Care Quality Commission

The Sandwell Community Caring Trust

Sandwell Community Caring Trust

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sandwell Community Care Trust is located in West Bromwich in the West Midlands. It is a charity run trust and supports people who live in their own home. It is registered to provide personal care to people who have a learning disability or may have a physical disability. At the time of the inspection Sandwell Community Care Trust provided support to 150 people.

People's experience of using this service and what we found
A safeguarding concern had not been reported to the relevant authority without delay. Risks were assessed but guidance to staff was not always clear. Some improvements were needed to ensure good infection prevention and control practices. People and relatives told us they felt safe. A consistent staff group supported people who knew their needs well.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. There were no mental capacity assessment or best interest decisions in place and the MCA policy was unclear on staff and managers responsibilities.

Staff had not received up to date training and competency assessments to ensure they had the necessary skills to support people. The service worked with other professionals to support people with complex health needs to remain living in the community.

Audits had not been robust to identify the concerns and shortfalls we found on the inspection. The provider had not always followed good practice guidance and legislation to ensure people received good quality care. People and most relatives felt able to raise concerns with the management team and were positive about the care they received.

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

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

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

Rating at last inspection (and update)
The last rating for this service was Good (published 9 April 2019).

Why we inspected

We received concerns in relation to the providers understanding of obtaining consent and the principles and codes of conduct associated with the Mental Capacity Act 2005. We were made aware of an incident where Sandwell Community Caring Trust failed to apply these principles for the people they were caring for. We reviewed information we held about the service and identified concerns related to staff training and safeguarding. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well Led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sandwell Community Caring Trust on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, staff competency and training, consent to care and governance at this inspection. In response we issued a warning notice, imposed conditions on the provider's registration and asked them to send a report that says what action they are going to take.

Follow up: Special Measures

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 provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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Sandwell Community Caring Trust

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an assistant inspector. An Expert by Experience completed telephone calls to relatives following the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 66 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service supports many people at multiple locations, and we wanted to ensure documentation from some settings was available to review on arrival.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and eight relatives about their experience of the care provided. We spoke with nine staff members including the nominated individual, the registered manager, two managers and five senior carers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and several medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including checks and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, provider policies, risk assessments, quality assurance records, feedback records and staff rotas. We spoke with one professional who regularly visits the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
● Where a whistle blowing concern had been raised about potential neglect, the provider had failed to follow procedures to safeguard vulnerable adults and there had been delay in reporting the concern to the relevant external agency. This meant people had been exposed to ongoing risk.
● The provider's safeguarding policy was out of date and did not reference current legislation. When we brought this to their attention, they agreed to update this immediately.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

● People and relatives told us they felt safe. One person said, "I feel safe, I have care 24:7, staff are so good."

Assessing risk, safety monitoring and management
● Whilst risk assessments were in place, some care records contained unclear information. For example, for one person who had a specialist health condition there was conflicting information about when the GP should be contacted. However, the person had consistent carers who knew them well and could describe the appropriate action to take to support them safely.
● Monitoring records were completed to support people with specialist health conditions. Records showed that people were receiving support in line with their care plans.
● Staff were knowledgeable about people's needs and the action required to keep people safe and reduce the risks of harm.

Learning lessons when things go wrong
● Recording and oversight of medical appointments had been improved across the service after the provider identified concerns. However, the provider had not taken enough action to share learning across the organisation and improve care following a safeguarding incident.
● Incidents and accidents were recorded and there was action taken to improve care. For example, in response to a medicine error the handover process was being updated to improve information sharing between staff.

Preventing and controlling infection
● We were somewhat assured that staff used Personal Protective Equipment (PPE) effectively to safeguard staff and people using services. Although we had assurances staff were wearing PPE some staff did not know

the correct way to don and doff their PPE. This is important as it helps to reduce the risk of contamination. The registered manager took immediate steps to address this following our feedback.
● We were somewhat assured that staff training, practices and deployment showed the provider could prevent transmission of infection and/or manage outbreaks. The provider had ensured staff were deployed to work with a small group of people in order to reduce transmission and one person had been supported to isolate with a small staff team on their own to reduce risks. However, a large number of staff had not received Infection Prevention and Control training for over four years, and there were no competencies in place to ensure good practice in this area. At the time of the inspection staff were being booked onto this training.
● We were assured that people were supported with safe visits.
● We were assured that there was adequate access and take up of testing for care staff and people using services.
● We were assured that people were supported to minimise the risk of catching and spreading infection.
●We were assured that people were supported to maintain safe levels of hygiene to minimise the risk of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely
● Where people needed their medicines 'as and when required' protocols required more guidance for staff to follow. Staff we spoke with knew people well, but the lack of guidance increased the risk of people not having their medicines when required.
● Staff told us they felt confident providing support with medicines and had received training.
● Medicines administration records showed people received their medicines as prescribed.

Staffing and recruitment
● The service did not use agency staff and a consistent care staff team was used to meet people's needs. This meant people received their care from staff who knew them well and the support they required. A relative told us, "They know [person] better than I do. [Person] is so happy."
● The provider had a recruitment process which involved recruitment checks to ensure newly appointed staff were suitable to support people. We found that the process included the completion of a Disclosure and Barring Service (DBS) check and references. A DBS check was carried out to ensure the provider had employed suitable care staff to support people.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- We found decisions had been made on behalf of people who lacked capacity without the principles of the MCA having been followed. This included using surveillance equipment and administering medicines covertly. The management team had limited knowledge of MCA and the process of how decisions should be made for people who lacked capacity.
- Most staff hadn't received any recent training in relation to MCA and some staff had never received training. Staff knowledge was limited.
- The service had not explored how to support people in the least restrictive way. One person was unable to access their kitchen due to identified risk. Alternatives had not been explored, which meant people were not able to freely move around their home.
- The provider had failed to ensure people's needs were assessed in line with good practice guidance and the law. Some records referred to relatives making decisions on behalf of people when they had no legal authority to do so. This was not in adherence with national guidance in modernising care models such as Right Care, Right Support, Right Culture. This guidance promotes a model of care which maximises people's choice, control and independence.
- The provider's Mental Capacity Policy did not include how they would ensure the principles of the MCA were applied in practice or the responsibilities of staff to support people to make decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

● Staff and relatives told us how they supported people to make day to day choices. One relative said, "[Person] dictates to them. [Person] has a lie in at the weekend."

Staff support: induction, training, skills and experience

● Regular competency assessments were not taking place to ensure staff had the skills and knowledge to support people. A medication competency assessment was completed when staff began to work with the provider, but this was a one-off assessment unless there were concerns. Although medication errors were low, some staff hadn't had a medication competency completed for over four years which increased the risk of unsafe care.

● Some people required support with clinical tasks, which required oversight from a health care professional. Although staff had received training there was no written evidence of regular staff competencies to assess if they had the skills to carry out these tasks. Following our feedback, the registered manager told us they would address this concern.

● The provider shared their training matrix which showed a significant number of staff had not received some training for over four years. This included mental capacity, infection control, fluid and nutrition, health and safety and equality and diversity. Whilst training had been impacted by COVID-19, the provider had not explored alternative methods, such as e-learning. Although, we saw evidence that the provider had begun to address this concern, the lack of training meant some staff had poor understanding, for example in relation to mental capacity and infection control practices.

The provider's failure to ensure staff had the required skills and competencies was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

● People had oral health care assessments in their care plans and had recently seen a dentist. Some people's daily records were not always completed to show the support they had received with oral hygiene and staff had not received training. Following this feedback, the registered manager agreed to address this.

● Staff had a good understanding of people's dietary needs and personal preferences and could explain how they safely supported someone who needed a specialised diet due to a choking risk.

● People had been supported to attend Slimming groups in the community, and staff supported people to make healthier choices.

● Referrals were made to a range of health and social care professionals to ensure people's changing needs were addressed. One health care professional told us, "I've never had any concerns, if you ask them to do something it will be done."

Staff working with other agencies to provide consistent, effective, timely care

● Staff confirmed there was a handover process and staff diary to share information so staff could update each other on changes to people's care and support needs.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider had failed to develop effective systems to assess staff competency and to provide adequate training and development as required. We were advised that training had been impacted by the COVID-19 pandemic, however there had been no other consideration of how staff could receive support to ensure their knowledge was up to date and they were competent. We found concerns in some areas with the knowledge and skills of staff which had not been identified by the provider.

● Systems had failed to ensure good practice and adherence to the Mental Capacity Act. Knowledge of managers and staff was inconsistent in this area which meant people's rights had not always been upheld.

● Governance systems to ensure the safety and quality of the service were not robust. The telephone audit system that was introduced at the start of the COVID-19 pandemic was still in place at the time of our inspection despite government guidance changes allowing visits. This meant the provider was reliant on staff to report concerns rather than the provider having pro-active oversight.

● The provider had not consistently followed required standards, guidance and their own policies. Systems in place had not always identified or taken appropriate action to address risk of harm.

There were insufficient systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)
Regulation 2014.

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

● Although people, relatives and staff shared positive outcomes for people, we found concerns that decisions were made for people without the correct processes being followed. This meant for some people, ways to engage them in decisions about their care had not been fully explored.

● People and most relatives were positive about the care and support received and the positive impact it had. One person told us, "Taxis are organised to take me swimming or to the special Olympics." A relative said, "[Person's} skills and interests are catered for. They love gardening and they bought a greenhouse."

● Staff felt the service was well led and managers were approachable. One staff member told us, "The support is brilliant, [manager] is always on the other end of the phone."

● The service had carried out a survey with relatives to gain their views on the quality of the care and most relatives told us there was good communication with managers and they were involved in reviews. One

relative said, "I can talk to the management team. They listen."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The registered manager and provider were open and transparent during the inspection. The registered manager took action in response to a number of the concerns raised, for example by ensuring staff were wearing PPE in line with guidance and ensuring training needs for staff were being addressed.
● Following incidents and accidents, changes were made to improve the care for the person and prevent this happening again. However, the provider's system to analyse incidents and ensure lessons learned were shared across the organisation had not always been effective.

Working in partnership with others

● The service worked in partnership with other professionals and agencies, such as occupational therapists and social workers to ensure that people received the care and support they needed.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not referred a safeguarding concern without delay.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure adherence to the MCA and associated code of practice.

The enforcement action we took:

Warning notice was issued.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to ensure the quality of the service. The provider did not have effective systems to ensure service users' rights were upheld at all times.

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems had been ineffective in ensuring staff training was up to date and competencies were assessed.

The enforcement action we took:

Conditions were imposed on the provider's registration.