the risk of harm.
• Relatives we spoke with told us the service supported people to achieve positive outcomes, with comments such as, "[Family member] is definitely well settled. Staff are keeping them busy with the things they like to avoid challenging behaviour" and "We could not provide for them what they provide here. [Staff] are so good and [family member] is very happy."

• A health care professional was positive about the support provided by the service, commenting, "The care team seem very skilled in the management of customers who present with challenging behaviour." They described that since moving to the service the person's 'when required' medicine had significantly reduced as a result.
• Another healthcare professional told us staff followed guidance and provided effective feedback when they telephoned or visited the service.

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

People can only be deprived of their liberty to receive care and treatment 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Applications to deprive people of their liberty were made by Local Authorities (LA) and authorised by the Court of Protection in most cases. One person who received continuous supervision from staff who potentially met the criteria for an application had not been identified by the service. The registered manager said they would follow this up with the local authority.
• People's consent was recorded and mental capacity assessments were completed, however, information was brief and did not detail how people were involved in the process.
• Staff received mental capacity training and demonstrated they understood principles and practiced this when supporting people.

We recommend the service seeks guidance from a reputable source to make sure processes and documentation fully reflects the mental capacity code of practice.

Staff support: induction, training, skills and experience
• In general, there was a comprehensive induction and training programme appropriate to staffs' different job roles to make sure people benefitted from trained staff. However, staff were not trained in physical intervention strategies, which was indicated as a need in one person's PBS plan.
• The training and compliance manager was trained to deliver positive behaviour strategies and planned to complete an accredited instructor's course, so they could teach staff physical interventions to keep people and others safe in a crisis. The registered manager told us they would source external training in the meantime to meet people's needs.
• A plan was in place to make sure all staff completed training and we saw this was progressing.
• Staff told us they received regular supervision where they were able to talk through and address any issues. New staff members confirmed they received increased supervision to monitor and support their induction with comments such as, "We get an induction, we go to a tutor. I found it very useful" and "My induction was great. I had to read everything. Support plans, medicines, what medicines do. I had a few days where I shadowed other staff and got to know the service users."

Supporting people to eat and drink enough to maintain a balanced diet
• People had detailed nutritional support plans. Records were kept of people's food intake and monthly checks of people's weights were recorded. Risk assessments provide guidance to staff to report changes in people's weight to management.
• Staff supported one person to adapt their menu in accordance with their blood glucose levels. Care plans documented where people required support to prepare nutritious meals.
• During our visit to people we observed staff to regularly offer prompts and support to encourage people to drink enough fluids.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service had improved internal staff communication systems to promote continuity or care. We saw that staff used a communication book to good effect and completed shift handovers; to make sure people's health care appointments were followed-up and shared information about changes in people's needs.
• A healthcare professional told us staff supported the person effectively with their emotional needs and to attend their clinic on a regular basis to access the treatment they required.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people were not always involved in a meaningful way to make decision about their care.

Supporting people to express their views and be involved in making decisions about their care
• People and relatives felt involved in decision about their care, however, care planning documentation did not always capture this.
• Records showed that some people were supported to review their care plans through key working sessions. However, this was not consistent across all settings.
• Relatives we spoke with told us they felt staff involved them and their family member in decisions about their care. Relatives told us they could visit any time and were kept informed of their family member's wellbeing.
• We asked one person if they were able to make choices, they replied; "Oh yes. You have a free hand."

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity was protected and people's independence was valued. However, methods to support people to develop their skills and independence were not systematic or documented in care plans.
• The registered manager told us staff were being trained to support people to develop skills, however, this was not yet embedded in practice and people's goals were not planned systematically. This meant that staff approaches to supporting people were at risk of being inconsistent.
• A member of staff told us, "I encourage [the person] to help in the kitchen by preparing food and doing the washing up. This is a new thing that [the person] likes to do and I am encouraging this as it is a good thing for him to do."
• Staff told us how they protect people's dignity and independence; "We are always mindful to try and ensure people stay independent as possible. A lot of this is about prompting to keep people independent", "We all get training in dignity in care. We always explain to people what we are going to do. We support them, for example, to wash themselves, and where they need help, we tell them what we are doing."

Ensuring people are well treated and supported; respecting equality and diversity
• People experiences indicated staff treated them well and with respect.
• People and relatives told us, "Staff are kind and funny", "Staff are nice" and "We could not be happier. He loves his bedroom. We fell in love with the whole place."
• Staff said, "We care for people in a caring way and we make sure we do things that [the person] likes, and we know what [the person] wants and we ensure we respect his dignity and respect.
• One person's hobby was to sing and play the guitar. They tended to initiate spontaneous sing songs; staff appeared to really enjoy hearing the person sing and these seemed to be positive interactions.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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 registered manager was not familiar with AIS and information in people's care plans about their communications needs varied. Some had detailed information to identify and meet people's communication plans, but others did not.
• Staff were able to describe people's communication needs and referred to different communication aids such as pictures and an iPad. When discussing one person's needs staff explained they break information down into bite size junks which worked.
• At one setting staff told us, "Everyone is trained in Makaton signs. They use pictures and photographs to help communicate with people. They have a board where activities are recorded in a pictorial form. There is a large one for everyone, but each person also has their own pictorial activity plan with removable signs, so the person can change their mind and choose an alternative activity."

We recommend the provider seeks advice from a reputable source to consistently meet the AIS requirements.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• In general care plans contained detailed information about people's background, likes, dislikes and preferences. However, regular reviews of people's care plans were not always consistently applied and some information and did not always contain up-to-date or accurate information.
• People's religious and cultural needs were identified, however other aspects of people's protected characteristics were not captured to make sure their diverse needs were identified and met.
• The registered manager described how staff supported people in practice to meet their diverse needs. They provided examples where staff respected people's gender identity and they addressed people in accordance with their preferences.
• Staff we spoke with were knowledgeable about people's needs in general. For example, one member of staff understood how important one person's routine was to them and made sure they supported this.
• The registered manager said they recognised that care planning needed to be standardised and there were in the process of developing a standard form to support team leaders in capturing relevant information about people's needs.

Improving care quality in response to complaints or concerns
• People were supported to raise their concerns and complaints. However, the service did not always formally respond to confirm what they had done to address the complaint.
• One person had made a complaint to the provider which was documented, however the person had not received a written response in accordance with their complaints policy and procedure. We were provided with evidence that appropriate action had been taken and the service wrote to the person after our inspection in response to our feedback.
• The registered manager assured us they would make sure people's complaint were formally responded to in future.

End of life care and support
• People's end of life wishes were explored, however this was not consistently reviewed.
• Records showed that the service had attempted to engage with a person about their end of life needs but the person did not wish to discuss this. This had been completed in January 2018 and was to be reviewed in 3 months, however there was no further review of this.
• The service did not support anyone at the end of their life. The registered manager told us they would review this with people to plan and capture people's preferences where they were willing to engage, in case of sudden death.

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 benefitted from a range of opportunities to participate in social activities, access the community and develop their interests and skills.
• One person told us "I like living here, I like the football I go and play on a Monday. We all support Chelsea and we like to watch the games on a Saturday. I like to go for a walk and bowling on a Wednesday. I go out to big places like Buckingham Palace and Brent Cross shopping centre."
• A relative said, "We think [family member] gets enough stimulation here. We could not provide for him what they provide here. He goes out swimming, the gym, London etc. They are so good and he is very happy."
• The service employed two qualified recovery coaches and drama therapists who provided support and activities on a weekly basis.
• A trainer provided functional skills sessions to develop people's ICT as well as courses such as personal social development, personal care and hygiene and cookery.
• The service supported people to celebrate a cultural day where people and staff wore their traditional clothes and shared foods that represented their different cultures. Photos showed this was well attended and people appeared happy with smiles.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
• The provider did not always have systems in place to provide high quality care.
• Policies and procedures were not always in line with national legislation or best practice guidance. This meant staff did not have appropriate information to follow to achieve good outcomes for people.
• The quality of care planning documentation varied depending on the skills and knowledge of the author. There was no standard care planning or risk assessment form for staff to follow. There was no system in place for a competent manager to check and authorise care plans and risk assessments. This meant people's needs were not always effectively identified or risks mitigated to prevent avoidable harm.
• The provider's business improvement plan identified organisational initiatives such as a new software system to centralise and standardise care plans and risk assessments, dated October 2019, to be completed by January 2020. However, there was no operational improvement plan or information about how the provider would over-see that people's current care plans and risk assessments were up-to-date and accurate in a timely manner.
• CQC and local authorities received multiple whistleblowing concerns about the safety and poor quality of the service. This did not reflect a healthy and open culture, where staff concerns could be raised and addressed appropriately by managers internally.
• The service did not always liaise or communicate effectively with other agencies such as local authority departments or social workers. We received feedback from social care professionals that they were not always kept up-to-date with people's changing needs or notified of incidents in a timely manner.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• Managers did not always identify and respond to risk appropriately or fulfil their regulatory requirements. Systems to check the quality of the service were not always effective to drive improvements to people's care.

• The provider had not completed any provider audits at any of the settings where people received personal care to check the safety and quality of care provided. There were no audits of care plans to make sure these were comprehensive and met people's care needs or known risks to prevent avoidable harm. There was no follow-up to check whether team leaders had updated people's risk assessments to protect them from scalding water.
• There were some quality assurance processes in place. For example, team leaders completed weekly and monthly checks which were sent to the registered manager. However, these were not comprehensive and

did not provide any analysis of the information provided. For example, the standard form asked how many incidents had occurred without any comments or follow-up and whether team leaders had verified fire records with a Yes/No answer option.
• The medicines stock issue we found had not been reported to the registered manager via the weekly check, which the registered manager confirmed should have been reported to them. Inaccurate reporting meant the registered oversight could not have effective oversight or make sure appropriate action and learning was taken.
• There was no system in place for thematic analysis of incidents or accidents to feed-into organisational learning.
• Care planning documentation and management records were not always complete, accurate or kept up-to-date.
• The registered manager was not able to provide us with accurate information about which people using the service received the regulated activity personal care. There was no system in place to make sure they had an overview of people's needs across the service.

The above key questions are evidence of poor governance systems and processes in place, which meant people were not protected from risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they would complete timely comprehensive audits to check the safety and quality of the service.

• The registered manager did not always make sure CQC were notified of events as required. This meant we could not monitor the safety of the service or follow-up any actions if required. For example, during our visit we were made aware of an incident which the service reported to the Police but had not notified CQC. We received a retrospective notification for this which included satisfactory information.
• We were not always notified of safeguarding concerns in relation to people who left the service unsupervised. We received a delayed notification of an allegation of physical abuse after we received anonymous whistle-blowing concerns and we prompted the provider to notify us.

The registered manager and provider did not always make sure they notified CQC of events where required. This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

The registered manager took action during and after our inspection to make sure we were notified of events. After the inspection we received a retrospective notification.

• The provider's newly formed internal safeguarding board was responsible for making sure that the correct reporting procedures are followed including notifications to CQC. At the time of our inspection this was in place but not fully embedded, so we could not assess the effectiveness of this.
• Regular team leader workshops had been introduced and led by the training and compliance manager and registered manager to develop senior staff knowledge and skills and to share learning. However, learning was not yet evident in practice in relation to care planning documentation, the management of risk, or reporting procedures.
• Staff we spoke with demonstrated cohesion with the organisation's values, with comments such as; "The vision is to support people to live independent lives to the fullest. We want the clients to be included in everything because it is their home. We discuss menu plans for the week. It's about increasing people's independence and treated them individually. That's the values of the company and we all share this" and "We have training in equality and diversity, and recognise individual people's needs, including their

sexuality. We support people and respect their individual rights and needs."

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 registered manager understood their duty of candour and acted upon this when things went wrong. For example, they offered an apology and an explanation of what actions were being taken to investigate in writing to people involved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider had systems in place to engage and involve people and staff in the service.
• Records showed that residents meetings were facilitated. For example, people were involved in planning a BBQ.
• People's feed-back about the service was collected through surveys. Only seven people had completed the most recent survey; the registered manager said they would be looking at ways to encourage and facilitate more people to engage with this. Results were planned to be fed-back to staff and goals set to focus upon the areas identified for improvement.
• The service facilitated an online blog for people using the service to encourage people's involvement and to exchange information. For example, a 'men's night', other activities and trips in the community were posted on the blog by people for other people using the service who might want to join-in.
• There was a separate blog for staff which was used to share important organisational information and updates. Staff also received virtual coins when they achieved required training and to recognise performance, which accumulated and could be used to purchase items of their choice.
• People were supported to access community services. The provider had links with key organisations such as dementia friends and shared information from their newsletters with staff.

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 service did not always notify the Commission without delay of incidents of abuse, allegations of abuse, or incidents which were reported to, or investigated by the police.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service failed to establish and operate effective recruitment procedures to make sure staff employed were of good character.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate support through supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The service did not establish or operate an effective system to show that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.