Kisimul Group Limited

An Darach Care Lincolnshire

Inspection report

The Old Vicarage
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Lincolnshire
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Website: www.kismul.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
An Darach Care Lincolnshire is a community supported living service. The registered office is in the village of Swinderby in Lincolnshire. The service provides personal care support, to young adults who live in their own homes independently in the community. At the time of the inspection the service was providing care for 15 people who experienced needs relating to learning disabilities and autism. Each person has a tenancy agreement in place. At the time of the inspection there were four supported living houses, with between three to four people living in each house. There were staff supporting people in each house 24 hours a day.

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

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The lack of management oversight at the service meant people did not always receive care appropriate to their needs. Some of the accommodation did not allow people the space they needed. Some care plans represented people in a negative manner.

The experience of people using the service varied depending on which supported living house they were living in. The management structure of the service did not promote consistency across the four homes.

Staff at the service were not always trained and confident in managing people's complex behaviours. Staff in one of the homes, were using a method of restraint in order to contain a person. This method is not an approved technique for use in this service. This meant people were at risk of avoidable harm.

There was not always enough staff to give the people living at the service the support they needed and to keep them safe from harm. People did not always receive the staff support they needed in order to access the community safely.

Risk assessments and care plans at the service were not always effectively reviewed to ensure staff guidance was in place. The registered manager and senior staff did not have good oversight of the service.
People were not always supported to eat in their chosen area of the home. This was due to conflict with other people living at the service.

Care records were not always written in a person-centred way. There was evidence of derogatory language used in care plans. This put the service at risk of becoming a closed culture.

Overall, people received their medicines safely. However, due to staffing levels there was a risk of medicines not being given in a timely manner. Staff did not always have sufficient written guidance to administer medicines safely.

Safe recruitment checks were in place and completed before staff commenced their employment. The service relied on staff supplied by agencies. Safe recruitment for these staff was also covered in the providers safe recruitment policy.

PPE was available for all staff. Infection prevention and control best practice guidance had been implemented by the provider.

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 outstanding (7 September 2017).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about people's care, staffing levels and the safety of the people receiving care at the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the providers management and oversight of the service, so we widened the scope of the inspection to become a fully comprehensive inspection which included the key questions of Safe, Effective, Caring, Responsive and Well-led.

The overall rating for the service has changed from outstanding to requires improvement. This is based on the findings at this inspection.

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

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

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

We have identified breaches in relation to safe care and treatment, staffing levels at the service, person centred care, as well as how the service was managed.

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 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.

Requires Improvement

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

An Darach Care Lincolnshire

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 two inspectors, an inspection manager and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in four '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 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. The provider had not given the registered manager the authority to manage all four homes that make up the service. There were two home managers in place as well as a peripatetic manager providing support on a part time basis.

Notice of inspection
This inspection to the office was unannounced. When visiting the homes of the people using the service, 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 allowed the provider time to prepare people using the service. Inspection activity started on 29 June 2021 and ended on 28 July 2021. We visited the office location on 29 June 2021 and again on 28 July 202.

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 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
On 29 June 2021 we requested staff phone numbers were emailed to us. We then spoke with seven care staff to discuss their experience of working for An Darach Care Lincolnshire.

We visited the An Darach Care Lincolnshire office and spoke with the Registered manager, and a peripatetic manager. We reviewed a range of records. Including four peoples care records. We looked at five staff files in relation to recruitment. We saw a variety of records relating to the management of the service, including policies and procedures, audits and staff training.

On 8 July 2021 we visited two community supported living properties and spoke with the registered manager, a deputy manager, a home manager and a high-level support worker. We reviewed risk assessment, quality audits and multiple medication records.

On 12 July 2021 we phoned five relatives for their feedback about the service,

On 13 July 2021 the nominated individual and the Director of Adult Services (North) were present when feedback was given regarding the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

On 28 July we returned to the registered office to review additional records and talk with the registered manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a senior contracting officer from the local authority.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks associated with people's care had not always been accurately and consistently recorded. This meant staff lacked information on how to provide safe care to people.
- Positive behaviour support (PBS) plans were in place but did not always provide adequate and concise information to ensure people's safety. Staff did not always follow the PBS plans. This placed people at risk of harm.
- One person's risk assessment around their epilepsy did not give the staff enough information on how to manage the person's seizures safely. This put them at risk of not receiving their epilepsy rescue medicine in a timely manner.
- Peoples risk assessments and care plans often made reference to other care plans and risk assessments without giving the staff the information, they needed to care for a person at the service effectively.

Using medicines safely

- Not all staff were trained to administer medicines. Staff from one home told us of an occasion when there were no medicines trained staff on a night shift. The manager had needed to return to the service to administer medicines. However, had there been a need to give an as required medicine the staff would have needed to wait for an on-call person to return to the service. This meant there was a risk that people may not always receive their medicines in a timely manner.
- In order for people to receive their medicines when accessing the community, a medicine trained staff member would take the required medicines with them. The systems and processes for recording that staff had taken medicines off site was confusing. This meant there is the risk of medicines errors being made.
- People were supported in the safe administration of their prescribed medicines. However, where people had medicines prescribed to be taken 'as required' there was a lack of information to support staff to consistently offer the medicine when needed. This meant people were at potential risk of experiencing avoidable pain, discomfort or distress.
- Since the inspection 'as and when required' protocols for two people have been reassessed. However, this still did not provide staff with all the information needed.
- We recommend the provider consider current guidance on giving 'as and when required medicines' and take action to update their practice accordingly.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always kept safe from the risk of abuse. Lincolnshire safeguarding team and the police had been involved in issues at one of the homes. The police have yet to conclude their investigation. One

person living at the service had chosen not to return as they did not feel safe. The persons relatives told us that there had been several incidents that had led to [the person] not feeling safe at the service, including an incident where their bedroom window had been broken by another person living at the service.
● The home where people were being supported by the safeguarding team and the police did not always have consistent management oversight. There was no evidence that the provider was supporting staff to learn from incidents when things went wrong.
● A person's relative told us, that they had not felt the provider had listened to them when they had shared advice on how best to support their relative in relation to past emotional trauma.

Care and treatment had not always been in a safe way for people. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The experience of people feeling safe depended on the home in which they were living in. For example, a relative from one home said, "My relative was only coming out of their room when they knew others were out of the house, as they did not feel safe." Whereas feedback from relatives at another home said, "Yes I think they feel safe, they would not be able to communicate that, but the way they are, tells us they feel safe."

Staffing and recruitment
● The provider did not always ensure there was a sufficient amount of suitable trained staff at all of the homes. In order to support the needs of the people living there.
● Two of the homes relied on the use of agency staff. However, the provider had not ensured that all agency staff were trained to meet the needs of people living at the service. This meant people could be put at risk of abuse and be treated without dignity and respect.
● People at the service received funding to be supported individually. However, this support was not always received. Incident reports showed there were times, when people using the service needed the support of four or more staff members. This meant that other people living at the service were not receiving support at these times, putting them at risk of abuse and or neglect. The provider had identified this issue prior to the inspection. In order to address the issue, the provider had given notice to several people living at the service whose needs were not being met. They were working with commissioners to identify more suitable placements for these people.
● Some people at the service require two staff to support them to access the community safely. There was not always enough staff at the service for this to happen. Staff told us some people living at the service would become distressed, when they saw other people being able to access the community, when they themselves were not being supported to do so.
● The staffing levels at the service at night-time were not always in line with the commissioning of the service. Some people were funded to receive 15 hours of individual support. However, rotas we analysed showed this was only possible for 12 hours a day. The contingency plan, advising staff what to do if there was an incident at night was not robust. Additionally, at times the staff at night did not have all the skills needed to provide safe care and had to call in other staff if needed. This meant that people were at risk of not receiving care in a timely manner and the increased risk of becoming distressed.
● Night staff from one home told us, night shifts were very difficult to manage due to staffing levels. They said that the complex needs of the people at the service meant that behaviours could be unpredictable. They did not feel the staffing levels at the service were safe.

Sufficient staff with the appropriate training were not always 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 has safe recruitment policies in place, which includes the checking of the Disclosure and Barring Service (DBS) ensuring staff were suitable to work with vulnerable young adults. This policy included the safe recruitment of agency staff.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance

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.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now 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

- People did not receive consistent and effective care from competent and experienced staff. In one of the homes staff lacked confidence and training when managing people with complex needs. This had led to inexperienced staff secluding a person in order to manage their complex needs and keep others safe. This was a breach of the person's human rights and demonstrates an ineffective approach in managing complex care needs.
- Staff did not receive consistent opportunities to discuss their work, training and development at the frequency the provider expected. Staff did not receive regular supervision in all of the supported living homes. This was most evident in one of the homes where there had been periods of time with no home manager.
- Staff informed us that they received a period of induction when they started working at the service. This covered mandatory training. However, there were staff that we spoke with who although they had completed their induction had not yet fully completed all of their mandatory training. The registered manager advised us there had been some delay in face to face training due to the constraints of the pandemic.

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.

- One person at the service was being secluded on occasions in order to keep others safe. The registered manager informed us this type of restriction is not in line with the provider's policies. The home manager was aware of the practices and had not followed guidance from local health professionals to support the

person. As a result, the service had not learnt from repeated events. We have informed the local safeguarding team of the practice of seclusion. Local commissioning services are working to support the individual to find a more suitable placement.

Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager and the home managers had worked with local authorities in order for applications to be made to the court of protection. However, Local authorities had not always responded to these requests in a timely manner. The provider had challenged this where appropriate.
● The registered manager acknowledged that systems and processes for recording their conversations with local authorities, regarding the Court of Protection process could be more robust and that she was going to look into ensuring their records were clearer.
Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider's pre-admission assessment process was ineffective. Assessments were not consistently robust or effective, they did not always give an accurate assessment of the needs of the individual. This has led to people not being compatible with their peers, and the service being unable to meet people's individual needs.
● For example, the provider had given notice to four people from two of the homes within the community supported living services. The provider had said that people were either not compatible with other people living at the service, or that the service was not able to meet the needs of the individuals due to their complex needs. This is despite the majority of the people at the service having previously been supported by the provider's children's service. This had impacted on people experiencing uncertainty whilst placements were sought.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not receive effective and consistent support to maintain a balance diet and or meet their preferences. People at the service were not always supported in all of the homes to maintain a balanced diet, or to eat their food in their chosen part of the home.
● For example, a relative informed us that their relative did not want to access the kitchen when their peers were in the home. This had led to them refusing breakfast at home and picking up unhealthy options when accessing the community. The person's care plan stated staff should offer support to have breakfast, including the use of the snug to eat.
● Another person at the service experienced complex behaviours around food. This included requesting to have multiple breakfasts. There was not a robust management plan or guidance for staff in how to support this person effectively when they wanted extra food.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We spoke with the local authority contracting team, and local NHS Clinical commissioning groups, who said that the provider had not worked with them in order to maintain the placements of people using the service. This was reflective of two of the homes where people had been given notice.
● However, the registered manager was able to share positive experiences, for people living at the other two homes. For example, most of the people at the service were accessing a community dentist who specialise in supporting people with complex needs. One person had chosen to use a dentist closer to them. They were supported to do so by their staff team.

● People had been assessed for their individual oral health needs. Care plans gave staff the information they needed to support individuals with their oral health.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- There was a risk of a negative or closed culture developing in one of the homes in the service, due to the derogatory language used in some people's care plans.
- One person's care plan around personal care stated they "Can be lazy surrounding the completion of household tasks." Another care plan said, "This behaviour is unacceptable."
- The service did not always evidence that they had involved people in the planning and decisions about their care. Some care plans were over complicated and did not give the views of the person.
- A person's communication plan discussed how the person was entrenched on their way of communicating and would find it difficult if others had different styles of communicating. This care plan did not give staff guidance of how to communicate well with the person, only how in the authors experience the person had made communicating difficult.
- One person's positive behaviour support plan PBS states, that they enjoyed sensory play and baking. However, we were informed by the home manager that [person] was not allowed in the kitchen during food preparation. This was due to the complex behaviours that they display around food. There was no evidence to show how staff supported the person to access other appropriate ways of using ingredients to fulfil a sensory need.

The provider failed to ensure all people received care that met their needs and preferences. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

- Other homes in the service had care plans that were person centred and tailored around the needs of the person. For example, "It is important that [person] is supported with their self-esteem. Staff need to be very positive and praise [person] when they have accomplished something, they are working towards".

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

- The staff used tenant meetings to gain people's views about aspects of their care. Not all the people at the service fully engaged in this process. Following the inspection, the provider told us that where people had not engaged in this activity it was because they had chosen not to be involved. - Gaining people's views about their care worked well in two of the homes where people were encouraged to make decisions about their own activities daily. However, at the other two homes staff said they did not always provide the support needed for people as they were reacting to other tenants challenging behaviours.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- Records showed that the service was inconsistent in being able to plan people's care in a personalised way.
- For example, in one home a person with complex needs, whose behaviour was often challenging around food, had a positive behaviour support plan. However, there was not sufficient guidance for staff when supporting the person at mealtimes or when they were making attempts to access other people's food.
- However, in another of the homes staff had worked with a person who had missed going out to restaurants during the pandemic. Staff had supported them to make their own pizza restaurant. The [person] was fully involved in the planning of this activity.
- During the inspection, we saw positive interactions between staff and people who used the service. Staff were planning and including people in activities such as planting edible plants in the garden.

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 service demonstrated how they had used a variety of methods in order to make information more accessible to people using the service. However, they did not always ensure that this was as effective as it could be.
- For example, in one home there was a board telling people at the service which staff were working that day. The pictures on the board were of a generic man or woman. The senior contracting officer at the local authority advised the home manager that pictures of the staff members would support people to recognise who would be in their home that day. However, this recommendation had not been implemented.
- Some people's care plans documented clearly that [person] would become frustrated if certain communication methods were used.
- A staff member told us how they used pictures to communicate with a person who was not able to communicate verbally. They said they used the pictures to ask the person if they had tooth ache for example.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to take part in activities of their choosing. However due to staffing levels at one of the homes these activities had on occasions been cut short.

● People using the service had been supported during the pandemic to have visits from families as well as being supported to visit family. One relative told us that the staff had gone above and beyond when supporting a home visit, driving their relative halfway to meet them at a suitable location.

Improving care quality in response to complaints or concerns

● Relatives from two of the homes within the service expressed to us that they did not feel enough was done at the service when they had raised issues and made complaints. However, when we spoke to relatives of people living at the other two homes, they told us they were aware how to make complaints but had not needed to do so.

● The provider has two newly appointed Directors of Adult Services in post. They both said they were looking to improve communication with relatives and had recognised there were areas of the service that needed to be improved. They were working to ensure that the people placed at the service were compatible with each other.

End of life care and support

● At the time of the inspection, no one using the service required end of life care. The people using the service were young adults who did not have any serious underlying health conditions. We reviewed two peoples records where end of life care had been discussed with the person's family. This was due to the person lacking capacity in understanding what end of life care meant for them.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. 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-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 structure of the service was overly complicated. The registered manager had not been given responsibility to have oversight of each of the four homes that make up the service. Each home had a home manager, who did not report to the registered manager. Instead they each reported to one of the two different area managers. One of the houses was without a manager, currently having a peripatetic manager in place. The provider informed us of ongoing recruitment activity in order to fill this role. There was a risk that standards at each house were not to the same standard. No one person had oversight of the service.
- The provider had been aware that the structure of the service was not effective. The nominated individual for the provider, informed us, over a month before the inspection that a home manager would be employed. There was also plans for a regional manager who would have the oversight of the whole service. The provider had been engaging in on going recruitment activity in order to fill theses posts. This had been a long process in order to recruit the right person. As such, we were yet to see these improvements.
- The provider had not ensured staff followed the policy on restrictive intervention. Staff at one of the houses were restricting the movement of a person whose behaviours were often in response to wanting food. Their positive behaviour plan did not reflect the challenges around food nor did it offer staff support in how to manage this behaviour.
- The service was working with local health, learning disabilities teams, psychiatrists, commissioners and families. However, these relationships were often fractious, with poor communication. One home manager felt unsupported by other professionals. We were told by relatives that they were not kept informed if the needs of their loved ones had changed.
- The provider carried out pre-admission risk assessments for people. These assessments were not always robust or effective. This has led to people not being compatible with the peers they are living with, or at a service that cannot meet their needs. At one of the houses staff were finding the layout of the building added to challenges' when supporting people to remain safe.
- The training matrix analysed during the inspection showed that staff had not received training considered to be mandatory by the provider. The registered manager informed us systems in place to update the training matrix were not effective. Operational managers said they would look into improving this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Care plans at the service did not always reflect the achievements or strengths of a person. There was evidence of negative language used in care plans. One person's care plan talked about common barriers to effective communication. This care plan read that any barriers were due to the person who needed support, rather than discussing ways in which staff could effectively communicate with the person.
● People's care plans and associated documentation did not demonstrate that people and their relatives had been consistently involved in developing and reviewing their care.

The registered manager and provider did not have oversight of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements.
● The service had started to analyse incidents where people had become distressed. However, this analysis did not identify why, or when the incident had occurred, and incident forms were not fully completed. Staff did not always evidence that they had reflected on what had happened to trigger and incident, or how they could have responded in a more positive manner. There was a lack of oversight by the registered manager or senior management.
● People were put at risk because the provider failed to ensure suitable quality assurance checks drove improvements in the care provided. The home manager had failed to correctly identify and report safeguarding's which are notifiable to CQC. For example, in May 2021, the provider's internal compliance team identified a number of quality standards had not been met, including a safeguarding incident that had not been recorded for April 2021. this meant we were unable to monitor the safety of the care provided.
● During the inspection we found similar safeguarding's which we reported to the safeguarding team for May and June 2021. On another occasion a person was able to leave the service unsupported. This incident was reported to the local safeguarding team by the person's relative and not by the service.
● The provider had not consistently notified CQC of significant events in a timely manner as they are legally required to do. For example, in March 2021, CQC were informed of nine incidents where people at the service were having altercations with other people living at the service. These incidents had happened over a three-month period of time prior to the notifications having been made.

Failing to identify and report safeguarding's and to make timely notifications to CQC. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● Staff were actively looking to make improvements at the service. They were involving people by using their preferred methods of communication, asking them what activities they would like to take part in at the service.

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 Care records did not support person centred care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare had not been adequately assessed and mitigated. Staff were not always following the providers policy around restrictive interventions. Safeguarding's were not always reported to the local authority.

The enforcement action we took:

Full information about CQC regulatory response to the more serious concerns found during this inspection is added to reports after any representations and appeals have concluded.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Reg 17 People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks were in place. The provider was not able to demonstrate how they supported staff to deliver high quality specialist care for people with a learning disability and/or autistic people. Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. Individual incidents were treated as isolated occurrences, and the provider did not look for patterns or a wider context. There were missed opportunities to prevent further incidents and improve people's care.

The enforcement action we took:

Full information about CQC regulatory response to the more serious concerns found during this inspection is added to reports after any representations and appeals have concluded.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Reg 18 There were not enough staff to keep people safe and provide the support they were

assessed as needing. People were at risk of receiving support from staff who were not trained to meet their needs.

The enforcement action we took:

Full information about CQC regulatory response to the more serious concerns found during this inspection is added to reports after any representations and appeals have concluded.