Chiltern Support & Housing Ltd

Chiltern Support and Housing

Inspection report

20 Benjamin Road
High Wycombe
Buckinghamshire
HP13 6SR

Tel: 01494532926
Website: www.chilternsupport.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Chiltern Support and Housing provides care for people who live in supported living settings. The provider supports people in 8 properties in the Buckinghamshire, Barnet and Bexley local authority areas. The numbers of people supported in each property ranged from 1 to 9. The service supports people living with a range of needs, including learning disabilities and autism, acquired brain injury, mental health, sensory needs, and physical disabilities such as needs arising from progressive neurological conditions.

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.

People's experience of using this service and what we found
People did not always live free from the risk of avoidable harm. This was because the service did not assess, monitor or manage people's safety well, including risks of abuse and risks posed by the behaviours of people using the service. We also identified concerns in relation to the safe management of medicines and the safety of people's living environments, including measures for fire safety and controlling the risks of infection. Staff recruitment practices were not always fully followed in line with the provider's policy and procedure to ensure the safe recruitment of staff.

Some people and relatives told us they believed care was safe. One relative commented, "I do think my daughter is receiving safe care…they always make sure she walks safely." Another relative commented, "Yes they are absolutely safe." Some relatives were not fully assured regarding safety, with concerns raised about past unexplained injuries and a relative highlighted they did not always feel their family member was safe due to the management of people's distressed behaviours.

Governance processes had not been operated effectively to keep people safe, provide good quality care and protect people's rights. People were supported by a service which lacked effective oversight by the registered managers and provider. Audits had been inconsistently completed and did not effectively drive improvements to the quality and safety of the service. We found some incidents had not been reported to CQC in line with requirements, and the service had failed to provide an appropriate written response under their duty of candour.

We received variable feedback from people's representatives regarding communication and management of the service. One family member provided positive feedback regarding the responsiveness of management in meeting their relative's need for a bespoke support package, commenting, "I think the manager does a good job." Other relative feedback was more variable, with comments including, "I am to an extent involved in [relative's] care…only to an extent…I wouldn't say [relative] is involved in the running of the [setting]" and "We had a meeting last year but nothing really changed…I would go to [registered manager name] and she would try…when I told her about a lack of communication last year things changed in the short term."

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not consistently support this practice.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and 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 judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support:
People were not consistently supported by staff to pursue varied meaningful interests and care records did not always reflect that people had been offered choices on a day-to-day basis to promote their independence. Practice was inconsistent across the different settings operated by the service.

Right Care:
We observed people were treated with kindness and compassion. The service did not always promote people's privacy and human rights because the service failed to consider the need for consent for the use of CCTV and did not always ensure people's mental capacity to consent to aspects of their care and support was appropriately assessed.

Right Culture:
People were not consistently supported to lead inclusive and empowered lives. The service had failed to consistently evaluate the quality of support provided to people. Staff received training to enable them to support people however there was ineffective oversight by the registered managers and provider to ensure practice across all settings was consistent in supporting people to achieve good outcomes.

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

Rating at last inspection
The last rating for this service was good (published 11 October 2019).

At our last inspection we recommended the service seek support on the management of medicine records and guidance in relation to mental capacity assessment records. At this inspection we found the provider had not made sufficient improvements and the service was now in breach of regulation in both areas.

Why we inspected
We received concerns in relation to safeguarding adults from abuse. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

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

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding adults from abuse, consent, good governance, safe recruitment, duty of candour and in informing the Commission of information they are required to.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Chiltern Support and Housing

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 1 Inspector, 1 Inspection Manager and 1 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 8 'supported living' settings, so that they can live as independently as possible. At the time of our inspection not all of the settings supported people who required assistance 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were two registered managers in post.

Notice of inspection
We gave a short notice period of the inspection. This was because the service is small and some people go out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 30 January 2023 and ended on 13 February 2023. An Expert by Experience gathered telephone feedback from people and families on 30 January 2023. We visited some of the service's supported living sites on 31 January 2023 and 3 February 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from local authorities in which the service operated. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with 10 people using the service, some of whom did not require help with personal care, however we gathered their general feedback to support our wider understanding of how staff supported people within the supported living settings.

We also spoke with 5 relatives and 15 members of staff including 7 support workers, 1 senior support worker, 2 team leaders, 1 deputy manager, 1 trustee, the operations manager and 2 registered managers, one of whom was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received email or online feedback from 1 additional family member and 3 additional members of staff. We received feedback from 6 professionals who worked with or commissioned care from the service.

We reviewed a range of records. This included 7 people's care records, either in full or in part, and 6 people's medicines records. We looked at 6 staff files in relation to recruitment, induction and supervision. A variety of records relating to the management of the service were reviewed, including information relating to compliments and complaints, accidents and incidents, safeguarding, staff training, minutes of staff meetings, quality assurance audits, staff handover records, staffing rotas for 3 supported living settings, and policies and procedures. Following our site visits we continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection we recommended the service seek support from a reputable source on the management of medicine records. At this inspection we found the provider had not made sufficient improvements and was now in breach of regulation.

- Some people using the service required 'as and when required' medicines, known as PRN. At one setting the registered manager and staff on duty could not locate any PRN protocols. This meant we could not be assured staff had access to sufficient information to administer these medicines appropriately.
- People's records lacked information about when their medicines had last been reviewed, including for some people who were prescribed antipsychotic medicines.
- Care records contained information about the use and purpose of prescribed medicines, however this information was not always accurate. For example, one person's records did not include their prescribed inhaler and incorrectly identified a PRN medicine as a regular dose.
- We identified one medicine did not match the expected balance and asked the service to investigate. Other stock checks did match expected balances. We noted quality assurance checks at another setting identified stock balance concerns and found staff were applying a prescribed cream without documenting this on a medicines administration record (MAR). The only action identified was a request for the pharmacy to supply a MAR. There were no further actions identified in relation to reviewing staff competencies to administer medicines.
- We could not be assured one person's prescription of an antipsychotic had been given in line with prescription. The MAR record had been crossed through without signatures to confirm administration. Another person was prescribed a transdermal patch. Records were poorly completed and not in line with best practice guidance.
- Medicines should be stored under conditions which ensure their efficacy is maintained. This includes ensuring medicines are stored in line with the manufacturer's recommended temperature range. We identified medicines stored in three locations which were not subject to regular temperature monitoring, which could have posed a risk to people's wellbeing if the efficacy of the medicines had been compromised.
- A list was held of staff who were authorised to administer medicines. We requested a sample of medicines competency records however these were not available for all staff we identified who supported with medicines. The registered manager explained a competency form was available however when looking for evidence it was identified some assessors had not completed the form.
- One person received medicines using a nebuliser whilst they were asleep. We requested evidence of how staff were trained and competency assessed to assist with the nebuliser and were advised no evidence was available and training would be booked. There was no risk assessment in place to provide staff with

information about how to safely use the equipment. We also noted the medicine was prescribed as a variable dose however records did not provide guidance to staff about how to select the correct dose.

The service had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The service contacted people's GPs to request medicines reviews, put temperature monitoring forms in place, and advised improvements would be made to medicines records, including for the use of transdermal patches.

● People we spoke with told us they received their medicines appropriately. Comments from people's relatives included, "I think medication is dispensed safely" and "She receives medication and anything else she needs safely…medication [is] recorded using a MAR sheet."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider did not do all that was reasonably practical to mitigate risks. This was because some people's risk assessments and care plans lacked accurate and personalised detail to inform staff about how to manage risks. For example, one person's risk assessment in relation to their mobility included non-specific guidance for staff, such as, "Staff present encourage him to stand independently and to assist him and support him when he requires this."
● Staff supported one person to receive medicines via a percutaneous endoscopic gastrostomy (PEG). There was no specific care plan or risk assessment in place in relation to the person's PEG care. Records for a procedure regularly required to avoid the PEG becoming lodged in the stomach lining showed this was carried out at inconsistent intervals which could have placed the person at risk of avoidable harm.
● Risks in relation to water safety were not effectively managed. Staff used a kettle to boil and mix hot water for one person's personal care. There was no risk assessment in place and temperatures were checked by hand without the use of a thermometer which could have placed both the staff and the person at risk of scalds. At the same setting a legionella risk assessment completed in November 2022 stipulated various required actions including further staff training. The registered manager was unable to provide any evidence that these requirements had been actioned.
● One person expressed distressed behaviours. Risk assessments included details of agreed techniques however the manoeuvre we observed, and the registered manager described, to re-direct the person had not been subject to a documented risk assessment. This could have placed the person and staff at risk of injury. Staff had variable insight about triggers for distressed behaviours. The staff member working with the person during our visit was unable to identify any triggers and described the person as "in her own world, can be triggered with anything". Another staff member identified various triggers including pain, seeing new faces, and room temperature.
● Some people were at risk of weight loss. Care staff regularly documented people's weights however there was no evidence of registered manager oversight or analysis to identify if people were at increased risk of malnutrition.
● There was no registered manager oversight of one person's epilepsy. When asked about the frequency of the person's seizures the registered manager could not locate records and commented, "seizures not that often, 3 to 4 times per year". The log supplied after our visit showed the person had experienced seizures on 15 dates during 2022. There was no evidence the service had requested a review of the person's seizures prior to our visit, and the last seizure protocol accessible was dated 2017.
● We found risk assessments were not in place in relation to the storage of drink thickeners and found thickeners insecurely stored at two settings. A staff member we spoke with had not prepared a person's

drink with the required level of thickener to enable safe swallowing.
● People were not supported in well maintained environments and there was limited evidence of staff identifying, reporting and chasing maintenance issues. At one setting we identified several maintenance concerns and the registered manager said there was a system for reporting maintenance issues but was unable to demonstrate how this operated effectively.
● People were at risk because fire safety was not adequately managed. People had Personal Emergency Evacuation Plans (PEEPs) in place, however these did always contain sufficient information to enable people to be safely evacuated in an emergency and regular fire drills were not undertaken to identify any difficulties in evacuating people. At one setting the fire risk assessment had also identified a lack of staff training around fire safety especially in the use of fire extinguishers and commented there were not enough fire wardens at the service. The registered manager confirmed staff received online fire safety training but that staff had not had more practical fire safety training as recommended in the fire risk assessment. We received variable responses from staff about what they would do in an emergency evacuation situation, including a staff member who told us they would attempt to carry or drag people out who couldn't walk, if they thought they could do so without bringing harm to themselves.

Risks to people were not clearly identified and managed, and the provider had failed to ensure the premises were safe to use for their intended purpose and used in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and updated us about actions they were taking to address some of the risks we had identified. For example, the service contacted the GP and a nurse to request an epilepsy review for the person experiencing seizures. We were informed thickeners were now securely stored and that risk management arrangements would be reviewed, including systems for the oversight of weight monitoring records.

● Other environmental safety checks had been completed. For example, portable appliance testing, emergency lighting testing and gas safety checks had been completed at the required intervals. Servicing was in place for a stairlift, profiling bed, and a hoist and slings.
● We also found positive examples of risk management, particularly in relation to an adapted environment and staff support for a person with complex health and support needs. A staff member provided detailed feedback around risk management for this individual, including how significant risks to the person and staff associated with the person's behaviours were managed. The environment had been adapted to lower the risk of the person injuring themselves on hard surfaces and staff explained how they used bean bags and padded cushioning to prevent the person from injuring themselves on the ground. We noted staff were observant during our visit when the person moved around the service.

Preventing and controlling infection
● People were at risk of contracting infections as the service was not adequately cleaned.
● At one setting cleaning schedules were in place for toilets and bathrooms, however, despite these being fully completed these areas were not cleaned to a satisfactory standard. The most recent legionella risk assessment for the same setting had also identified issues with cleanliness in the top floor bathroom, the ground floor toilet and laundry. At another setting we also identified concerns regarding the cleanliness of flooring and found two bins were unhygienic with broken foot pedals, meaning staff needed to use their hands to open the bins, presenting a risk of cross contamination.
● The provider's December 2022 provider information return and internal documents mentioned infection control self-audits. One registered manager wasn't sure who completed these and could not provide evidence of any completed audits for the setting. At another setting we identified the health and safety

inspection checklist and the infection prevention and control self-audit were overdue review from 28 September 2022. We were advised these reviews would be completed.
● A registered manager told us that all people using one setting had received a COVID-19 vaccination, however, not all staff had. There were no clear processes in place about how this would be managed, for example if there was an outbreak. The registered manager was not aware of an infection control lead and wasn't clear on who they would contact if there was an infection outbreak. They said they would speak to their manager or perhaps the GP.
● Staff were encouraged to continue wearing a mask whilst at work as part of infection control measures, although we observed mask usage was inconsistent.

The service had not established or implemented robust infection prevention and control procedures to effectively mitigate risk to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Visitors were required to wear face masks and have their temperature taken.
● There were no restrictions on visitors at the time of our inspection.

Systems and processes to safeguard people from the risk of abuse
● The service had failed to consistently identify and provide a timely response to potential safeguarding concerns of abuse or neglect. One person's relative told us they had raised concerns in June 2022 regarding alleged unexplained injuries. The feedback provided by a registered manager did not demonstrate a robust investigation had taken place, and no safeguarding referral had been made to the local authority. We raised a safeguarding alert.
● Staff told us, and records showed, another person's behaviours had resulted in them making physical contact with other people using the service. There was no evidence recent incidents had been identified as potential physical abuse, and the incidents had not been reported to the local authority at the time of our visit. One relative of a person living at the setting commented, "In general I believe [my relative] is safe however there have been occasions when service users are together when situations are not safe because of the complex nature of their needs."
● Where safeguarding concerns had been identified, we were not satisfied the service had taken timely action to ensure transferable risks to people were fully and effectively mitigated. For example, it was alleged one staff member had been present when an incident of alleged abuse had taken place. The staff member had received safeguarding training however there was no evidence supplied of any supervision meetings with the member of staff. Records also showed a different staff member who was subject to an investigation in relation to alleged financial abuse remained involved in people's financial transactions during December 2022 and January 2023.
● One registered manager did not understand their responsibility to report safeguarding concerns to the local authority where alleged abuse had taken place. The registered manager told us they had reported concerns to the local authority responsible for commissioning people's care and had later been told by this local authority that concerns should be sent to the local authority where people reside.

The service had failed to operate effective systems to identify, investigate and appropriately respond to allegations of abuse. This was a breach of Regulation 13(1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The registered manager advised additional safeguarding training was being booked to ensure managers understood their responsibilities in relation to safeguarding reporting requirements in the counties in which they operated.

● Safeguarding concerns were documented centrally on a log. We noted the log included lessons learnt identified in response to concerns. The service had commenced a face-to-face training programme for safeguarding across the organisation to reinforce training delivered online during the pandemic.
● A safeguarding and whistleblowing policy was in place. Staff we spoke with understood their responsibility to report concerns to the management of the service. One person lived alone and was unable to communicate verbally. The team leader responsible for overseeing staff at this setting understood their responsibility to regularly observe staff practice to ensure this was safe and to ensure staff understood whistleblowing procedures.

Staffing and recruitment
● The provider's Recruitment Policy and Procedure stated, "Candidates need to submit a fully completed Application Form. CVs will not be accepted." We found curriculum vitaes (CVs) were routinely accepted and this meant some information usually obtained as part of an application form for safe recruitment was frequently absent, such as reasons for leaving previous job roles.
● Gaps in employment history were not consistently identified and explored.
● Arrangements were in place to access an Occupational Health service where the service had concerns about staff fitness for work. However, we found information supplied in health declaration forms as part of recruitment was insufficiently reviewed. For example, one candidate did not complete declarations in relation to their HIV and Hepatitis status and another applicant noted they had not received all childhood vaccines. There was no evidence this information had been followed up with these applicants.
● The provider's Recruitment Policy and Procedure stated, "the job offer will be subject to the receipt of two satisfactory references, one of which must be from the previous employer". We identified an applicant whose references did not include their most recent employer and another person who supplied character references. The registered manager confirmed as part of the provider's standard procedure a risk assessment should be in place where references could not be obtained in line with the policy, however risk assessments were not in place for the staff members we reviewed.

Systems were not consistently operated for safe recruitment of staff. 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 service was responsive to our feedback and acted promptly to contact staff about gaps in employment and completed risk assessments for staff references. The registered manager told us they would review the decision to accept CVs to ensure moving forwards the correct information, including a written explanation for gaps in employment, would be obtained during recruitment.

● Other required recruitment checks were completed. Staff attended for interview, supplied proof of identification and the service undertook Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The service proactively recruited to ensure sustainable staffing levels were maintained, which included arrangements for overseas recruitment.
● People received funded support hours which were used to allocate the required number of staff to support them. Rotas for one person who required 3 staff during the day and 2 staff at night showed the right number of people were consistently scheduled, and we observed the correct number of staff on duty at the time of our visit.
● Staff at another setting provided mixed feedback regarding staffing levels, with a staff member expressing a view that short staffing had an impact on both staff and people. The staff member commented, "Sometimes always short staffed, don't think we have enough staff on every shift…makes work more

strenuous…most times stressed out…for service users, think affects them too. Sometimes when staff on duty, not able to care for everyone…won't say being neglected, [but] don't get the support they need." It was noted by another staff member that efforts were made to provide cover if someone didn't arrive for a shift. Rotas showed staffing numbers considered where people needed allocated 1, 2 or 3 to 1 support.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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; Continuous learning and improving care

At our last inspection we recommended the service seek guidance to ensure people were supported in line with the Mental Capacity Act 2005. At this inspection we found the provider had not made sufficient improvements and was now in breach of Regulation.

- Mental capacity assessments (MCA) and best interests assessments were not consistently completed in line with the Mental Capacity Act 2005 and associated code of practice. Some MCAs were not decision specific, and some best interests checklists had been completed after the assessor had documented that the person had mental capacity to make their own decision. The MCAs frequently lacked detail to demonstrate how the assessor's judgements about a person's ability to understand, retain and weigh information had been reached.
- Where best interests decision making had taken place, some records were only partially completed. We noted a lack of detail in relation to the contributions from people's representatives, and in some cases the outcome of the best interests assessments had been documented as 'None', meaning it was unclear what outcome had been agreed.
- A registered manager we spoke with demonstrated a lack of understanding about the application of the MCA, in particular in relation to deprivation of liberty safeguards (DoLS) requirements for supported living settings.
- Some people were receiving support without evidence of either signed consent or best interests decision making in relation to their supported accommodation and care support.
- We observed CCTV in use in external and communal spaces. People's care records did not contain evidence of consent in relation to the use of CCTV. We asked the registered manager for feedback about how people's consent had been sought, and whether a data protection impact assessment had been conducted. In response to our information requests the service explained they had suspended the use of CCTV until arrangements could be reviewed.

Mental capacity and best interests assessments were not consistently conducted in line with the Mental Capacity Act 2005 Code of Practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and told us additional training would be arranged for staff

including managers to ensure there was a better understanding of, and compliance with, MCA and DoLS requirements.

● Staff understood the importance of offering day-to-day choices, although this was not consistently evidenced within daily records. One person experienced a sensory impairment and was unable to communicate using speech. Their regular staff member explained the person's senses of smell and taste were good. They told us they prepared different food options which the person sampled to choose which dish they wanted to eat. This helped the person to make day to day meal choices.

● The service had failed to submit notifications to CQC in line with requirements, including the failure to notify CQC of some instances of alleged abuse. In some cases notifications were either not submitted in a timely manner, or had been incorrectly submitted for people who were supported by another service operated by the same provider. These errors were only identified after we queried information during our inspection. This meant prior to our inspection we were unable to gain a full and contemporaneous understanding of risks.

Effective systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The service was responsive to our feedback and agreed to submit the missing notifications retrospectively.

● At the time of our inspection two registered managers provided cover across multiple sites following the departure of another manager. One registered manager also supported another location operated by the same provider. Another registered manager from a different provider oversaw another of the supported living sites. A range of responsibilities were delegated to team leaders, however we were not assured registered managers had sufficient oversight. For example, one registered manager demonstrated a lack of awareness about the frequency of incidents such as a person's seizures and struggled to locate routine paperwork during our visit.
● One registered manager was unclear about the systems in place for assessing and addressing quality improvement issues. We saw a health and safety inspection form that had been completed in January 2022, but no further inspection forms were seen for this site and the registered manager was not sure if any further inspections had taken place. The registered manager when asked for any audits they had completed was unable to provide any. They confirmed they did not complete any audits and that audits were completed by the quality team. They said they were given an action sheet which would be checked on the quality team's next visit. The registered manager was asked to provide a copy of this action sheet, but it was not received.
● The provider employed quality assurance staff to visit sites to oversee quality and safety. The quality assurance reports produced did not evidence robust monitoring, and we did not receive a report for one of the sites we visited. The audits were not effective in identifying all the issues we found and had not been effective in driving timely improvements. For example, we reviewed a report for one site dated 26 April 2022. Most progress comments were added on 31 January 2023 after the commencement of our inspection. One recommendation stated, "I was unable to locate information regarding the day and night cleaning schedules. The house could benefit from more frequent cleaning". The update added on 31 January 2023 stated, "Day and night schedule resumed from 23.01.23 and [staff] checking daily if schedule is complete". This indicated a significant delay in corrective actions being taken.
● Where checks or audit tools were completed within settings, we found the frequency of audits was inconsistent and checks were not always effective. For example, a first aid box monthly check sheet at one site was last completed on 10 December (year of check not logged). When checking the contents of the first aid box we identified it contained no plasters.

● Care records were incomplete, not always up-to-date and did not consistently represent people's individual needs. For example, information about how to support people when distressed was not always up to date. Health Action Plans contained minimal information, lacking detail around arrangements for people's dental care, medicines reviews and eye testing. One person's care plan was reviewed on 30 January 2023. A staff member told us they used a system of blinking where the person blinked twice for yes and once for no. Information about this communication strategy had not been added to the person's care plan, which instead stated staff should, "support [person] to use language, symbol boards/cards to communicate".
● Confidential information was not always securely maintained. We observed confidential records stored in the dining area at one setting, which was accessed by visitors, relatives and people. At another site we found confidential paperwork left in an unlocked desk in a hallway accessible to people. We also noted staff at another site had attended a joint team meeting with staff from a different provider, which presented a risk to people's confidentiality. We also found one person's room had confidential documents displayed. There was no evidence the service had considered whether this person would want information about their needs displayed in this visible manner.

Systems had not been operated fully effectively to assess, monitor and improve the quality and safety of the services. The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. At the time of our inspection the service was recruiting an additional registered manager which would enable managers to have increased oversight of a smaller number of settings each. We were advised the provider had reviewed management induction processes to ensure new managers would be equipped with the knowledge and skills to perform their roles. Prior to our inspection the provider had recruited an operations manager whose role involved oversight and support for registered managers, in addition to developing stronger links with commissioning partners. The service also benefitted from dedicated human resources and administrative support.

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 failed to carry out all required steps in relation to notifiable safety incidents. This was because they did not provide a written account, including an apology to a person and their representative, in relation to an incident of serious injury sustained in October 2021. Records showed the service had verbally notified the relative of the accident and engaged with the relative about the person's care and treatment, however their response did not include a written account about the circumstances of the incident.
● The service's provider information return, received 9 December 2022, noted one notifiable safety incident triggering the harm thresholds of the duty of candour regulation had occurred within the previous 12 months. The provider information return is information services are required to submit to CQC on an annual basis. We requested evidence relating to this duty of candour incident but received no information during our inspection.
● We found accident and incident forms were frequently partially completed, with the section reserved for management oversight and comments left blank, which is where comments would be added about who had been notified of the incident. This meant we could not be assured people's representatives had been consistently contacted when accidents or incidents occurred.
● Some relatives told us they had not received sufficient feedback when people had sustained injuries to help them understand how these injuries may have occurred.

The service had failed to provide people and their representatives with an appropriate written account when notifiable safety incidents occurred. This was a breach of Regulation 20(1) (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to our feedback. The registered manager stated all staff would complete duty of candour e-learning training and all managers would complete a face-to-face training course to ensure the service understood the requirements of the duty of candour.

● The service had a duty of candour policy in place.
● We found one supported living setting, supporting a person with complex disabilities, had systems in place to ensure they regularly communicated with the person's representative. The team leader explained staff provided the relative with daily updates via phone and email.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
● People provided variable feedback regarding staff support, with most people advising they found staff supportive. People appeared comfortable in the presence of staff, and we observed examples of good practice, such as staff showing care and patience when assisting with meals.
● Some staff demonstrated a good knowledge of people's needs. At one setting staff could speak confidently about all aspects of the person's support including complex communication and behavioural needs, sensory, personal care and nutritional needs.
● Where the service was responsible for supporting people to engage in meaningful activities and access their community, we were concerned practice was inconsistent. Relative comments included, "My son doesn't get any exercise" and "She is not really encouraged to try new things…as far as I can gather she has only been out with staff once in the last year."
● Records showed one person engaged in a very limited range of activities. Records identified activities the person had previously enjoyed, such as walks in the park, which they were not regularly supported by staff to access. A staff member could not recall the last time staff had assisted the person to access the park and expressed concern staff would struggle to encourage the person back into the vehicle if they were to get out. We were therefore concerned staff confidence or skills in managing the person's behaviours may present a barrier in enabling them to access the community. We reviewed notes for another person for a period covering six weeks and again found a very limited range of meaningful activities.
● We found some people were supported to access more varied activities. One person had an adapted vehicle and was supported to attend a day centre and go on trips such as the cinema. Another person had been supported to go on a summer holiday.
● Two supported living sites we visited had one communal space for everyone using the service. The spaces were minimally furnished with limited resources for meaningful activities. At each site a television was on during our visits. This meant where people required quieter spaces to meet their sensory needs the main option would be spending longer periods of time in their bedrooms and one person sat in the corridor and used the stairs for exercise.
● The nominated individual told us they were committed to delivering what was required to meet people's needs and goals. We noted some people accessed in-house professional support such as physiotherapy to help improve their mobility. This had assisted one person to increase their skills in using a wheelchair and walking frame, enhancing their overall confidence.
● Staff spoke about people with respect and kindness. Staff told us handover meetings and support from team leaders enabled them to remain up to date with changes to people's needs.
● Staff provided positive feedback about opportunities for development and support from their supervisors. A staff member advised, "Chiltern Support puts all their service users first and staff is continuously provided

with…training. The company goes out their [way] to make sure that the staff is fully supported with everything needed to deliver excellent and quality care."

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

● Some staff and people completed surveys to provide feedback. There was no evidence supplied of written analysis, however a registered manager provided verbal feedback about how results were used to improve the service. For example, the registered manager explained following one person's feedback that they wished to self-medicate, steps were taken to support the person to do so, and staff training was updated to ensure where possible people were encouraged to self-medicate.

● Staff could log how they were feeling at the end of each shift using an electronic system, with options ranging from 'happy' to 'stressed'. The registered manager explained these responses enabled managers to identify and respond to potential concerns, such as any impact from people's behaviours on staff wellbeing.

● Staff were encouraged to access training, however we found supervisions had not been conducted at frequencies in line with the provider's policy. Most supervision records we reviewed contained minimal detail and therefore did not indicate the sessions had been used for meaningful in-depth discussion. Team meetings were held however the evidence we received for some settings indicated recent team meetings had not been documented.

Working in partnership with others

● We received positive feedback from professionals working with the service. For example, a professional commented, "Referrals appear timely and appropriate with the support staff appearing aware of when support from different professionals in the MDT may be beneficial. They are receptive to support but can benefit from modelling, training and other continued input from professionals to help them implement guidelines/recommendations into practice. They are willing to make changes to the physical environment of their homes to help meet individual's physical and sensory needs."

● The service worked with commissioning bodies to provide bespoke settings for people with complex needs. We visited a setting where the environment had been adapted and a staff team assembled at very short notice to assist a person with complex needs. A professional involved in the person's support advised, "They did not compromise or take short cuts on the essential safety features needed in the structure and equipment needed and the staff ratios, quality of care and support needed…The way they managed the transition exceeded my expectations, I have met the staff team on a number of occasions and have been impressed by the gentle and understanding approach held by them."

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 Effective systems were not in place to identify or report incidents to CQC in accordance with requirements.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity and best interests assessments were not consistently conducted in line with the Mental Capacity Act 2005 and the associated Code of Practice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to operate effective systems to identify, investigate and appropriately respond to allegations of abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been operated fully effectively to assess, monitor and improve the quality and safety of the services. The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not consistently operated for safe recruitment of staff.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service had failed to provide people and their representatives with an appropriate written account when notifiable safety incidents occurred.

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 The service had not ensured the proper and safe management of medicines. Risks to people were not clearly identified and managed, and the provider had failed to ensure the premises were safe to use for their intended purpose and used in a safe way. The service had not established or implemented robust infection prevention and control procedures to effectively mitigate risk to people.

The enforcement action we took:

We served a warning notice.