Purple Oak Support

Opportunities for Adults and Children

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Opportunities for Adults and Children provides care and support for people who may have a learning disability, mental health needs or autistic people. At the time of the inspection, 54 people were receiving support.

The provider had a several 24 hour supported living houses, each with their own allocated house manager and staff team. Other people living in the community received care and support under the same registration.

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

The provider failed to ensure sufficient numbers of suitably skilled, qualified, and experienced staff were deployed to meet people's needs at all times.

People were not always provided with appropriate support to manage their medicines, and monitoring medication administration was not carried out effectively.

The provider did not always conduct robust assessments to determine risk. Risk was not always managed effectively.

The providers governance systems were not embedded and on occasions failed to drive improvement in a reasonable timescale.

Safe recruitment processes had not always been thoroughly followed. We have made a recommendation about this.

Decisions made in people's best interest were not always assessed in line with the requirements of the Mental Capacity Act 2005. Records failed to demonstrate referrals had been made to the Court of Protection when this was required.

We received mixed feedback from people, relatives, and staff about the quality of care provided and the organisations leadership and governance procedures.

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.

Right Support: Model of care and the setting failed to consistently maximise people's choice, control, and independence

People were not always supported to have maximum choice and control of their lives and staff did not always support people in the least restrictive way possible.

Right Care: Care was not always person-centred and, at times failed to promote people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff sometimes failed to ensure people using services lead confident, inclusive and empowered lives.

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 2 November 2019).

Why we inspected
We received information of concern relating to the quality of care provided, the leadership within the organisation and the arrangements in place for governance. 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.

Enforcement and Recommendations
We identified breaches in relation to regulation medicines, staffing and quality assurance processes. Please see the action we have told the provider to take at the end of this report. We have also made a recommendation in relation to recruitment shortfalls found at this inspection.

During our inspection, the provider sent us various action plans, records and correspondence demonstrating they had responded promptly and appropriately regarding the concerns we identified. The provider also contacted the local authority safeguarding team to share information of concern.

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

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 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?

Requires Improvement

The service was not always safe.

Please see our detailed findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Please see detailed findings below.

Opportunities for Adults and Children

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 2 Inspectors 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 a 'supported living' setting, so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection 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 was not a registered manager in post. The provider had identified a member of staff who recently applied to become registered with CQC.

Notice of inspection
The inspection was not announced. Inspection activity started on 21 February 2023 and ended on 13 March

2023. We visited the location's office on 21 February, 22 February and 13 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 this information to plan our inspection.

During the inspection
We visited four 24 hour supported living houses. We spoke with 8 relatives, 7 people, the provider's representative, the the Acting Operations & Quality Lead, 6 house managers and we obtained feedback from 9 support workers. We reviewed 7 people's care plans, we looked at staff training records, staff recruitment records, safeguarding incidents and accident reports, quality and compliance records and we checked whether the provider was compliant with the requirements of the MCA.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Staffing and recruitment

● We were not assured staff received appropriate support, training, professional development, supervision, and appraisal as necessary to enable them to carry out their duties. Staff told us, "Staffing needs to get better. I use bank staff 30 per cent of the week in one of my houses", "I haven't had much management support, they've given excuses saying they are busy" and "To be honest we struggle about staffing level as this is always an issue especially when it comes to sickness of staff. To be fair Purple Oak are trying their best to cover the shift to work in a safe environment".

● At the time of our inspection, the provider's representative informed us the organisation had 7 staff vacancies. During our inspection, 4 staff from one particular house resigned which increased the number of staff vacancies to 11. In the short term the provider's representative informed us they had arrangements in place with agencies to provide cover until successful recruitment had taken place. They also told us permanent staff from other houses were being utilised to provide consistency across the houses where there were significant vacancies.

A failure to deploy sufficient numbers of suitably skilled, qualified, and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed our concerns back to the provider and we were satisfied with the action they had taken. Whilst we identified staffing concerns, we found no evidence to suggest people were placed at harm.

● Safe recruitment processes were not always followed. For example, we identified unexplained employment gaps in one staff member's application, there was no identification in another staff members file and for a third member of staff we found unexplored gaps in their employment history.

We recommend the provider takes actions to ensure thorough recruitment procedures are in place and followed at all times.

Using medicines safely

● We were not satisfied people were supported appropriately with their medicines. A PRN medication is most often prescribed for acute or intermittent conditions and is not intended to be given as a regular dose. PRN medications are not restricted to the times of medication administration rounds and should be administered 'as and when' required. For one person, we found no PRN protocol for the use of Timodine Cream, Daktacort Cream, Daktarin Miconazole nitrate cream and Laxido. For another person we found no PRN protocols in place for the use of Laxido, Epimax Cream and salbutamol inhaler.

● We could not be assured people who required time specific medicines were appropriately supported. For example, a person required sodium valproate (for epilepsy) to be administered twice a day. The times on the person's medication administration record (MAR) stated the medicine should be administered at 8am and 5pm. It was unclear from the MAR if a specific duration was required between doses. On 20 February 2023, the MAR stated the medicine was administered at 7.15am and then at 6.25pm.

A failure to appropriately support people with their medicine was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed our concerns back to the provider who responded appropriately. Whilst the records relating to the management of medicines need to improve, we found no evidence to suggest anyone was harmed.

Assessing risk, safety monitoring and management
● Risks associated with people's care were not always properly assessed or documented. For example, one person's care plans failed to detail the required actions staff should take to reduce the possibility of acquiring an infection. Two staff told us they didn't know what cleaning products should be used and said they had not received training in this area. A second person's care plan stated, "(Person) has a catheter bag which is attached to (person's) leg day and night so it should be moved to the other leg everyday". We found no records in place demonstrating staff had repositioned the catheter, emptied the bag or they had received appropriate training in this area. Care plans and risk assessments failed to detail strategies to be used to support a third person with their particular interests and desires. No referrals were made to the relevant organisations to support the person to explore their preferences. This placed people at possible risk.

A failure to assess, record and mitigate risk at all times, was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We fed our concerns back to the provider and we were satisfied with the action they had taken. Whilst the records relating to risk require improvement, we found no evidence of harm, abuse or neglect.

Systems and processes to safeguard people from the risk of abuse
● The provider had not consistently taken appropriate steps to protect people from the risk of possible abuse. For example, it was noted in one person's care plan they may exhibit behaviours which could place people at risk of harm. Whilst the record did detail some behaviours and triggers, it failed to provide sufficient guidance to ensure all people were supported to stay safe at all times. We fed our concerns back to the provider and were satisfied with the action they took and their plans moving forward. The provider was in the process of working with the local authority safeguarding team regarding the matter.
● Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures, which provided them with guidance on the actions to take if they identified any abuse.
● Comments from relatives included, "Staff are so kind, they enable her to see her grandmother", "She's incredibly safe, I'm over the moon with her care. They do an amazing job". Staff told us, "Safeguarding is protecting vulnerable people and making sure we work together to ensure to prevent all risks from abuse" and "I understand safeguarding to be about protecting people's health, wellbeing, and human rights. Through safeguarding we can assist them in living free from harm and abuse. I always do my very best in this regard and if I had any concerns, I would escalate them to the relevant people in my organisation".

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 MCA 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 Mental Capacity Act (MCA).

● We found the service was not always working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. For people in supported living, at home or somewhere other than care homes or hospitals a deprivation of liberty will need to be authorised by the Court of Protection rather than by a local authority.
● Whilst managers for people's homes were knowledgeable about the requirements of the MCA, restrictions were in place which had not been authorised in people's best interests. A member of staff told us about one person who had an alarm on their bedroom door, an alarm on their front door and an alarm on their kitchen door. The member of staff told us these measures were in place to promote safety within the particular shared house. We found no record of a best interest decision for these measures, and no approved authorisations agreed by the court of protection. The controlled measures also impacted on other people living in the shared house and their ability to have freedom of movement. We fed our concerns back to the provider and were satisfied with the action they took and their plans moving forward.

Preventing and controlling infection
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was using PPE effectively and safely.
● One staff member commented, "I always follow the guidance provided by the organisation to ensure that infection control is in place. I always use the appropriate PPE, face coverings, and ensure regular, thorough handwashing as well as the correct disposal of said equipment post usage.

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

- Managers and staff were not always clear about their roles and responsibilities which created inconsistency in respect of oversight and leadership within people's shared support living houses, and own homes in the community. The service did not have a registered manager; the nominated individual was not available at the time of the inspection. A new Chief Executive Officer for Purple Oak Support had started their role in August 2022, and they assisted throughout the inspection.
- The provider told us Purple Oak Support had successfully been awarded 4 new contracts during a six-month period. They said, "We have had 4 different organisations come in within a 6-month period. November 2021 was the first 2 and April 2022 was another 2. They have all combined into one. It seen a huge amount of growth in a short amount of time."
- A member of staff said, "We are all working differently. Some houses don't have enough audits, I don't think some of the house managers always know what they are doing because they don't have effective management support. I think it's partly because we have had loads of new companies join at once and we have had a lot of staff leave recently. It's all a bit of a mess".
- We identified a number of concerns in relation to medicine management, risk management, staffing, recruitment and how people were supported in line with the requirements of the MCA. Whilst some of these areas of concern had been identified through the providers audits, action taken was not effective.
- We received mixed feedback from relatives in relation to the leadership of Purple Oak Support. One relative said, "Purple oak is not fit for purpose. I don't know how they got the contract" another relative said, "I am so pleased with Purple Oaks, I wouldn't want to go back now".

A failure to regularly assess and monitor the quality of care provided, was a breach of regulation 17 Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- During and after the inspection, the provider sent us audits, action plans and records demonstrating they were in the process of implementing a more robust governance system and responding to risk. The Acting Operations & Quality Lead said, "It's the harmonising of everything together. We are working on quality and compliance. It's the framework, the structure, it's the consistency we need to improve. I am keen to make sure everyone understands their role, they need good feedback about how they are doing in relation to expectations. I have an in-progress action plan against CQC regulations. We have a good relationship with Hampshire County Council".

Learning lessons and improving care

● The provider acknowledged improvements were needed in respect of oversight and leadership and told us more steps needed to be taken to support managers and staff in their role. The provider's representative said, "I would say we are requires improvement. Some of that is around the structure and the framework. I don't have concerns about the care. We have the action plan building. The mixture from the Transfer of Undertakings (Protection of Employment) TUPE process, and the previous ways from working has been a massive challenge which we will need to learn from". A 'TUPE transfer' happens when: an organisation, or part of it, is transferred from one employer to another.

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

● We identified inconsistency in the quality of care provided across people's shared houses and own homes and feedback from relatives was mixed. Comments included, "(Person) is incredibly safe. You can see the kindness. I think they have good banter. It's really nice to see", "(Staff) all seem responsive to her needs, they are attentive", "They take him for drives to garden centres, Charlton Lakes, goes to the pub for a walk. Saturday, they go to the National Trust in the car or visit museums", "(Person) attends a day centre which Purple Oak organised, where she can see friends. She can meet regular people, it's in one place. It's lovely for her, she's much happier" and "We have a good relationship with the staff. We as parents do the garden. The staff do the washing. He puts it in the machine, helps to clean then puts the washing on the line".

● Other comments from relatives included, "(Person) lays in bed days on end. They (staff) allow this to happen. She used to have a little job but now she does nothing". One relative expressed concern that staff failed to recognise when a person was unwell and needed professional 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

● Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice.

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

● The provider's representative and Head of Operations told us, involving people, the staff and the public needed to improve to ensure equality and diversity was fully respected and supported through the organisation. A member of staff said, "Because there has been so much change and a lot of confusion, we are fighting a lot of fires. Once things calm down, we can get to know each other a bit more and we can work together to make sure people are given the best care and support possible".

Working in partnership with others

● Feedback from relatives and records we looked at generally suggested the staff worked effectively with other health and social care professionals. A relative said, "(Person) had a review meeting 2 or 3 weeks ago to discuss (person's) care and the social worker attended. The manager makes referrals to outside agencies when needed. She does what she says she is going to do". During our inspection a number of people had care reviews arranged with various professionals invited to attend.

● Records demonstrated staff worked effectively with external professionals and supported people to attend various medical appointment.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were appropriately supported with their medicines. Records did not always contain sufficient information to mitigate risk,

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance arrangements failed to drive improvement on a consistent basis.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficiently skilled, experienced and qualified staff at all times to meet people's needs.