Exclusive Care Limited

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Inspection report

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13 July 2018
18 July 2018
23 July 2018

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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

This inspection took place on 11, 13, 18 and 23 July 2018 and was unannounced. This was the first inspection of Exclusive Care Ltd since it registered with the Care Quality Commission on 16 June 2017.

Exclusive Care Limited is registered to provide personal care and support to people living in 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.
The service did not have a manager who was not registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Prior to this inspection the registered provider, who was also registering as the manager was dismissed. The remaining Director of the company identified a replacement provider, and new manager, who had both started at the time of this inspection. Throughout this report they will be referred to as the new provider and manager.

Prior to this inspection we received information of concern about the management of the service. Concerns were also raised regarding people receiving unsafe care from staff who were not sufficiently trained and supported, and management arrangements did not address these issues.

The service was registered to provide personal care from unit G.41, Business And Technology Centre, Bessemer Drive, Stevenage, SG1 2DX. On arrival we found the service had moved location to another office in the same building. This inspection was carried out at unit F.06 of the same address as they had moved location on 06 February 2018 but not informed the Care Quality Commission as required.

During the inspection, we found multiple breaches of regulations. These related to a lack of safe care and unsafe risk management, placing people at risk of harm; insufficient staff to support people safely; the safe management of medicines; poor quality staff training; care planning and review; poor-quality monitoring system and poor managerial/provider oversight.

As a result, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The

expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

People were not supported by a sufficient and consistent numbers of staff. This led to the provider closing of one of the supported living schemes and the two-people living there having to move to other services. Staff were recruited safely and employment checks carried out before they started work.

Risk management required improvement. People had some risk assessments in place but these required more information to help staff minimise the risk. Where there was no risk assessment to manage the change in a person's physical, emotional, mental health needs, people had suffered poor standards or care. Staff were not all confident in identifying and reporting concerns about a person's welfare. We identified incidents where people may have been at risk of harm that had not been reported as required. People's medicines were not managed in a safe manner.

People felt that staff competency and ability to provide care effectively varied. Staff told us they did not feel all the training provided to them was beneficial, and did not all feel supported in their role. Staff did report an improvement since the new manager started.

People's consent was sought when care was provided, however consents to care were not signed. People were supported to choose and prepare their own meals, but staff did not support people to consider healthy choices. People were supported by a range of health professionals but did at times experience a delay in being referred.

People's relatives felt the service was caring and felt staff treated people in a dignified manner. However, we found examples where people had not received care in a dignified manner and staff had not promoted people's own choices at all times. Staff supported people to maintain links with their families and friends. Staff knew how to keep personal information confidential.

People's care needs were assessed and care plans developed. However, some care plans were missing, some were significantly out of date, or did not contain all the required information to guide staff in supporting people in a safe manner. Staff knew people's needs well and were good at supporting them to access a range of community facilities of their choice. This helped people to remain part of their local community. People's relatives gave a mixed response regarding raising their concerns. Some felt comfortable in doing so, however others felt they did not receive an outcome when they did.

Staff and relatives did not think the service was well led. The current provider and new manager were open and honest throughout this inspection, responding quickly when issues were identified to mitigate the risks. There was not an effective system of governance in place to monitor the quality of care people received and identify where improvements were required.

The service was incorrectly registered with the Care Quality Commission, and did not submit notifications of changes to the management team, or significant incidents as required.

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.

People were not supported by sufficient numbers of staff.

Risks to people's safety and wellbeing were not managed or assessed, staff did not have sufficient skills or experience to provide care safely.

People were not consistently protected from harm as staff were not confident in identifying, reporting or responding to the risks of abuse occurring.

Staff did not routinely review and learn lessons from incidents.

Peoples medicines were not managed safely by staff who were not competent to do so.

People lived in a clean environment, staff provided care to people in a hygienic and sanitary manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not sufficiently trained or supported to provide effective care.

Staff felt the training they received from the provider was of poor quality and did not equip them with the skills needed.

Verbal consent was sought from people prior to assisting them, however consent was not documented in care records.

People's nutritional needs were not consistently met.

People were supported by a range of health professionals, however staff did not always refer to those professionals promptly.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care records and the language used to describe people's behaviours or personalities was not dignified at all times.

Staff knew peoples social needs well but did not consistently support them in a way that met their preferences and choices around the way they lived their lives.

All the people's relatives we spoke with felt that staff all had a caring approach.

Staff respected people's privacy and dignity and supported them to maintain relationships that were important to them.

Staff knew how to keep personal information confidential.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples care records were not reflective of the persons current needs. An assessment of people's needs was not always carried out.

Staff knew people's social needs well but not all people were supported to follow their own hobbies and interests when they chose.

A complaints policy was in place but people's relatives gave mixed feedback about how effective this was.

Is the service well-led?

Inadequate

The service was not well led.

People's relatives and staff told us the service had not been well led, but had improved with the new management team.

Systems and processes to monitor the quality of the service were not effectively used to identify areas for improvement and ensure people received safe care.

The service was incorrectly registered at the wrong address.

Notifications of significant events were not made in a timely manner as required.

People's care records, and records relating to the management

of the service were not accurately maintained.

Exclusive Care Limited

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of the departure of the nominated individual, who was also registering as the manager of the service. Concerns were raised about the nature of this person's departure and risks to the safety and welfare of people were also reported.

The information shared with CQC indicated potential concerns about the risk of unsafe care, insufficient staff, poor training and support to staff and a lack of overall managerial oversight. This inspection examined those risks.

This inspection took place on 11,13,18 and 23 July 2018. On 11 and 13 July 2018 we visited the office and one of the supported living schemes. On 18 and 23 July 2018 we spoke with health professionals, people's relatives and staff by telephone to gain their views. Further concerns were also reported to CQC regarding people's nutritional needs which we followed up by speaking with the local authority and the provider to ensure these needs were met. This inspection was carried out by one inspector. We gave the service 48 hours' notice of the inspection visit because it is small and we needed to be sure management would be available to meet with us.

We asked for a Provider Information Return (PIR) to be submitted to us and reviewed this as part of our inspection planning. This is information that we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, during our inspection visit, we gave the provider the opportunity to give some key information about the service, what the service does well and improvements they planned to make. We reviewed the information we held about the service such as statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

During this inspection we spoke with the remaining company director, newly appointed nominated individual, newly employed manager, the deputy manager, a registered manager from another of the providers locations, the deputy manager, four members of staff, and five people's relatives. We reviewed care records relating to four people who used the service, along with records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

There were not enough staff deployed to safely meet the needs of people who used the service. At the time of our inspection the provider was not aware of the total number of care hours they were meant to provide people. We requested on three occasions for a breakdown of core staff hours required, and a breakdown of the hours provided at the time of our inspection. This was not provided and the new provider told us this was not an area they monitored. This meant when planning how to provide care to people the management team were unaware of the required number of care hours.

People's relatives told us there were insufficient staff available to support people, and that staffing was not consistent. One person's relative said, "The staff count is poor only one or two members of staff on at the weekend when they [People living in the supported accommodation] are all requiring one to one support there should be three staff during the day. They continued "[Person] has autism and so likes to know plans for the week so they can talk and prepare for them. To now [Person] can do what they need so it's not too bad and we take [Person] out at the weekend, but if staffing gets any more stretched there will be problems."

The provider supported people across five supported living schemes. We found at four of these schemes staffing levels fluctuated, however people received their personal care as required. For example, people were assisted with shaving, applying creams and prompting to get ready for the day. However, people's quality of life was at times affected by the inconsistency of staffing levels. One person's relative told us, "I would like them to be more organised to plan ahead with staffing levels. To relate to [Person] in a way to give [Person] choice of an activity not just say what would you like to do? [Person] enjoys going out but staffing doesn't allow it all the time." They continued to say, "Until the staffing levels are consistent [Person] won't get the Motability car as [Person] would be losing out on money. The car would be wasted with no staff to drive it, staff levels are improving but there is still a way to go before making it feel like home for [person]." In the four supported living schemes with people with lower personal care and support needs we found the staffing levels impacted mostly around people's independence and choice about how they spent their day.

However in one of the units based at Neptune House we found staffing levels contributed to the breakdown of the placements of two people living there. One health professional told us," Despite a multi-professional approach [Person] required moving to a new placement. Over the last few weeks there had been issues with staffing for [Person] who struggles with agency workers." We found that this person required stability with staff and having staff around them they trusted and felt secure with was key to providing care and support the person would respond to. This person had been supported by numerous agency staff, none whom were trained to specifically support people with autism, as well as by constantly changing employed staff drafted in from other locations operated by the provider. One of the key support requirements for this person and another person living at the scheme were to have support provided by a regular and consistent staffing team. This did not happen.

During our inspection, the second person living at this scheme was removed by the local authority as the

service was not able to provide sufficient staff over the weekend, and could not guarantee sufficiently skilled staff would be available to meet that person's needs. We spoke with this person's relative who told us they recently attended a meeting with the provider who advised them they could no longer provide care for this person, and that they could not be sure they could manage the next few days due to staffing. We found the registered manager from another of the providers residential services had been covering shifts, using agency staff and existing staff who had been working excessively long additional hours in an attempt to stabilise the staffing in the short term. For example, we found one person had worked the previous waking night shift, then collected the person from the college they attended daily and worked the following night shift.

As the lack of staff had negatively impacted on people's care and well-being and placed them at risk of harm, we reported our findings to the local authority commissioning and safeguarding team.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 as sufficient numbers of suitably skilled and experienced staff were not effectively deployed.

Risks to people's welfare were known but not routinely assessed. For example, one person with diabetes did not have a management plan in place or risk assessment to document the concerns. A second person was identified as at risk of choking and physical sickness and although staff considered this to be due to anxiety, they had not developed a risk assessment to manage the risk or made an appropriate referral for a specialist speech and language therapy assessment.

Where risks to people's safety and welfare were not routinely assessed or managed this had led to unsafe care being provided. For example, one person who required a higher level of support both with their learning disability and day to day care did not receive this. Staff were poorly trained to identify and respond to incidents where this person needs changed, resulting in the care package being removed for the persons own safety by the local authority. We also found that one person had been removed from the service and transferred to a different provider because staff were not equipped to manage the risks associated with this person's care safely.

Daily records showed that for another person who had been displaying signs of agitation and aggressiveness, and staff suspected they had been hearing voices. This indicated there may have an undiagnosed mental health condition. However at that time the person had not been referred to specialist mental health services, and was receiving no treatment for this to relieve the symptoms.

Staff monitored the food and drinks that people ate and drank, however where people refused their meals, this did not prompt staff to develop a risk assessment or refer people to the appropriate professional. There were no environmental risk assessments carried out on people's homes to ensure areas of risk had been identified. For example, to identify any potential trip hazards to staff or people when providing personal care.

People's medicines were not safely managed or administered. Medication administration records [MAR] were not completed as required. For example, staff did not counter sign the MAR when signing in medicines, and had not recorded the dosage or quantity for one persons medicine even though they had been administered on two days. Dates when medicines were opened were not recorded, and we were unable to effectively audit the medicines administered to people as stock records were not available. We were able to ascertain that as required [PRN] medicines for one person had too many held in stock, and where people's relatives brought medicines over the counter, staff did not check with the GP if it was safe to administer in conjunction with the prescribed medicines. Where people took medicines home, staff did not sign them out, and did not sign them back in when they returned. Staff would not be aware if a person had not taken their

medicines, and would not be aware they were putting additional stock into the cupboard as they did not routinely audit these.

People had PRN protocols in place that described when and how to administer medicines such as pain relief and medicines for epileptic seizures. We looked at one PRN protocol, which did not describe the difference between types of seizure and when to administer the medicine. Although this person had not had a seizure for over two years, the guidance was not clear and placed the person at risk as staff awareness and training had not been effectively provided.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People's relatives told us they felt the care provided was safe. One relative said, "Its safe, but there are niggles, like at the weekend they have 1 or 2 staff when they are all one to one so should be three. I think they are well cared for." A second relative said, "I don't worry about [Person] when I'm not with them, I am sure they are well cared for."

Staff spoken with told us they were not confident in reporting concerns where people may have been at risk of harm or abuse. We found that not all incidents or concerns were reported to the provider. This meant that repeated behavioural incidents, unexplained bruising or other incidents were not considered to be referred to the local authority safeguarding team. Incidents had not been robustly investigated or reported to the appropriate authority. For example, a staff member expressed their concerns to the previous manager about a particular support worker following an incident,. The staff member was asked to go on annual leave and was then demoted and moved to another service without full investigation of the incident or staff member's conduct.

We reviewed a second incident and found one person had become agitated when staff prompted him to go to bed. Staff response to the person had compromised the person's dignity but there had been no follow up action by the management of the service.

Where incidents had been identified and investigated, or the outcome of safeguarding concerns known, lessons about these had not been discussed or shared to minimise the incident recurring. For example, medication errors that were identified were not addressed through a reflective discussion, neither were staff responses when people's behaviour challenged others. This opportunity was not provided for staff to reflect and learn from incidents, and subsequently similar issues recurred which may have been avoided had staff considered their practise.

This meant that where people may be at risk of harm or abuse, staff knowledge and management of the incidents did not ensure people were kept safe from the risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were employed following a robust recruitment process to ensure they were of sufficiently good character to work with people. We saw that references had been sought from previous employers, a criminal records check had been carried out, and people's identity had been verified. Where people worked in the service from overseas, the appropriate immigration checks had been made to ensure people were entitled to work. However, where there were gaps in people's employment history these had not been documented. Staff advised us they had discussed this with the staff member, but could not recall the gaps.

People lived in a clean environment that was well maintained. People's relatives told us that staff were

aware of infection control processes, and wore appropriate protective equipment when providing personal care to people.

Requires Improvement

Is the service effective?

Our findings

People's relatives gave mixed views on the skills and experience of staff who supported people. One person's relative said, "The permanent staff for [Person] seem to be equipped for the job, they know what they are doing." However, a second relative said, "The quality of the staff is not great." A third relative spoke about the scheme manager at the supported accommodation their relative lived at, saying, "Manager" has the enthusiasm, energy, knowledge, knows how to interact, but the other staff, I want to give them a kick them up the backside to get them to be proactive, enthusiastic, interactive."

Staff spoken to told us they did not feel supported by the management team. Regular supervision meetings were not consistently held to give staff the opportunity to discuss their performance, set objectives and talk about their role. Supervisions were due monthly, however none of the 28 staff employed received supervision monthly. Four of these staff members had received no formal support since January 2018. One staff member told us, "Supervisions were not as frequent as they should, when I went on the system to look at the notes of my last one they had not been updated so there was no record of what I needed. I didn't feel supported not by [Previous provider] we could never get hold of them, if we needed support, their phones were off especially Friday to Monday."

Competency assessments of staff's ability to carry out their role safely were not completed. The provider told us, "All of the training on the training matrix is e-learning and neither previous manager assessed people's competency to make sure they had absorbed some of the training."

We looked at the training provided to people and reviewed training records. When we spoke with staff about the quality of in house training provided they told us it was not very informative. One staff member told us, "The epilepsy and buccal training was done in half an hour, the rest is e-learning but [Training manager] doesn't check what we learnt. They just want the certificate at the end to show we did it." A second staff member said, "The training was rubbish, nothing to help us do the job. We all sat around a laptop in the middle of a desk, crouched round looking at something I could have got off the internet. I didn't learn anything it was just done to tick a box."

Training that was provided to people was not always specific to the individual needs of people. For example, people who were supported lived with some form of autism. However, staff had not received training relevant to supporting this need. The provider told us, "We didn't adapt our training to meet [People's] behaviour changes. Autism training has been delivered by [Manager from another of the providers service's], but they are currently not qualified, but they had been asking but it was never given." One staff member told us, "In my view, the whole thing has been mismanaged. Most of the staff were never trained sufficiently to deal with challenging behaviour, or had any skills in de-escalation strategies or last-resort restraint techniques. We have had breakaway training, that's as far as it's gone. Epilepsy training was 20 minutes."

Staff who had difficulty using the technology or understanding the content did not receive additional support from the provider. We read the minutes of a team meeting chaired by the previous nominated

individual, with the training manager present. These minutes showed that one of the managers raised concerns about a staff member being able to complete an online course. They said this staff member struggled with the light in the service and found using technology challenging. The response from the previous nominated individual was that this staff member would then lose their job. Staff were not supported in the role to develop their skills.

This meant that the provider and management team did not ensure staff were provided with the appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives told us that staff sought people's consent when seeking to offer them assistance or when asking how people wanted to spend their day. Staff were aware of the need to seek consent, and were aware of the numerous ways people can provide their consent, either through verbal agreement or where people may not be able to verbalise their consent and use other methods. Staff were able to tell us where people did not consent to certain things, such as getting up or going out for an arranged activity. Staff told us that they would respect the persons decision, but would then gently prompt and guide the person. However, care records consistently did not record either the persons or their representatives consent being signed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that staff were knowledgeable about the principles of the MCA and the need of best interest decisions to ensure the care people received was in their best interest. For those people who were unable to make their own decisions around areas such as finance, we saw the appropriate deputyships were in place. These are people who are authorised by the Court of Protection to make decisions on their behalf,

The homes people lived in were comfortably furnished and separate space for people to eat their meals was provided. This dining area was spacious, clean and enabled people to eat together and create a warm and sociable atmosphere when people ate. Staff ensured people were provided with sufficient drinks and were aware of any dietary needs that people may have. For example, if people were diabetic or had swallowing difficulties. We were told about one person that staff were supporting with weight loss, introducing lower calorie snacks and supporting them to attend slimming services which was resulting in the person achieving their target weight.

People were able to choose what they ate, and staff gave varying levels of support to people to either eat their meal or offer encouragement. However, we found that staff did not consistently promote healthy choices for people, and although they respected people's choices, did not encourage people to eat a varied balanced diet. For example, one person for a period of two months ate bread for breakfast and mash, peas and sauce for dinner. When they ate lunch this was usually take away foods. Staff did not review this with the person or support them to consider alternatives . We found similar entries in people's food records that demonstrated staff did not support them to make healthy food choices.

People were supported by a range of health professionals; however people had experienced a delay in staff referring them for specialist support or care. Relatives and staff told us people saw the GP and care records showed people also saw the dentist, optician, community psychiatric teams, and specialist associated with their learning disability such as social workers or speech and language therapists.

Requires Improvement

Is the service caring?

Our findings

People's relatives told us they service was caring. They told us staff were friendly with their relative and where staff were regular had formed relationships with people they supported and knew them well. One person's relative said, "[Staff name] is fantastic, always very patient and kind which I know can be a challenge. All the staff I have come across in fairness are deeply caring, it's just a shame that Exclusive Care didn't show the same respect." During the inspection we found this was an emerging theme from the feedback we received. The views or people, staff and health professionals all felt staff were caring in their approach, but the management of the service meant the provider was not viewed to be a caring organisation.

People's relatives and health professionals told us that staff took the time to get to know people and listen to their views and opinions. People's relatives told us that staff were sensitive and kind, and were always prepared to go the extra mile to make someone happy. They further explained that staff know the little things about people and know it is important to do the little tasks. For example, one person before going to college was supported by staff to get their rucksack ready the night before. Staff and the person spent time preparing the equipment and getting things ready so to relieve this person's anxieties.

Things that were important to people around their preferences, likes and dislikes were equally important to staff. For example, one person was clearly very fond of the colour purple. Staff had supported the person to decorate their room, which when we looked saw it was adorned in various shades of purple from the wallpaper to the bedding and furnishings. When this person required support from staff to acquire a vehicle, they all ensured the colour was purple. This demonstrated to us that staff clearly understood and listened to people's views, and went beyond of what was expected of them to support people's individual preferences.

However, although people's preferences were recorded and clearly identified where people liked to go to spend their day and when to go to bed, staff did not always follow this choice. For example one incident recorded that a person was happy sitting in the lounge using their iPad. Staff approached and told them it is time for bed. The person becomes agitated as staff tried to prompt them to go to bed. The situation escalated and the person became challenging, aggressive and angry, challenging the staff who subsequently withdrew. The person settled down, returned to their activity and when ready to go to bed, took themselves away with no issues. Had staff respected this person's choices and preferences around how they lived their life, this incident may not have occurred.

We identified other examples where staff had tried to implement 'House rules' which remained in place from when the service was a residential care home. Staff's understanding of supported living was conflicting, they did not appreciate that people lived in their own home and staff merely supported them with their personal care needs. Staff who worked in a more structured residential environment were not used to people having full control and autonomy over their day to day decisions.

The language used by staff to describe people in daily records did not always promote their dignity. For example when one person became agitated and upset, staff recorded that they, "Were crying like a baby!."

When describing what people had done with their day, we saw numerous comments such as, "[Person] was playing in the lounge." This language did not promote respectful, dignified support.

All the relatives we spoke with told us they were encouraged and supported by staff to maintain relationships with them, and to develop new relationships with people they met through day to day activity. People had a varied activity schedule that enabled them to build and maintain close ties at places such as day centres, activity clubs and social functions. People's relatives told us staff were welcoming and friendly and did not feel under pressure when they visited, and that staff were happy to bring people to the family home for evening meals and social events if needed.

People's confidential care records were not stored securely within the shared home. People's care records containing sensitive information about their support needs were stored in an unlocked cupboard under the stairs in one house, which meant visitors had access to this information when they visited.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support that did not respond to their needs. Each person had an individual care plan; however, the quality of the information contained in them was variable. Where a care plan had been developed, these were well written detailed and left the reader in no doubt about how the person received their care. However other identified needs had not consistently been updated to accurately reflect people's changing needs. For example, two people's support needs had changed significantly in the weeks prior to our inspection but their care plan had not been amended to reflect this. Staff did not have access to clear guidance to inform the support provided and placed people at risk of inconsistent support that did not meet their needs.

People were provided with opportunities for social activity and regular holidays. Staff were planning a camping trip this summer for two people, whilst another person had been on holiday camping with their day centre. In another scheme one person had been on holiday abroad with their family and was planning a further trip with staff. Staff actively encouraged people to take a holiday each year, and where necessary looked at ways they could support them with a short trip if relatives were unable to.

Peoples experiences of being supported with their interests and activity was variable. At most of the supported living schemes activities were provided by staff on an individual basis in accordance with people's wishes. Weekly schedules of activity were organised such as going to day centres, colleges, or specialist groups to aid people's independent living skills. Outside of these times people were free to choose how to spend their time. For example, one person woke up on one weekend, liked the look of the weather and wanted to swim in the sea, so staff took them. Other examples of impromptu activity were things such as shopping trips, regular trips to the zoo, bowling, or disco's among a range of other things people could do. However, other people in another supported living scheme were not supported in the same manner due to insufficient staffing.

People were supported to remain as independent as possible. Where people required help with getting washed or dressed, staff ensured the person did as much as they could. Staff would intervene with help to shave people, or wash areas difficult to reach. The ethos of the service was to enable people to manage as many areas of their life as they could. For example, with people's medicines, we were told how staff supported people to be independent. They told us they were encouraging one person to inject their own medicine. They were working with a health professional to gain the confidence and understanding to manage this themselves. A second person staff were beginning to support to self-administer were gently making them aware of what the medicines were, what they looked like and what they did so they could begin. A third person, not ready to administer their own medicine was encouraged to complete their own temperature records of the medicine cabinet in their room. Staff had developed an accessible format MAR sheet for the person to complete themselves as the staff administer their medicine so they can become comfortable with the process. These were all areas that people had expressed their wish to manage and staff were actively supporting them with tis to respond to their individual wishes.

However, people were set daily targets which when reviewed were meaningless and not person centred. For

example, staff recorded 'people to have a good day or too remain happy.' People's targets did not link to the persons wishes, and did not link in with behavioural support plans. Where the target given was to be happy, there was no plan for how this would be achieved, recognised and responded to.

People's relatives told us they felt confident in raising a concern or complaint with the management team. One person told us, "I would have no problem discussing any issue with the staff or with the manager if the need arose, and they would follow it up." Complaints were mostly dealt with by the supported living scheme team leader. However when we asked the same question about the previous management team relatives were not so positive. One said, "I tried to raise one [complaint] but just felt I was getting nowhere so dropped it."

People's relatives told us that they had been kept informed of developments within the service, by both the previous management regime and the new one. They told us they felt it important to be kept abreast of developments, particularly given the emerging management concerns, One person told us, "I have been unsettled by the recent events but was reassured at the meeting yesterday that the service is and will continue to be sustainable." A second relative said, "I think they [Exclusive Care Ltd] have been very open and I feel confident things will move in the right direction given time."

Inadequate

Is the service well-led?

Our findings

People's relatives and staff told us the service had not been well led. One person's relative said, "I feel really disappointed, let down and sad by the management." One health professional said, "This is the current issue, it is not well led by a management team that listens to their staff. There is not management overnight, three levels of management from area manager to Director have left." Staff spoken with were equally critical of the previous management support, however, through the inspection we found staff's opinion changed positively. One staff member said, "They are the three musketeers, they are working well. Before it wasn't what it should have been, we were told things would happen and we would be an outstanding company but it never emerged. Now we all have stepped back and looked at how it was we can see how bad things were. It is going to be a massive learning process for all of us, but it feels we are in it together." A second staff member said, "Management are there now, last night I emailed [Manager] and they came straight back to me. The new managers are approachable and we see them, which is a big change. I know we are going to have a tough time over the next few months, but I feel we will get there now the managers are listening."

The service at the time of our inspection did not have a manager registered with the Care Quality Commission [CQC] as they are required to. The service also did not have a nominated individual registered with CQC as required. These two posts had been covered by the same person who was the Managing Director of the company. Prior to our inspection they had been asked to step down from their position by the Director.

Staff told us they had team meetings with the previous manager but did not feel they listened to their views and opinions. Meetings were held infrequently, and did not follow a set agenda. Staff were not able to suggest items to add to the agenda for discussion. One staff member said, "[Previous manager] wouldn't listen to us and increase staff wages in line with other companies, so attracting and keeping staff was nearly impossible. That's partly why we couldn't provide care at [Location]. [New NI] has at least listened to this and has increased wages at our request." A second staff member said, "We had a team meeting last week and I honestly think it was the best we've ever had, and I have been here for two years. It was very honest and they wanted to hear our thoughts and ideas of how we can improve."

During the inspection, the new manager, new provider and remaining company director met with people's relatives to explain the changes in the management structure, to listen to people's concerns and offer reassurance regarding the viability of the company moving forward. Relatives we spoke with told us this was a positive meeting and they felt more at ease having been informed. One person's relative confirmed this by saying, "I was assured, as other parents were, that the recent issues did not compromise peoples individual care". They continued, "There are issues but I have every faith that the silent partner will work to bring the service back up."

Systems were in place but were not effectively operated to monitor the quality of care people received. Areas such as staffing levels, staff absence, incidents, injuries, medication errors and safeguarding concerns were not routinely reported to the provider. The provider did not have a system in place to review, monitor and improve the safety and quality of care. One senior staff member told us, "The [Previous provider] used

to do the quality audits, but we had to stop them as they were of poor quality. [Previous provider] would do them in an hour. Then we outsourced it and had an external company do it, but that had to stop as they didn't understand supported living and the actions they gave were not relevant. Then one of the managers [Supported living] did them but later left the company. At the moment nobody is carrying out the audits. The last audit carried out by the provider was on 29 December 2018."

Action arising from audits completed by senior staff in the individual supported living schemes were not completed. Many of the issues identified For example, one scheme completed their own in house audit in December 2017. This was the last one completed. Actions arising were for specific training in relation to autism and first aid for staff, medicines competencies and completion of the care certificate. It was also identified that monthly reviews of incidents were not carried out, and medicines audits, which were required monthly had not been completed since September 2017. An audit of medicines was not completed until after our inspection.

When reviewing the audits for the various supported schemes, we found duplications of the findings, which demonstrated they had not been completed robustly. However, where the auditor raised concerns with the previous provider, such as training, these concerns were ignored. Once the quality auditor had left the organisation in January 2018, no further audits of the quality of care were carried out until the new manager carried out their own in July 2018.

The local authority commissioning team had visited the service in July 2017 and had identified concerns around management , quality of care, staffing levels, training and development and management of medicines. An action plan had been put in place by the local authority, however none of the historical actions had been addressed and remained outstanding at this inspection.

At the time of the inspection the service did not have a service improvement plan. There were no plans to improve the quality of care people received, feedback on the service had not been sought, and staff and team leaders told us they had been left to manage themselves. One staff member said, "Looking back we were just left, if we wanted to make things better or suggest an improvement we were told not to worry and things would be alright. It's better since the new management structure is in place, we are all in it together now and I can see a way forward, but before we were on our own."

People's care records when completed were accurate depictions of the care people required or had received. However, gaps were consistently found in areas such as recording what people ate or drank, they did not record or document a review of people's changing needs, such as when people displayed behaviours that challenged. For example, where people experienced changes to their mood or mental health. Although care plans were descriptive, they were not accompanied by a written risk assessment for all people. For example, one person had a risk assessment in place for finance, medicine, eating and drinking and personal care. However, for a second person, the accompanying risk assessments were not present. Areas that staff had identified people required additional support were not documented, for example with support during the night. Care plans were not regularly reviewed. For example, one person had moved to the service in September 2017. No further update or reviews of the care records had been completed. This meant that an accurate, up to date record of people's care needs had not been maintained.

Due to the ongoing lack of managerial oversight and effective governance to ensure people received safe care, lack of staff support and not documenting when people's care needs changed. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was incorrectly registered. The service was registered to provide personal care from unit G.41,

Business And Technology Centre, Bessemer Drive, Stevenage, SG1 2DX. On arrival we found the service had moved location to unit F.06 at the same address without notifying the commission as they are required to do. We confirmed with the interim nominated individual that the service had moved location on 06 February 2018. Additionally, where there had been changes to the organisational structure, CQC had not been informed in a timely manner. The provider had also failed to inform CQC of the departure of the nominated individual and manager on 20 June 2018. CQC was informed by people's relatives and an anonymous telephone call. This was a breach of Regulation 15 of the Care Quality Commission Regulations 2009.

Notifications of events within the service such as safeguarding had not been made in a timely manner. This was a breach of Regulation 18 of the Care Quality Registration Regulations 2009.

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 15 Registration Regulations 2009 Notifications – notices of change Regulation 15 (1) (d) (e) (i) (ii) Care Quality Commission (Registration) Regulations 2009 Notification in writing was not submitted to the Commission, as soon as it was reasonably practicable to do so. Where the service provider is a partnership, there had been a change to the membership of the partnership. CQC had not been notified in writing of the change address of the location that regulated activities were carried out. CQC had not been notified that there had been a change of director and nominated individual.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) Notification of other incidents. The provider had not notified CQC in a timely manner of incidents specified in paragraph (2).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) Safe Care and Treatment

Risks to people's safety and welfare were not routinely assessed or managed and staff were not sufficiently trained or equipped to manage people's changing needs.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment Regulation 13 [1] [2] and [3] People were not protected from the risks of harm or abuse. Systems were in place but not operated effectively to identify, respond, investigate and monitor immediately upon becoming aware of any allegation or evidence of such abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Good governance The provider had not assessed, monitored and improved the quality and safety of the services provided. The provider also had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of people using the service. An accurate and contemporaneous record of people care and support needs had not been maintained.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a) Staffing

Sufficient numbers of suitably skilled and experienced staff were not deployed to safely meet people's needs.

The provider and management team did not ensure staff were provided with the appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties.