Life Path Trust Limited

Life Path Trust Limited

Inspection report

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Date of inspection visit:
12 July 2021
19 July 2021
20 July 2021
30 July 2021

Date of publication:
26 October 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Life Path Trust is a supported living service which at the time of our inspection supported 127 people with learning disabilities or autism spectrum disorder with personal care. People lived in their own homes and some people lived in shared accommodation with private bedrooms and shared communal areas. People had differing levels of support needs, some people required 24-hour support whilst other people required support only at specific times. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People did not receive safe care. People were not protected from abuse and mistreatment and did not always feel safe with the staff who supported them. Allegations of abuse were not always referred to the appropriate organisations to be investigated and actions were not taken to protect people from further harm. Risks to people's health and wellbeing were not always assessed and information was not available to staff about how to support people safely. Risks relating to COVID-19 were not always adequately assessed and actions were not taken to reduce the risk of transmission of infection when staff worked at more than one location. Pre-employment checks were not always completed to ensure staff were of suitable character. Staff were supplied with and wore appropriate personal protective equipment (PPE) to reduce the spread of infection. People who were prescribed medicines were administered these safely by staff who had received training.

People were not supported to have maximum choice and control of their lives and staff did not 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 was conflicting information about people's dietary requirements.

People were not supported in a caring way and some people experienced discrimination from staff. Staff did not always respect people's confidentiality and private information had been shared with people who were not entitled to it.

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 the underpinning principles of right support, right care, right culture. People were not involved in decisions about their care and restrictions were in place which reduced their independence and choice. The care provided was not person centred and

did not respect people's dignity, privacy and human rights. There was a culture within the service which dismissed concerns raised by people and they were labelled as people who make false allegations. This resulted in people experiencing abuse and harm even after they had reported it.

Complaints and concerns were not always responded to in line with the providers complaints policy. Complaints were not used to improve the quality of the service. People and relatives were not meaningfully involved in planning or reviewing care. People were not always supported to follow their hobbies and interests. People receiving end of life care received support based on their preferences.

The service was not well led. Governance systems, and management and provider oversight of the service, were inadequate. Systems and processes designed to identify areas of improvement were ineffective. They had not identified the concerns we found.

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

Rating at last inspection
The last rating for this service was Good (published 30 November 2017)

Why we inspected
The inspection was prompted in part due to concerns received about people being subject to abuse. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive 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.

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 keeping people safe from abuse, providing safe care and treatment, providing consent to care, treating people with dignity and respect and oversight of the service. We also identified the provider had not notified us of incidents they were required to.

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

Follow up

We will continue to monitor information we receive about the service. We will work alongside the provider and local authority to monitor actions taken to address the concerns we identified. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective Details are in our effective findings below	**Inadequate**
Is the service caring? The service was not caring Details are in our caring findings below	**Inadequate**
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**

Life Path Trust Limited

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
This inspection was carried out by four inspectors and two Expert's by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors visited the office and homes of people supported by the service. Two Experts by Experience spoke with people and their family members to gain their views of the support received. Two inspectors spoke with staff over the telephone to gather feedback on their experience of working at the 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.

Notice of inspection
The first day of our inspection was unannounced. We gave the provider 24 hours' notice before we returned to the office for a second inspection visit. This was to give the provider time to contact people who used the service and gain their permission to visit them in their homes. The third day of inspection at the office was unannounced.

Inspection activity started on 12 July 2021 and ended on 04 August 2021. We visited the office location on 12, 19 July and 30 July 2021. We visited people in their homes on 20 July 2021.

What we did before 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 15 relatives about their experience of the care provided. We spoke with 12 members of staff including the provider, registered manager, human resources staff, care co-ordinators and care workers.

We reviewed a range of records. This included 17 people's care records and multiple medication records. We looked at four staff files in relation to recruitment of staff. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider regarding evidence found and actions planned to improve the service. We spoke with health and social care professionals who visit people who are supported by the service and we made referrals to the local safeguarding adults' team.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of abuse as systems and processes to keep people safe were not always followed.
- People told us they did not feel safe with staff. One person described incidents when they had been physically abused and restrained by a member of staff. Other people told us of incidents when staff had shouted and sworn at them. One person told us they were not happy living there because of some of the staff and said they had nightmares about them. People told us staff asked them to behave in ways they were unhappy about. We raised safeguarding alerts about these concerns.
- One person told us they did not speak up about the abuse because they were scared of staff and another person told us they had told staff, but they were not listened to and no action was taken.
- When allegations of abuse were reported to the management team these were not always investigated and there was not sufficient action taken to protect people from ongoing abuse.
- People's care records had statements which contributed to a culture of allegations of abuse not being reported or appropriate action taken. One person's care records stated 'I have made three false allegations of assault that have led to the arrest of staff supporting me', a second person's care records said 'I get anxious and hide this with over-confidence, aggression and not telling the truth' and a third person's care records stated they had historically made 'false allegations against staff and family members.'
- We reviewed records of five serious safeguarding allegations including physical, emotional and sexual abuse. We found the provider response was not in line with their policy and did not meet safeguarding standards. For example, staff were moved location after substantiated claims which did not protect other people and were given instructions to 'remain professional and not forget their boundaries.' External agencies such as police and safeguarding authorities were not always informed of the allegations.
- Staff had received training about how to safeguard people and identify signs of abuse. This training had not been effective because staff had not followed the organisations procedures to report abuse when they were made aware of it and had not identified incidents as potential abuse.

This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safeguarding service users from abuse and improper treatment.

We made the registered manager and provider aware of these concerns and requested assurances that actions were taken to safeguard people supported by the service which included removing members of staff from the service whilst the allegations were investigated. The provider took the actions we requested to safeguard people.

Assessing risk, safety monitoring and management

● Risks to people's health and wellbeing were not assessed and staff did not have the necessary information to support them safely.
● Care records did not contain necessary information for staff to safely support people's health needs. We identified there were no care plans or risk assessments in place for people with epilepsy, diabetes and dysphagia (difficulty swallowing). This meant staff may not identity or know how to respond to symptoms associated with these healthcare conditions to keep people safe. This placed people at increased risk of harm.
● Some people could behave in ways which could cause harm to themselves or others at times of emotional distress. Their care records did not provide details of how staff were to manage these or how to de-escalate the situation. The lack of clear instructions meant there could be an inconsistent approach to support people and de-escalate behaviours placing them at increased risk of harm
● We reviewed records for people were prescribed creams which were flammable (could set fire if come into contact with a naked flame). Creams can dry onto fabric and bedding and can create a highly flammable combination. This risk increases with every application of the cream as it transfers, dries and builds up on the fabric. If this should come into contact with a naked flame it could cause serious injury and death. This risk was not identified in the people's support plans and guidance was not provided to staff about how to reduce this risk to keep people safe from burns.
● Risks were not always reviewed when a person's circumstances changed, in one home where a number of people lived a decision had been made by staff to lock the kettle and tv in a cupboard overnight. The kettle was initially locked away due to a person being at risk of scalding themselves if they used the kettle unsupervised, however this person no longer lived at this address and the risk had not been reviewed.
●COVID-19 risk assessments were completed for people, but they did not always include information about people who had underlying health conditions which would place them in the "high risk" group or how staff were to minimise the risk for these people.
●Staff who worked in more than one location were not required to complete regular tests before working in a new location, this placed people at risk of the transmission of COVID-19. Staff were required to complete one COVID-19 test a week, this was not in line with current Government guidance.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 – Safe Care and Treatment.

We brought these concerns to the attention of the registered manager and asked they provided assurances the risk assessments and care records would be reviewed so they contained all the information required for staff to support people with safe care

Staffing and recruitment
● Most staff were recruited safely with pre-employment checks however, we identified one member of staff had been employed without references from previous employers and with an unexplained gap in their employment history. This had not been identified by the registered manager or provider. Failure to complete the appropriate pre-employment checks meant the provider could not be assured the member of staff would not place the people supported by the service at risk.
● We received mixed feedback from people and relatives about if they received the support they needed at times they wanted. One relative told us they didn't think there were enough staff available and told us of an example when their family member was in pain and had to go to another flat to find someone to help. Another relative told us "[Name] is sometimes asked to go to someone else's flat due to staff shortage. [Name] doesn't like to go but will do because they're told to." Staff rota's showed that some staff supported people in different flats at the same time. However, one person told us "[Staff] always come at the right time and stay the time." A second person told us, "Yes, they are always here in the day."

Learning lessons when things go wrong

● The provider did not have robust systems in place to monitor the service. This meant they were not aware of issues we identified that required improvement and had not been able to drive improvement within the service.

Using medicines safely

● Overall, medicines were managed safely. People told us if they required support to take them, they received them when they expected to. Relatives told us they had no concerns about their family members medicines. One relative said "Yes they support [Name] to take them and when they need them, they [medicines] are locked away."

● Staff received training before they were able to support people with medicines and had regular checks to make sure they did this safely.

Preventing and controlling infection

● People told us that staff wore personal protective equipment (PPE) whilst supporting them.

● Staff had received training about preventing transmission of infections and the increased precautions during the COVID-19 pandemic.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service was not working within the principles of the MCA.
- People's decision-making abilities were not clearly recorded in care plans. This meant staff did not have clear information on what decisions a person could make.
- When people did not have capacity to make a decision, best interest decisions were not recorded which meant it could not be guaranteed that decisions made were in line with what the person would choose. One person who did not have capacity to make decisions about their healthcare had undergone an invasive procedure. There was no best interest decision making records to show what alternative less invasive had been considered.
- The provider was recorded as the appointee for a number of people they supported. An appointee is a person or organisation that is registered with the Department of Work and Pensions to manage a person's benefits if they lack capacity to do this themselves. The provider was not able to evidence how these arrangements had been authorised. Some people had alternative legal arrangements for relatives to be responsible for their financial decisions, but the provider was named as their appointee.
- Restrictions were placed on people without authorisation or best interest decisions. People told us, and records confirmed, they were told to go to bed at certain times because that's when staff shifts ended.

Another person told us they were not allowed to go to an entertainment venue with a relative in the evening because staff shifts finished at a set time.

● One person had been asked to sign a document stating they would wear a medical device and failure to do so could result in them losing their tenancy. It was unclear if the person had capacity to agree to this restriction on their freedom.

● People had signed documents to consent to care and to provide consent for photographs to be taken but it was not clear that people has capacity to agree to this.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 – Need for Consent.

We brought these concerns to the attention of the registered manager and asked they ensured appropriate capacity assessments were in place and unnecessary restrictions were addressed. We informed the local authority about our concerns and they told us they would review the appointeeships in place.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

● Overall, people and relatives told us they were supported to access health and social care services when required. However, one relative told us that when their family member contracted an infection appropriate medical attention was not sought in a timely way and this resulted in their family member requiring a longer period of treatment.

● People were not always supported to eat a diet of their choice. One person had instructions within their care records which stated, 'It has been deemed by the management from Life Path Trust that [name] needs to have a healthy lifestyle in his best interests.' This went on to say '[Name] will only be permitted to eat wholemeal bread and only two slices in any one day.' There was no evidence that the person or healthcare professionals were involved in this decision. Another person told us that a staff member had stopped them from cooking meals using ingredients prominent in their culture because the staff member did not like the smell.

● Fluid monitoring charts were in place for people who were at risk of dehydration however these did not have a goal amount for the person and there was no running daily total which meant staff could not make sure a person was drinking enough. We brought this to the attention of the registered manager who agreed to review the charts.

Staff support: induction, training, skills and experience

● The majority of staff we spoke to told us they had received the training they needed to provide them with the skills to support people. However, staff did not always demonstrate these skills in some of their practice. For example, staff did not recognise restrictions on people's liberty and did not always respond appropriately to allegations of abuse.

● One member of staff who supported people with autism told us they had not received any training about autism or de-escalation techniques and another member of staff told us they had received training about autism but could "not remember what it covered." We reviewed staff training records which showed not all staff had received training about how to support people with autism.

● Staff did not receive regular supervisions or appraisals at the frequency as outlined in the provider's policies and procedures. The registered manager had identified this was an area for improvement and that the frequency had decreased since the start of the COVID-19 pandemic.

● New staff received an induction when they started working at the service and spent time with more experienced staff members to understand how to support people.

Inadequate

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not supported in a way that promoted their privacy or upheld their dignity.
- One person explained that they were not able to use their en-suite bathroom due to damage and were waiting for it to be repaired. They explained to us that there was a bathroom available to staff which they had been told to use whilst there's was waiting to be repaired . The person went on to say a member of staff had told them not to use it. The person told us they were scared of this member of staff and felt they could not have a bath on days the staff member was there. Following our inspection the provider informed us this bathroom was not risk assessed for people to use. A relative told us that a carer did not support a person to maintain their dignity. They told us that the staff member did not help the person to stay clean and their relative would be left with "faeces on their bottom" after going to the toilet. The relative told us this member of staff no longer supported their family member.
- People and relatives told us people were not always supported by staff they knew. A person told us "[There are] lots of different staff" and went on to say, "Some are and some aren't introduced." A relative told us They [staff] change a lot, different faces every time.
- People told us their privacy was not respected and staff would enter their rooms without knocking or waiting permission.
- People provided us mixed feedback about how they were supported to be independent. One person told us "I go to the library, go to town on my own, I tell support workers where I'm going, I'm independent." However, another person told us they were limited in the activities they could do because staff had told them they "weren't allowed." There was no court of protection order in place limiting this person's freedom and their care records did not explain why these restrictions were in place.
- Staff did not always understand the need to respect people's confidentiality and not to discuss issues in public or disclose information to people who did not need to know.

This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People's support was not delivered in a non-discriminatory way and the rights of people with a protected characteristic were not respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality.

● One person told us of an occasion when they were speaking to a relative in their first language, but a staff member took the phone from them and shouted at their relative to "Speak English." Another person told us staff did not always call them by their preferred name and did not support them to wear their choice of clothing. The person told us "If I go out with staff looking how I want to staff don't like it. They seem annoyed at me and I feel ashamed." The person went on to explain they had been made to feel uncomfortable when staff asked them probing questions about their sexuality.
● People told us that staff did not always speak to them in a caring way and some people told us they had been shouted and sworn at.

Requires Improvement

Is the service responsive?

Our findings

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

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 people's needs were not always met.

Improving care quality in response to complaints or concerns

●People reported that complaints and concerns were not always responded to. The service complaints policy stated that complaints would be responded to in writing within 28 days, there was no evidence that people's complaints had been responded to as the policy required.

● Where complaints had been received, ineffective action had been taken to improve care. For example, a member of the public had reported concerns a staff member was shouting at people using the service. During our inspection visits the registered manager was unable to provide us with details of how this was investigated or what action was taken to protect people from risk of harm. Following our inspection the provider sent us details of how the complaint was investigated and the response they sent to the member of the public however the actions taken did not include informing the local authority or us of an allegation of abuse.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care records included people's life history. However, care plans lacked detailed information about their physical, emotional and mental health needs. These details are needed so staff can provide personalised and responsive care to people.

● People and relatives were not meaningfully involved in planning and reviewing care. A relative said "At the annual review, they ask [name] what would you like to do. It's not followed through, nothing happens. It's a tick box exercise"

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People and relatives said they had not seen any care records or been asked about their preferences for communication. Information for people was not available in a variety of ways to support their understanding.

● The registered manager told us that they had information in a variety of formats (For example larger size font or in an Easy Read format. Easy Read is a style of communication which uses a mixture of images and short sentences.) They told us they would review the information available to people and make sure it was available in a way they could understand.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People and relatives told us they had maintained contact during COVID-19 restrictions by telephone calls. However, relatives told us they had not been able to visit in person as restrictions were lifted. Arrangements to visit in an outdoor area such as a garden whilst maintaining social distancing had not been offered. A relative told us they were, "not allowed to visit, [Name's] mental health suffered."

● People and relatives told us they were not always supported to follow their interests. One person told us, "I want to go back to work at [name of work place], I worked voluntary on a Thursday, there's nobody to take me to work on Thursday, I miss my friends especially [Name]." A second person told us they used to enjoy riding their bicycle, but they were now told by staff they couldn't do this. The person told us they had not been given a reason for this change and their care records did not specify that there were any risks to the person. A relative told us, "It's very rare anything happens now, [Name] sits in his flat all day long. He asks to go out."

End of life care and support

● End of life care plans were in place for people who were receiving end of life support. These plans included people's preferences for how they wished to be supported and who they wanted to be involved in their care.

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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager did not have oversight of the care provided and had not identified the issues we brought to their attention. This meant they were unable to identify where areas of improvement were required.
- Audits of care records were completed by staff and the registered manager completed checks looking for trends and patterns from the reports provided to them by staff. This meant they were not the reviewing the information in people's care records and were not able to identify where there were errors, outdated or incorrect information. For example, the registered manager stated they were not aware a written agreement had been made with a person supported by the service which threatened their tenancy if they did not comply with medical guidance. This document was created in January 2020.
- Staff were not always aware of the providers systems in place to report concerns and did not feel confident action would be taken to address them by the registered manager or provider.
- Systems in place for staff to gain support from a manager were not always effective. Staff told us there was always an on call manager at times when the office was closed however they were not always available when staff tried to contact them.
- Systems in place were not effective and meant the provider did not have oversight of disciplinary action that was taken against staff. When a member of staff was found to have physically and verbally abused people, they were supporting the provider was not aware the action taken by the registered manager was inappropriate and continued to place people at risk of harm.
- The registered manager and the provider did not have adequate oversight of systems and processes relating to people's finances and appointeeships which left people vulnerable to financial abuse.
- People's and relatives told us they were not regularly asked for their views about the service. People had been asked to complete a questionnaire about their experiences but the last one that had been completed was in 2018. Each questionnaire had been completed by staff members and not the person or an independent advocate, this meant the responses were not necessarily accurate to people's views.
- Relatives told us they had not been asked for feedback and the communication from the provider, in particular during the COVID-19 pandemic, was poor.
- Staff told us they were not regularly asked for feedback. We were told before the start of the COVID-19 pandemic there had been regular team meetings to share information however these stopped due to the restrictions in place and regular virtual meetings were not arranged.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 – Good Governance.

Following our inspection, the provider arranged for an independent audit of people's finances and have been supported by the local authority to ensure appropriate action has been taken to protect people from the risk of financial abuse. The provider also sent us a report of the results of a survey which had been sent to people in February 2021 which had not been available for us to review during our inspection. This survey asked people about their views of the support they had received during the COVID-19 pandemic and the responses were overall positive.

● It is a requirement of registration that the provider notifies us of certain events within the service. The registered manager did not understand their regulatory responsibilities and did not notify us of allegations of abuse. The provider had not identified this omission prior to our inspection. This had a potentially significant impact on people supported by the service, we were not made aware of allegations of abuse which would have resulted in us inspecting the service at an earlier date and taking action to safeguard people.

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

● An open and honest culture was not promoted in the service. There was a culture where people were not believed or empowered and experienced abuse and discrimination.

● People told us when they reported incidents of abuse to staff members, they were not confident these would be acted on and they lived in fear of some staff members.

● Relatives had not been informed allegations of abuse were made and when police investigations were undertaken.

● Staff did not speak positively of people or uphold their rights to raise concerns. One member of staff told us "Staff aren't listened to. Clients [are] listened to above the staff and they've got learning disabilities. If they [people] say stuff it's all ears but if carers say something nothing happens. Deflates the staff even more. The clients have realised that and they know if a manager comes through the door they can start moaning about people or saying stuff that suits their agendas- they get all the attention and staff can't do or say anything."

● Care records were written in a way which fed into the culture that people they supported were not honest and their feedback was not to be believed.

● Following our inspection the provider told us they had begun an election process for a "staff forum" which would provide staff with a "platform for discussions" and would "Promote effective communication." The provider told us they intend for these forums to be held four to six times a year.

Working in partnership with others

● There was little evidence of partnership working, when people did not have capacity to make decisions, independent advocates were not used and instead staff members were consulted.

● People had been referred to appropriate health care professionals when required but the advice given was not always incorporated into people's care records.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people were treated with dignity and respect.