The Regard Partnership Limited

The Regard Group - Domiciliary Care Cornwall

Inspection report

First Floor, Duchy Business Centre
Wislon Way, Pool
Redruth
Cornwall
TR15 3RT

Tel: 01209217335
Website: www.achievetogether.co.uk

Date of inspection visit:
17 November 2020
19 November 2020
20 November 2020
24 November 2020
25 November 2020

Date of publication:
12 January 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Regard Group is registered both as a domiciliary care agency and a supported living service. It provides personal care to people living in their own houses and flats, and to people living in a 'supported living' setting, so they can live as independently as possible.

People's care and housing are provided under separate contractual arrangements. The CQC does not regulate premises used for supported living; this inspection looked at people's care and support.

People using the service lived in five locations around the surrounding area of West Cornwall. Locations included Govis House, Fox House, Meadow View and Connexion Street and one location in East Cornwall called Buttermill. Not everyone using The Regard Group received regulated activity; CQC only inspects the service being received by people provided with the regulated activity of 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The service was able to support 44 people but only 16 people received personal care. This included one person at Govis House, four people at Fox House, five people at Meadow View, one person at Connexion Street and five people at Buttermill.

People's experience of using this service and what we found

Relatives and staff told us they did not feel one of the services was safe. Safeguarding concerns had not always been consistently reported by staff and management in a timely manner. Staff were not always clear of their roles and responsibilities in relation to safeguarding.

People, relatives, health and social care professionals and staff were concerned about the lack of consistent leadership in the services, and high staff turnover. Staff morale was low. All commented that communication was poor.

People, relatives and staff lacked confidence that any concerns they had would be listened to or acted upon.

People were not always supported by consistently caring and suitably trained staff. Staffing levels were not sufficient to meet people's care needs in a person-centred way. This was confirmed by feedback received from people living at the service and some staff.

The delivery and planning of care were not consistently person centred and did not always promote good outcomes for people. Support plans did not contain detailed and person-centred information and therefore they did not always accurately reflect the needs of those who used the service.

Staff did not receive effective support from the management team and lacked understanding of their roles and the principles of providing high-quality care. The lack of robust management meant there was no consistent oversight of the service.

There were no effective processes in place for assessing and monitoring the quality of the services provided and to ensure records were accurate and complete. Systems had failed to identify that people were not always protected from avoidable harm. Safe care practices were not always recorded accurately within people's care records. Action had not been taken to make all necessary changes and sustain improvements following the concerns found in our previous inspection report.

The registered manager resigned in September 2020. A registered manager has been appointed and aims to commence this post in January 2021. The registered manager role is that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The service provides care and support to people living in five 'supported living' settings. However, the supportive living services are also used for office space and have communal areas, which is not in line with the principles of Supportive living.

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

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

Right support:
The model of care and setting did not always maximise people's choice, control and independence and measures had not been taken by the provider to mitigate this. One service we visited was in a rural location and there was an absence of local amenities and public transport options. The other service was in a town and had access to the local community and amenities.

Right care:
There was a lack of person-centered care and the support people received did not promote dignity, privacy and human rights. People's needs and preferences were not always known or respected.

Staff did not always have, or display, the skills and knowledge to meet people's needs. People did not have choice in who provided their care.

Right culture:
The ethos, values, attitudes and behaviours of some leaders and care staff did not ensure people using the service led confident, inclusive and empowered lives. People were not empowered to have choice and control over their lives. People did not always receive person centered support to live meaningful and active lives. People did not have opportunities to form community connections and make choices about who they lived with and the support they received.

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

Rating at last inspection

The last rating for this service was requires improvement (published 24 August 2020) and there were two breaches of regulation. At this inspection we found not enough improvements had been made and the provider was still in breach of regulation

Why we inspected
The inspection was prompted in part due to concerns received about people's safety, staffing and leadership. A person using the service sustained a serious injury. The information CQC received about the incident indicated concerns about the leadership of the service, the safety of people using the service and the quality of care and support that was being provided. This inspection examined those risks.

As a result, we carried out a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

During the inspection process we held a meeting with the senior managers to consider if we needed to take urgent action to ensure people's safety. Senior managers provided us with an action plan and provided assurances that they would respond to immediate concerns raised.

We have identified two continued breaches and four new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safeguarding service users from abuse and improper treatment, person-centered care, safe care and treatment, staffing and good governance.

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.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

The Regard Group - Domiciliary Care Cornwall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

The inspection
This was a focused inspection to check on specific concerns that had been reported to the Commission. We looked at the service's staffing arrangements, risk management systems, incident recording and review processes and governance.

Inspection team
The inspection was carried out by a lead inspector. Two inspectors visited two supportive living services, Fox house and Meadowview.

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

The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection

This inspection was announced. We announced the inspection a day in advance to ensure that people would give us permission to visit them in their home. Before we visited the supportive living services, we discussed infection control processes for people, staff and inspectors, with reference to Covid 19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and the information we had requested when the inspection was announced.

We had not requested the provider send us a provider information return as this inspection was completed in response to information of concern that the commission had received. We used all this information to plan our inspection.

During the inspection
We spoke with five people at their homes. We spoke with nine staff. We invited staff to contact us following the inspection but received no feedback.

We reviewed a range of records. This included four people's care records and a sample of medicines records. We looked at a variety of records relating to the management of the service, including policies, procedures and staff training records were reviewed.

After the inspection visit
We sought feedback from health and social care professionals regularly involved in people's care. We received feedback from seven health and social care professionals.

We spoke with five relatives. We continued to seek clarification from the provider to validate evidence found. We reviewed the additional documentation we had requested from the service managers prior and during the site visit.

During the inspection process we held a meeting with the senior managers to consider if we needed to take urgent action to ensure people's safety. Senior managers provided us with an action plan and provided assurances that they would respond to immediate concerns raised.

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 Requires Improvement. At this inspection this key question has now changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to safeguarding service users from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation.

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

- At the previous two inspections people had not always been kept safe as the service had experienced a high number of safeguarding concerns and staffing problems. There remained a high number of safeguarding concerns and staffing problems. This has meant that people remained at risk of significant harm.
- Relatives told us they did not feel that their family members were safe. Comments included, "It's not safe. We wish we had never heard of The Regard and if we could move [person's name] we would" and "We don't trust [person] is getting the care that [person's name] needs." Four out of five relatives said they wished for their family members in one service to move to a new placement as they did not feel it was safe.
- Staff told us that they did not feel the service was safe. Comments included, "It's not safe for staff and it's certainly not safe for service users". Staff said they did not always feel able to speak to managers about their concerns as they felt they would not be listened to and were not confident that any action would be taken.
- The provider had safeguarding systems in place. However, staff were not confident how to make safeguarding alerts. This meant that safeguarding concerns were not highlighted in a timely manner. This meant no action had been taken to ensure people were protected from the risk of harm or abuse.
- We had received notifications of incidents where people had been at risk of harm, which led us to bring this inspection forward. Professionals involved in investigating these incidents raised concerns that people were not being provided with the care or safety that they needed.

The failure to protect the person from abuse and improper treatment was a repeated breach of Regulation 13 (Safeguarding) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Some people could find it difficult to express themselves or manage their emotions. This could lead to distressed behaviour which could put them, or others at risk. People's support plans were either absent, not up to date, and contained inaccurate information. They did not always inform, direct or guide staff in the actions to take when people were becoming distressed and how to support them. This meant staff did not have the relevant information to enable them to support people when they were distressed.
- Staff told us that the behavioural support plans were not accurate and therefore they did not read them.

They instead asked other staff for advice on how to support people. This meant that there was no consistent understanding or approach in how to support people.
● We looked at behavioural support plans for two people living in different houses and found that they were written identically. This indicated they had been written without considering people's individual needs and were not person centred.
● Where it had been identified that people were at particular risks, due to medical conditions such as diabetes, guidance from relevant professionals had been sought. However, this had not been transferred to the support plan. The risk information was not easily available which meant staff had limited written guidance in place to help them support people to reduce the risk of avoidable harm.
● Security arrangements were not robust. There was a particular security issue at one of the supported living houses and to ensure everyone's safety was more robust, checks of visitors were needed. On arrival, we rang the bell which was not answered, we then walked into the house. This meant people were at risk of harm as members of the public could freely enter the home without being challenged.

Risks were either not assessed or ways to mitigate them in place. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Peoples medicine profiles identified what medicines were to be administered, the dose, time, possible side effects and how it should be given. However, in some people's care records there was more than one copy of the medicine profiles for the individual, neither were dated, and so staff were unable to clearly identify which one was the correct one to use. The medication profiles had different medicine doses of the same medicine to be administered and could lead to potential error if the wrong medicine profile was used.
● Staff told us, and records confirmed, that some staff had not received medicine administration training or had their competencies assessed to ensure correct administration practices were being followed. This placed people at potential risk in respect of the administration of medicines.
● Some people were prescribed 'as required' (PRN) medicines for pain relief or to help them to manage anxiety. PRN protocols outlining when and how to administer their medicines varied in their quality. Some identified when PRN medicine should be considered and how to administer it. However, they did not monitor the impact of the medicine when given to the person, so that they could review its effectiveness. Some people did not have PRN medicine protocols in place so there was no guidance for staff as to when to administer some PRN medicines.
● The manager at one supported living service told us that the amount of medicine errors had decreased. However, they felt the reason for this was due to the GP insisting that all medicines were to be dispensed by a monitored dose system (blister pack) as they were concerned by the high number of errors.
● Since the last inspection the provider had undertaken medicine audits in all of the five supported living services. It identified areas where action needed to be taken to ensure that medicine procedures were more robust. However, these systems we not embedded and there remained some shortfalls with safe medicines management.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Security arrangements were not robust. Our visit took place during the pandemic and the country was in 'lockdown'. On arrival at both properties we completed a Covid 19 questionnaire and took our own

temperatures. This was not checked by any member of staff. Infection control risks as outlined by local and national guidance was not being followed.

We recommend that Infection control measures are adhered to as stated in Public Health England local and national guidance.

● Staff had completed infection control training and had access to personal protective clothing, such as masks, aprons and gloves to reduce cross infection risks.
● Staff encouraged and supported people to participate in cleaning and domestic chores within their homes.

Staffing and recruitment
● At the previous two inspections there were concerns about the recruitment of staff, and staff retention. A recruitment programme was ongoing.
● Relatives, people, health and social care professionals and staff reported that due to the changes within the staff team, and with managers there had been a lack of consistency within the service.
● People were concerned about the amount of changes within their staff teams. They were not involved in the recruitment of the staff and so had no say in who would provide them with their support.
●Health and social care professionals expressed "concern" and "frustration" about the speed of staff turnover. This meant that staff knowledge of how to support people effectively was not consistent as the persons core staff team and managers were constantly changing.
● Staff turnover was high and there was a high level of staff sickness. Staff told us some staff were frequently late for their shift and this had not been addressed. One commented, "They just saunter in, no apology."
● Staff told us that on the day of inspection they had sufficient staff, but they were often short staffed. Staff were working long hours to cover staff shortages and said they were tired which impacted on how they provided care to people. We were told of occasions when staffing was below their minimum staffing levels which impacted on people's care, and their one to one support. We asked the manager to look into this concern and are waiting for their findings
●The combined impact of the remote location of the service and the complexity of people's needs meant the staffing levels in place were not sufficient to support people to live as independent a life as possible with opportunities for social inclusion and taking part in new and meaningful activities. This was not in line with the principles of Right Support, Right Care, Right Culture.

The provider had not ensured sufficient staff were available to provide a person-centred service for people. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Due to previous safeguarding concerns, the senior managers had conducted an audit of all their services and developed a comprehensive action plan. However, the action plan had not been completed and systems did not appear to have been embedded as there remained significant shortfalls. This had placed people and staff at risk.
● Accidents and incidents were not always recorded and analysed so any trends or patterns could be highlighted. This meant the opportunity to reduce such events had been missed.
● Service managers stated, at the previous inspection, that staff team meetings would be reinstated to look at issues such as closed cultures in care settings, medicines, and safeguarding. Staff told us these meetings had not occurred. Therefore, reflective practice to improve the quality of care was not evident.

The provider failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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 Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff completed "one or two" shadowing or supernumerary shifts before being included on the service's rota. Staff did not feel this gave them enough time to build and develop a rapport with people, before providing them with care and support.
- Staff told us they did not have regular supervision. Comments included, "I've never had one" and "I've not had one in 6 months and when you do any issues aren't actioned."
- Managers at both services acknowledged that supervision had been "scant" and had implemented a supervision matrix to plan supervision sessions for all staff with a manager.
- Staff new to the service were required to support some people without appropriate training. Staff said the quality of training was not detailed enough and they did not always feel confident to support people with the level of training they had received. A new employee to care told us, "I had four hours training and I'm deemed to be competent, I'm still missing some training."
- Managers at two services we visited acknowledged that there were gaps in training and had devised a training matrix so that staff training needs could be identified and addressed.
- Health and social care professionals said that they had provided bespoke training to staff in how to support individuals, but due to the high turnover of staff/ managers this training was not embedded or carried forward to new staff. This meant staff were not equipped to meet people's individual's needs.

The provider had not ensured sufficient suitable qualified staff were available to provide a person-centred service for people. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People and relatives told us that since they moved into the service, they had not been involved in the development of the support plan or its review. The detail of one person's support plan was identical to the placement they had moved from. It had not been reviewed for the last 11 months.
- The service did not have effective systems in place to ensure people's needs were identified and understood before they moved into the service so that they could meet their needs and expectations.
- Relatives commented, "The transition of moving into the service wasn't very good. There was a lack of communication." Relatives did not feel confident that information provided to the service regarding how to support the person had been adopted. This meant that the service had not considered the full range of the persons diverse needs.

The failure of the provider to ensure assessments of people's needs were completed to demonstrate they could meet the persons needs and expectations. This was a breach of Regulation 9 (Person centered care) Health and Social care Act Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● Some relatives raised concerns about how people, who had specific health conditions, were being supported with their dietary needs. Whilst it was acknowledged people had a choice in their menu plans, work to help the person understand the impact of their choices on their health had not occurred. This placed some people's health at risk.
● Support plans did not inform, direct or guide staff in how to manage people's individual dietary needs. Daily logs did not always record what the person had eaten or drunk that day. There was no ongoing monitoring of people's diet to gain an understanding in how their diet may impact on the persons health. This placed some people's health at risk.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The Regard is a supported living service. The services varied in their presentation. One service was person centred with people's accommodation evidencing people's preferences and tastes. The other was barren and the managers acknowledged it needed a lot of maintenance for example mending broken items, repairing leaks and issues with heating. People, relatives and professionals told us that works to repairs on the property 'took a long time', quoting examples of six months to a year. Following our feedback to the operations director they instructed the services to provide an 'amnesty' of all outstanding works to the properties and have assured us necessary works are now being undertaken.

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.
● There were limited records available of best interest decision making processes. Where decisions had been recorded, they were not about specific decisions and were instead of a generalised nature.
● Some people who lacked capacity were the subjects of continuous monitoring and control. Some necessary applications to the local authority had been made for the authorisation of these arrangements under the Deprivation of Liberty Safeguards.

Peoples consent to care, and treatment was not always gained. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

- People had been supported to access healthcare services when required. However, there was limited information available to demonstrate people had been supported to access annual health and well-being checks.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centered care.

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

At our last inspection the provider had failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a breach of Regulation 17 Health and Social Care Act Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- There had been a lack of stability in the management structure at the locations. Due to the recent safeguarding concerns, service managers had again been changed at Fox house and Meadowview as this was an appropriate measure to safeguard individuals. Relatives commented, "I couldn't tell you who the manager is, the staff change so quickly." Health and Social Care professionals also shared this view.
- The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run.
- There were significant failings in the management of people's records which could place people at risk of harm. For example, support plans were out of date, had not been reviewed and did not inform, direct or guide staff in how a person's care needs should be met; some risk assessment records did not evidence how the risk was assessed and the findings were not consistently transferred to the care records; medicine records did not have clear guidance for staff to know when to administer as required medication to people.
- Due to the management changes there had been limited support or guidance for staff to help ensure they were aware of their roles, the expectations placed on them and an understanding of the needs of the people they support. Staff recognised that the lack of consistent leadership had impacted on the service's performance.
- The service provides care and support to people living in five 'supported living' settings, so that they can live as independently as possible. People have their own private accommodation. However, the services all had a dedicated office, and in one location a staff room, plus communal kitchen areas. This is not in line with the principles of supported living.

The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and areas of poor practice. The care provider did not have good leadership and management in place. The care provider did not ensure people's care records contained the required level of detail relating to risk and care needs. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The Provider is required to ensure there is a manager registered with the Care Quality Commission who is in day to day control of the service. The provider had recruited to this post and the candidate aimed to commence employment in the next month.

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

● Some people told us staff had little experience and were not sensitive in their approach to them. For example, staff referring to people as 'mate' which was not their preference and discussing in front of them how they were looking forward to going home. This made the person feel undervalued and indicated to them that staff would rather not be there. Some people also told us that staff did not respect their confidentiality and therefore would not disclose information as they were concerned it would be discussed with other people.

● We found evidence of a closed culture in one setting. Staff told us morale was low and there were pockets of staff groups who did not work well as a team together. Staff comments included, "The atmosphere is toxic, there is a lot of scapegoating. If something goes wrong staff blame each other" and "There is a lot of gossiping and bitching which never gets addressed."

● A senior staff member told us they had recently suggested to a member of staff that they went for a walk with one of the people they supported. The member of staff replied, 'I don't feel like it.' The senior staff member did not challenge this as they felt they would not be supported by their managers. This suggested there was a culture within the staff team of staff organising the working day to suit their preferences rather than the people they supported.

● There was no strong ethos or value base in place. Staff told us people could be supported to be more independent, but this did not happen. Staff said, "That is my ethos (supporting people to be independent) but it isn't the organisations."

● Staff told us that at times when they supported people who were anxious it could have an emotional or physical impact on them. There had been no debriefings following incidents to provide staff support or reflective practice. This meant opportunities to learn from experiences were lost.

● People told us, confirmed by staff and care records, that they had not had their monthly reviews to set their goals and aspirations.

● Care was not person-centred. Support records did not describe how to support people's individual needs. Support records were written generically and in one case it referred to the person in the incorrect gender.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● After speaking to people, staff and managers we were not assured that staff were consistently respectful of people or each other. We were concerned that there was a closed culture within the staff team, which could discourage people and staff from raising concerns or acknowledging when something went wrong, in line with their duty of candour.

● Following safeguarding concerns that had been raised with the service, the regional manager had completed, where necessary, individual protection plans. However, the protection plan contents had not been shared with staff and therefore were not followed. This demonstrated that actions identified were not clearly communicated to staff. This could place people and staff at risk.

● The registered manager had notified us of incidents and safeguarding when they had been raised to them.

● Where incidents had occurred, there had been ineffective governance to review the incident and learn lessons. Care plans had not been reviewed, following incidents, to provide up to date guidance. The poor review of incidents limited the provider's ability to effectively and robustly monitor the service provided.
● The failure to ensure that the service met regulatory requirements, was due to inadequate governance. We highlighted risks of poor culture, inaccurate records, unsafe staffing levels, lack of staff supervision and training and poor governance to the provider.
● The providers senior management team manager and staff team took an open approach to the inspection process. They recognised that the service was not always meeting people's individual needs but had failed to take necessary effective action.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider acknowledged that people were not involved in the recruitment of staff house meetings, or their own regular support plan reviews. This meant people's views and experiences were not actively sought and considered.
● Relatives who had raised concerns were not assured that subsequent actions and improvements were being maintained. Comments included, "I've raised issues, and nothing gets done" and "If I had a concern, I'm not sure they would respond, I haven't got enough confidence to say they would."
● Relatives and health and social care professionals all raised concerns that communication was poor. For example, they were not told of the changes of the managers or staff in the services, not told promptly when a family member was admitted to hospital, specific protocols were not followed, and daily updates were not consistently sent to relatives as agreed.

The failure of the provider to gain views from people who use the service, their representatives and staff to improve the quality of the service had not been sought. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The senior management team have introduced 'Dignity Champions' from their staff group and people they support, so that they can hear their experiences and address issues.

Working in partnership with others
● Feedback from professionals raised concerns about the provider and the way the service was run on a day to day basis. We were given examples of poor staff skills where professionals guidance was not being implemented and leading to safeguarding concerns. There was a shared concern about the management's communication and leadership and how this impacted on the care that people received.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service worked in partnership with healthcare professionals and services from a variety of disciplines and commissioning authorities. During the national Covid 19 pandemic there had been a reduction in professionals visiting the service. Provision was in place to enable video meetings and telephone

consultations to take place instead of face to face meetings. Where practically possible, and where there was a need, healthcare professionals had visited the service over the last few months.

Continuous learning and improving care

● Shortfalls had been highlighted to the provider from the Local Authority Quality Assurance audit in 2019 and our previous inspection in July 2020. Appropriate action had not been taken to address all the issues and therefore opportunities to improve the service had been missed.

● The provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. Regional managers had completed audits which had identified significant issues with the service's performance prior to this inspection. However, action was not effective to address and resolve these quality issues.

● Relatives told us they had lost confidence in the provider's ability to meet their relatives needs and some reported they were actively looking into alternate care placements as referred to in the Safe section of this report.

● We met with the provider during this inspection to inform them of our serious concerns about the leadership of the service. The provider had reviewed the management structure to provide, with immediate effect, a senior manager to be in each service every day to support the service managers. The provider requested daily updates as to what actions each service had taken, so they could monitor the services more closely. The provider will submit weekly reports and meet weekly with us to review their progress.

The provider failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person centred care People were not receiving person centred care. Care plans were not fully understood by staff and guidance available in relation to people's communication needs was not being consistently followed. People were not being supported to live normal lives and engage with activities they enjoyed.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 (Need for consent) Peoples consent to care, and treatment was not always gained.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 (Safe Care and Treatment) Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.