FitzRoy Support

FitzRoy Supported Living - Uckfield

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

Fitzroy Supported Living Uckfield is a supported living service that was providing personal care for six adults living with a learning disability.

People's experience of using this service:

● People were not protected from the risk of avoidable harm. People were not protected from the risk of abuse.
● The service was not well-led, and the registered manager lacked oversight of the service. There had been significant shortfalls in the leadership of the service.
● The provider had reduced the management resource to the service and this had affected the quality of the service provided.
● Staff told us they did not feel valued in their roles and that there was a bullying culture within the service.
● Quality assurance processes were ineffective at identifying issues and improvements were not made to the quality of care people received.
● Risks to people were not always identified when people's needs changed.
● Medicines were not always managed safely.
● People were not consistently treated with kindness, dignity and respect and their privacy was not always respected or maintained.
● Complaints were not dealt with in line with the provider's policy.
● Staff did not have access to regular supervision and did not feel supported by the management team. Induction training for staff was inconsistent and the registered manager was not always assured of staff competency.
● Staff and the management team did not always work effectively with other professionals to ensure people's needs were met in a timely way, specifically relating to raising potential safeguarding concerns.
● People had access to healthcare services when they needed them.
● People's hydration and nutritional needs were met.
● People's care plan contained person-centred detail and most staff knew people well.
● People and staff told us they were happier in recent weeks as the provider and registered manager had acted in relation to the safeguarding concerns.

Rating at last inspection:

Good (The last report was published on 30 November 2016). The rating at this inspection had deteriorated to Inadequate.

Why we inspected:

This was an unannounced responsive inspection. We brought this comprehensive inspection forward as we had received concerns from a variety of sources that included community health and social care professionals and whistleblowing concerns. Concerns were regarding the care people were receiving. There were several individual safeguarding concerns being investigated by East Sussex County Council in progress.

Enforcement:

We found four breaches of regulation. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to the report after any appeals have been concluded.

Follow up:

The overall rating for this service is Inadequate and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the providers registration, we will re-inspect within six months to check for significant improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well led.

Details are in our Well Led findings below.

Inadequate

FitzRoy Supported Living - Uckfield

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by two whistleblowing concerns received by the Care Quality Commission (CQC). The information shared with CQC indicated potential concerns about people being at risk of avoidable harm and abuse.

Inspection team:

The inspection was completed by one inspector.

Service and service type:

This service provides care and support to people living in on supported living setting, two flats and two bungalows on one site, so they can live as independently as possible. People's care and housing were provided under separate contractual agreements. CQC does not regulate the premises used for supported living; this inspection looked at people's personal care and support.

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

Notice of inspection:

This inspection was unannounced.

What we did:

Before the inspection:

● We contacted the local authority for feedback regarding alleged safeguarding concerns.
● We reviewed notifications we received from the home about important events.
● We reviewed information sent to us from other stakeholders for example the local authority and members of the public.

During the inspection:

● We spoke with the registered manager, two members of staff, four relatives and four people who lived at the service. We observed the interactions with staff of the other two people who lived at the service.
● We pathway tracked the care of three people. Pathway tracking is where we check that the care detailed in individual plans matches the experience of the person receiving care.
● We reviewed records including safeguarding concerns, accident and incident logs, quality assurance records, compliments and complaints, policies and procedures, supervisions and three staff recruitment records.

After the inspection:

● We spoke with the operations manager and further spoke with the local authority regarding the alleged safeguarding concerns.
● We requested the registered manager send us copies of the providers policies and procedures and evidence of staff medicines competencies. The registered manager sent us copies of polices but could not locate the staff medication competencies requested.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse. One person told us a member of staff makes them feel, "not safe" and "frightened because they are horrible", "they are nasty and shout at me." Another person told us a different member of staff was, "not very nice, they speak to me miserably and tell me what to do. They shout at me."
● People's relatives told us they did not think their family members were safe due to ongoing safeguarding concerns. One relative told us, "I thought she was safe until recently. It has gone downhill."
● Staff understood signs of potential abuse but told us they did not feel confident in raising concerns as they felt they weren't listened to or acted on.
● Staff told us there was a bullying culture at the service and they were scared to raise concerns for fear of reprisals. The provider's whistleblowing policy was not followed by a senior member of staff. Staff raising concerns were not protected and their names were shared with other members of staff. One member of staff told us that another member of staff shouted at them for raising concerns and told them that it is, "not the right way to make friends." They told us this made them feel scared to raise concerns as other members of staff would make their working life difficult. The provider's whistleblowing policy had not been used effectively to protect people when raising concerns.
● The management team had failed to identify potential safeguarding concerns from incidents and complaints. For example, one person made a complaint that a member of staff had 'force fed' them breakfast and they had repeatedly told the member of staff they did not want to eat it. The management team had not recognised this as a potential safeguarding allegation and had not referred this to the local authority. Therefore, this incident had not been investigated to reduce further risks to the person. The person told us, "I forced it down as they would keep on at me if I didn't eat it." They told us the senior member of staff made them feel "scared and uncomfortable" when they reported it.
● A member of the management team had not acted on feedback from staff about their concerns regarding another staff member's practice. They had also not escalated these concerns to senior managers. Staff told us they had raised concerns that had not been acted upon. For example, one member of staff told us that they reported an incident of physical aggression and intimidation by a member of staff to a person. They said they witnessed the member of staff 'smack' the person on the hand whilst hoisting them and they were intimidating in their manner by 'shouting' at them, 'wagging their finger' and 'telling them off.' They said they had reported concerns about this member of staff three times and this had not been acted on. Several staff, including the registered manager, told us this had a significant psychological impact for this person, they did not want to be alone and continually asked when this member of staff would return. Staff told us they appeared fearful and unsettled by the situation. The impact of this had resulted in the person requiring additional professional support with their anxiety.
● Staff told us they had raised concerns about several potential safeguarding incidents over a period of

months and these had not been acted upon. Staff told us they had been raising concerns about particular staff's interactions with people. There was no evidence to demonstrate these concerns were acted upon. This meant people were placed at risk of avoidable harm as these concerns had not be addressed.
● Potential safeguarding concerns were not referred to the local authority safeguarding team. The local authority was not aware of any incidents of potential abuse by staff until they received whistleblowing concerns. This meant people were exposed to the ongoing risk of avoidable harm as concerns were not being investigated.
● There is an open organisational safeguarding enquiry being investigated by the local authority community learning disability team due to the nature and number of alleged concerns raised. The provider and registered manager are working openly with the local authority and took immediate action to reduce risks to people whilst allegations are being investigated.
● The failure to protect people from the potential risk of abuse and avoidable harm was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management.

● The registered manager and management staff had not always considered or assessed risks to people's safety. Reviews of risk assessments did not always happen when people's need changed.
● A relative raised a concern about an incident when their family member was supported to travel in their car in an unsafe way. Their wheelchair required special equipment to securely fasten them when in the car. Their relative noticed that this was not done correctly by staff which increased the risk of injury. This was reported by the local authority to senior staff on 4 March 2019. Although some staff had received additional training relating to the persons wheelchair, their risk assessment had not been reviewed or updated following this incident. This increased the potential risk a similar incident could reoccur as staff did not have access to the relevant guidance to support the person's safety.
● Risks relating to fire had not been acted on to improve people's safety. For example, an audit in October 2018 identified that fire drills had not been completed and this was a 'high priority.' These had still not been completed on the date of the inspection, five months later. The registered manager had not identified this and therefore people were at potential risk should there be a fire as they and new staff may to be aware of the fire procedures. A new member of staff to the service told us they had not received an induction and were not aware of risks to people should they need to evacuate the building.
● The failure to mitigate the risks relating to the safety of service users and the failure to act when risks to people were identified to improve their care was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● Some risks to people had been identified and assessments were in place to guide staff to support people in a safe way. For example, risks associated with one person's mobility had been assessed and guidance was in place to support staff to safely support them using their hoist.

Using medicines safely

● Medicines were not always managed safely. Staff had reported incidents relating to people not receiving their medicines. However, there was no evidence that these incidents had been investigated or medical advice sought. For example, an incident report identified that a member of staff had given two people their medicines on the incorrect day. There was no evidence of any immediate action taken to ensure the people's safety and management actions were not documented. The registered manager was unaware of this incident.
● Another person's medicine had been removed from their blister pack at the wrong time of day and the

person could not remember if they had taken their medicine or not. GP guidance was followed to not administer a further tablet. This meant the person received their medicines outside of the prescribed guidance. There was no evidence that this had been investigated and management actions were not documented. The registered manager was unaware of this incident.
● People's medicine stocks had not regularly been maintained. One person had non-prescribed Paracetamol which staff were administering to them. The person had both prescribed and non-prescribed Paracetamol in their medicine's cupboard. Staff told us they did not know why this was there and the registered manager told us this was not in line with their policy. The registered manager arranged for the non-prescribed paracetamol to be removed.
● Staff competency to administer medicines had not always been assessed annually in line with the providers policy. Although these had been logged as completed on the provider's computer system, there was no evidence that an assessment had been completed in full. The registered manager could not locate these during the inspection or afterwards. This did not provide assurance that staff were competent to administer medicines.
● The failure to ensure staff were competent to administer medicines and the failure to ensure medicines were administered safely was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● We reviewed two people's medicines with them and a member of staff. The member of staff was knowledgeable about their medicines, why they take them and how people like their medicines to be administered.

Learning lessons when things go wrong

●There was a significant lack of oversight in relation to accidents and incidents, this did not ensure lessons were learned when things went wrong.
●Incidents and accidents were not analysed by the registered manager to identify themes and trends. For example, incident reports identified that one person had several bruises over a period of time. This was justified as being part of the person's behaviours, however, these incidents had not been analysed to identify themes and trends and had not been considered as potential safeguarding concerns. A member of staff told us they had completed an incident form which detailed the person had a 'hand print' bruise on their arm but his had not been looked into. There was no evidence of this form during the inspection.
●Incidents were not responded to in a timely way to reduce ongoing risks to people. For example, one person reported that money had gone missing from their home. This was reported this to a senior member of staff but was not reviewed for a further five days following the alleged incident.
●The failure to assess, monitor the service to learn from incidents and improve the quality of the service provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● Recruitment processes ensured staff were suitable to work with people before they started working at the service.
● There were enough numbers of staff to meet people's needs. We observed staff responded to people's needs in a timely manner.
● People told us there were enough staff to support them to do what they wanted.

Preventing and controlling infection

● Staff were aware of infection control risks and received training in this area. People lived in a clean and hygienic environment.
● There was a cleaning rota in place which staff took part in. We observed staff use personal protective equipment (PPE) such as gloves during the inspection.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff did not have access to regular supervision or appraisal, in line with the provider's policy. The registered manager told us staff should have dedicated time for supervision every six to eight weeks. Of the staff records we reviewed there was no evidence that staff received supervision between the months of October and December 2018.The registered manager told us that this should not be the case but could not find evidence of supervisions during this time.
● Staff told us they did not have regular supervision and did not always feel supported. A member of staff told us they did not have the opportunity to talk with the management team, "my last supervision was September last year. There is a lack of management on site which means we feel unsupported and not valued."
● Staff access to a formal induction was inconsistent. Staff received a formal induction to the provider's organisation and ways of working, however, the process of staff induction within the service was not fully embedded. The registered manager told us, "We usually try and do shadowing, it depends if they have done the job before."
● Staff gave mixed feedback about their induction. A member of staff new to the service told us they had not received an induction and was, "reading care plans as they go". Another member of staff said, "This did not provide assurance that the member of staff knew how to support people's needs."
● This is an area of practice in need of improvement to ensure staff receive adequate supervision and induction to enable them to meet people's needs effectively.

● Some staff told us they received a good induction that allowed them the opportunity to meet people and shadow more experienced staff before working alone.
● Staff received a range of training opportunities with the aim of enabling them to deliver effective care and support. Training was tailored to support staff to meet individual's needs such as autism awareness and positive behaviour. One member of staff told us, "The online training portal is useful as you access this when you need to, and it keeps you up to date."

Ensuring consent to care and treatment in line with law and guidance

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

●Staff had a good understanding of the principles of the MCA. We observed staff ask people for consent before supporting them during the inspection. However, people told us that not all staff asked consent before supporting them and sometimes their choices of who supported them were not listened to. For example, one person told us they specifically asked for a member of staff not to support them as they were "frightened of them" but this was not always listened to. Records showed that this member of staff had continued to support the person until recently. This was against the persons wishes and they had not given consent for the member of staff to support them.
●This is an area of practice in need of improvement to ensure consent is sought and respected when allocating staff to support people.
●If people were assessed as not having capacity to make a specific decision, a best interest meeting was arranged to ensure decisions were made in people's best interest and in the least restrictive way. Appropriate people were included in these meetings. For example, one person required dental treatment they could not consent to. The registered manager involved an advocate and social worker to decide in their best interest.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.

● People were supported to access healthcare services in a timely manner. Records showed that when one person came to staff with a health problem, staff contacted the GP who prescribed medicines to treat the issue and they experienced no further complications with this aspect of their health.
● Staff were proactive to changes in people's health needs. For example, staff noted that one person was beginning to lose weight. They contacted a healthcare professional, in a timely way, who restarted them on a food supplement which improved their weight.
● Staff used guidance from health professionals to support people to live healthier lives. For example, one person required support to do daily exercises advised by their occupational therapists to improve their mobility and strength. Their care records showed that staff supported them with this daily.

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

●People's needs and choices were assessed prior to them moving into the service. The assessment process involved meeting with the person, their relatives, if appropriate, and relevant health and social care professionals.
●Protected characteristics under the Equality Act (2010), such as disability and gender and were considered as part of people's initial assessment. People's wishes in relation to contact with people they love and access to the local community and activities were part of the assessment process. This demonstrated that people's diversity was included in the assessment process.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to maintain a balanced diet and their care plans detailed their dietary likes and dislikes.
● Staff were aware of people's individual dietary needs and they had responded to changes in people's needs. For example, staff noted that one person was coughing during meals. A referral was made to the speech and language therapy team and guidance was in place for staff to support them. Their care plan directed staff to prepare thin fluids and provide a straw for the person to drink with. We observed staff to follow this guidance.
● People told us they enjoyed the meals that were prepared for them. One person told us their friend who

also lived at the service ate meals with them, "We have dinner together and we have developed a friendship. It is nice that staff support us to eat our meals together, some of them are good cooks."

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

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

● People were not consistently treated with kindness. People gave us mixed feedback regarding this depending on what members of staff were supporting them. One person told us, of a member of staff, "They are not nice and sometimes they are not friendly." Another person told us, "I don't like it when (member of staff) asks me personal questions and doesn't listen when I say I don't want to talk about my business." The person was upset by this and told us, "It is my business, I like it private. It's my choice and that's not respected by (member of staff)."
● People were not always respected, and their dignity was not always maintained. One person told us that a member of staff left them on the toilet for a significant period and did not respond to their requests to be helped, they told us this "upset" them. A member of staff told us that the same person needed support with their continence care at another time. They asked a member of staff for help who told them, 'It isn't their toileting time', in front of the person. The member of staff said this was degrading for the person involved and they reported this but had not received any feedback. The meant the persons dignity had not been maintained on two separate occasions.
● Relatives did not feel their family members were always treated with dignity and respect. A relative told us, "I want my daughter to be respected and cared for appropriately, which hasn't always been the case." They told us of an example where their relative had tried to raise concerns about how they were treated, and they had not been shown respect from senior staff in dealing with these appropriately.
● People were not always treated well. Two members of staff told us how a member of staff 'belittled' a person and had not respected their wishes to be able to wear a hat within their own home, which is something they had always done. Staff told us this left the person feeling anxious and scared to wear their hat as the member of staff had told them it was disrespectful. The registered manager referred this a potential safeguarding concern following the inspection.
● People's privacy was not always respected. People told us of how theirs and other's personal information was discussed openly in front of them by some members of staff. One person told us, "Staff talk about my business and other people's too loudly. It is not nice." This was confirmed by staff who told us some staff don't respect people's confidential information. One member of staff told us, "Staff talk about handover and people's needs in front of people which upsets them and has caused anxiety."
● People told us they had made requests to not have certain staff support them and their choices were not respected. People's care notes reflected that they had been supported by people they did not want to support them.
● The failure to ensure service users were treated with dignity and respect and the failure to maintain service user's privacy was a breach of Regulation 10 of the Health and Social Care Act 2008(Regulated Activities)

Regulations 2014.

● Staff, we spoke with, were empathetic when talking about people and were interested in their wellbeing. One member of staff told us, "I am here for the people, they are lovely, and I enjoy supporting them."
● People were supported to maintain relationships that were important to them. People care plans detailed who was important to them and how staff could support them to maintain their relationships. For example, staff supported one person to maintain a lifelong friendship by taking the person to meet their friend regularly.
●People's independence was supported. Staff encouraged people to do what they can for themselves. For example, one person's shower risk assessment guided staff to support the person's independence and documented their ability to ask for help should they need it.

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

● People did not always feel listened to or involved in making decisions about their care. One person told us they did not want to be supported by a particular member of staff, "I have told lots of staff but (the member of staff) keeps coming to see me. I am not listened to."
● People's relatives told us they had not always been given the opportunity to be involved in care planning and communication with the management team was poor. One relative told us, "The manager was never there. The communication is not good, you would write and email and not get a reply." Another relative told us, "Communication has been difficult. There is no communication with their key worker, I am not sure who they are."
● People's access to support from their key worker and key worker meetings to discuss their care and how they wanted to be supported was mixed. There was no evidence that people had key worker meetings between the months of October to December 2018. This did not provide assurance that people were given regular opportunities to express their views. The registered manager told us these meeting should have happened to ensure people were supported effectively.
● This is an area in need of improvement to ensure people are consistently supported to express their views and be involved in decision about their care and support.

● Some people told us staff listed to them and they had opportunities to express their views. One person told us, "I get to choose what I want to wear, and staff listen to my choices."
● People's communication needs were assessed, and their care plans guided staff on how to support these needs. For example, one person had their own words for different people and objects. Staff were aware of these and we observed staff use these effectively when talking with the person.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Staff did not always comply with the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.
● People were not always given information in the way they could understand. For example, one person had a communication board for staff to put their daily activities on and the staff who would be supporting them. The person told us this was "very important to me" as they liked to plan their day. They said this was not always done and that made them feel "upset and not listened to." On the day of the inspection the communication board was not completed, and the person did not know who was supporting them, they were visibly upset by this.
This is an area of practice that needs to improve to ensure staff are compliant with AIS and for people to receive information in a way they could understand, in line with their assessed needs.
● People's care plans were person centred and gave staff guidance on people's likes, dislikes and preferences, most staff knew people's needs. For example, one member of staff told us how a person loved going for a drive, walks on the beach regularly and had a love of the sea. This was documented in their care plan and their records showed that the person was supported to go to the beach. The person told us they enjoyed their outings to town and the beach with staff.
● People had access to activities that met their interest. People told us they enjoyed how they spent their time. For example, one person enjoyed going shopping, this was regularly planned, and staff took them to different towns, so they could access a variety of shops. Another person enjoyed going to a day centre, they were supported to attend weekly. A relative told us, "They get to do things they like they go swimming and to day centre."
● People had access to different technologies to meet their needs. For example, people used electronic tablets to research and plan outings and holidays. One person had booked a holiday to the Isle of Wight using the tablet to pick their accommodation.

Improving care quality in response to complaints or concerns

● There were systems in place to manage concerns and complaints. However, these were not always followed by the management team to ensure complaints were dealt with effectively.
● One person had made a complaint about the way a member of staff had treated them. A member of the management team did not follow the provider's complaints procedure. They arranged a meeting between the staff member and the person without the person's consent and had not involved an advocate. The person told us this made them feel "upset" and "not taken seriously". Their relative told us, "The (member of the management team) did not act appropriately and my relative was made to feel pressured to withdraw

their complaint, they put them in a very uncomfortable position."

● The management of complaints is an area in need of improvement to ensure complaints are addressed and responded to appropriately, in line with the provider's policy.

● Relatives told us they knew how to make a complaint should they need to.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not well managed, there were significant shortfalls in the oversight and leadership of the service which led to poor standards of care.
- People, their relatives and staff told us the service was not well managed. One relative told us, "I don't think the service is well managed, we feel very let down." Another relative told us, "The management of the service is the crux of the problem. The management have known about the issues and not done anything about them."
- People and their relatives did not know who the registered manager was and did not think the current registered manager still worked for the service. One relative told us, "I didn't realise she was still the manager of Fitzroy."
- Staff told us they did not feel respected or valued in their roles. One member of staff told us, "I don't feel valued at all. The (senior member of staff) can be so rude and never says thank you. Their communication is always negative." Another member of staff said, "I don't feel valued in the role, just there to make the numbers up."
- The registered manager told us they felt stretched across three services when the provider made the decision to reduce the number of deputy managers. This meant the deputy manager presence was reduced at the service for half of the week. Further to this the provider requested the registered manager support a fourth service in Kent in recent months. The registered manager attributed this as a factor to the deterioration of the quality of the service, whilst taking responsibility for failing to maintain oversight of the service. A significant deterioration in the quality of care happened within this time frame. A member of staff told us, "I don't often see the registered manager. She hasn't been around or available."
- The registered manager and provider had not taken ownership or fulfilled their responsibilities in monitoring and supervising of staff. They had not ensured that people were receiving a safe and effective service and that systems and processes were being adhered to. For example, there was a lack oversight by the registered manager of the person they left in charge in their absence. This lack of oversight lead to the quality of care deteriorating.
- Quality assurance systems and processes were ineffective in identifying and driving improvements to the service. There was no formal audit of accidents and incidents, safeguarding referrals or care plans. The lack of auditing meant that they did not have an oversight and could not demonstrate that they were able to identify trends or recognise potential issues.
- Issues we identified at this inspection had not been identified by the registered manager or provider. For example, lack of support and supervision for staff, audits and quality checks not being carried out and

additional safeguarding concerns from our observations of records and discussions with people.
● Issues identified through service audits were not always acted upon. For example, a safety audit of a person's wheelchair in March identified that the persons foot straps were 'wearing' and directed staff to 'keep an eye on them'. The registered manager was unaware of this issue and said a referral should have been made to wheelchair service to ensure the wheelchair was well maintained. This had not happened.
● The provider's Quality Manager had visited the service to complete an audit in January 2019. The audit was ineffective and had not identified concerns we identified at the inspection. There were no clear actions in place for concerns that were identified and there was no evidence that action had been taken or followed up. Their report stated that the service was safe and well-led even though staff had been raising concerns before this time. This did not provide assurance that the provider's processes were robust identifying concerns and driving improvements.
● Documentation relating to people's care needs were not always up to date or relevant. For example, one person experienced an incident of financial abuse. Their financial risk assessment had not been updated following this incident to provide staff with guidance to reduce the risk of this reoccurring. There was a large amount of historical paperwork in people's care plans which made it difficult to understand which guidance was relevant and up to date.
● The failure to assess, monitor and improve the quality of the service and the failure to maintain accurate, contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider failed to ensure they promoted a consistent person-centred, high quality care and support for people who lived at the service.
●The culture of the service was not supportive of person centred, high quality care. Staff told us there was a bullying culture within the service and this had not been addressed. A member of staff told us, "There is a really bullying culture, it makes me really sad." Another member of staff said, "There's bullying between staff and is has not been addressed. I have dreaded coming into work and seeing people looking sad."
● The registered manager arranged a meeting with the provider's HR team and staff in October 2018. This was to respond to concerns around teamwork as it had been identified that there were issues between some members of staff. Staff told us they had a meeting with HR who said they would provide feedback, but this had yet to happen. The registered manager confirmed that there had been not outcomes of feedback given to staff. This meant issues raised by staff had not been addressed or rectified.
●Although the registered manager was aware of the duty of candour, this understanding was not shared by the management team and when staff had raised concerns these had not been acted on in an open and transparent way.
● People and their relatives were not fully engaged in the running of the service. People had limited opportunities to provide feedback on the service they received and did not have access to the registered manager to raise concerns. A relative told us, "Communication has really gone down, something has just fallen apart. They said they were going to do a newsletter once a month but that never happened."
● Staff did not feel engaged in the service and they did not feel listened to. A member of staff told us, "I don't feel listened to and I haven't been listened to my comments to the management are never acted on, so what is the point of saying anything."
● The failure to ensure feedback was sought and acted on and the failure to ensure the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

● There were some opportunities for people to be engaged in the running of the service. One person

attended the provider's national service user forum. This allowed them to represent people living at the home and be involved in decision making about the service.

● Although improvements in management presence and oversight of the service had improved since the local authority began an organisational safeguarding investigation. This needed to be imbedded in practice to drive improvements to the quality of the service and to ensure these are sustained.

● People and staff told us the service had improved in recent weeks due to the steps the registered manager and provider had taken in relation to the safeguarding concerns.

Working in partnership with others

● Partnership working with others to meet people's needs was mixed. Staff had made good partnerships with healthcare professions but had failed to report safeguarding concerns to social care professionals. This had improved since the provider and registered manager were aware of these concerns.

● A member of staff from the local authority told us that the registered manager and provider had worked openly with them regarding organisational safeguarding concerns. They told us they found them to be responsive in making improvements to the service.

● This is an area of practice in need of improvement to ensure partnership working is imbedded within staff practice ensuring all people's needs are met in a timely way.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure service users were treated with dignity and respect and the failed to maintain service user's privacy.

The enforcement action we took:

Positive condition

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to mitigate the risks relating to the safety of service users and failed to act when risks to people were identified to improve their care. The provider failed to ensure staff were competent to administer medicines and the failure to ensure medicines were administered safely.

The enforcement action we took:

Positive condition

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from the potential risk of abuse and avoidable harm.

The enforcement action we took:

Positive condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider failed to assess, monitor and improve the quality of the service and failed to maintain accurate, contemporaneous records.

The provider failed to ensure feedback from people, their relative and staff was sought and acted on.

The enforcement action we took:

Positive condition