Cephas Care Limited

Cephas Care Ltd Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cephas Care Ltd Domiciliary Care Agency provides personal care to people who live in their own home. The service supports older people as well as autistic people and people with a learning disability. The supported living projects range in size from small to larger projects accommodating up to nine people in one dwelling sharing communal areas and staffing. In total they assisted 42 people with personal care in 15 supported living projects, across Suffolk. At the time of the inspection the domiciliary service supported 100 people of which 76 were in receipt of personal care across, the areas of Ipswich, Felixstowe, Sudbury and Bury St Edmunds.

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
At this inspection we found continued shortfalls in the management of medicines, staffing and risk management. There was a lack of consistency across both the supported living part of the service and the domiciliary service and although some people's experience was more positive this was not universal. Staff feedback was also contradictory, some told us they loved their job and felt supported, but others reported that morale was low, and they were not able to give the care they needed. Some changes had been introduced by the provider, but we could not see that these had yet made a significant impact.

People were not supported to have maximum choice and control of their lives and staff did not consistently 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.

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.

Right support:
• The service did not have enough skilled staff to meet peoples' needs and consistently promote choice control and independence. People told us not being able to access the community caused anxiety and frustration.
• There were mixed views about how well people's healthcare needs were being met. While we noted some

good collaborate work other people told us that staff were not sufficiently proactive.
• The service aimed to maximise people's choices, but staff were not clear, and records did not demonstrate best practice regarding the Mental Capacity Act.
• Staff did not always support people in the least restrictive way possible. Staff were not always clear about what was a restrictive practice.

Right Care:
• Risks to people's safety were not always identified and effectively managed.
• Staff did not have confidence in the safeguarding systems and that their concerns would be taken seriously.
• Positive behaviour support plans (PBSP) varied in detail and incident reports were not adequately completed so it was not always clear what actions staff took to support people. A PBSP provides staff with a step-by-step guide to making sure an individual not only has a great quality of life but also enables staff to recognise when they need to intervene to prevent or reduce the likelihood of an episode of challenging behaviour that may cause the person or others distress or harm.
• People were supported to maintain relationships with friends and family, and we saw that there were a variety of arrangements in place reflecting people's individuality.

Right culture:
• Staff were well intentioned, but people's care was not always person-centred and did not always promote people's dignity and privacy. There was culture of staff learning from each other and reflection was not embedded into the culture. Incidents were not effectively reviewed to identify learning.
• There were quality assurance systems in place, but they were not robust and had not independently identified some of the shortfalls that we had found to ensure people consistently received a good service.

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 requires improvement (published 18 August 2021) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations

Why we inspected
This inspection was prompted in part due to concerns received about staffing and safeguarding. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to risk management, staffing, safeguarding, consent, dignity, person centred care and governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when

we next inspect.

The 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 always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Cephas Care Ltd Domiciliary Care Agency

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by six inspectors and three Experts 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.

Inspectors visited the office and reviewed records; visits were made to seven supported living services and inspectors spoke to staff and people using both domiciliary and supported living services. The experts by experience made telephone calls to people and relatives about their experiences of care.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service also provides care and support to people living in 19 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there were two registered managers in post, one took the lead on the supported living service and the other the domiciliary care.

Notice of inspection
This inspection was announced, and we gave the service 24 hours' notice of the inspection as people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 26 April 2022 and ended on 17 May 2022. We visited the location's office on 26 April, 4 May and 6 May 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also sought feedback from the Local Authority. We used all this information to plan our inspection.

During the inspection
Some people we met during the inspection had complex needs and were not able to tell us about their experience of life at the inspection. We therefore used our observation of care and other evidence to help form our judgements.

We spoke with seven people who lived at the supported living services as well as ten people who used the domiciliary service. In addition, we spoke with 20 relatives. We spoke to 27 staff as well as the registered managers and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at selected care plans and risk assessments, medication and staffing rotas. We reviewed staff recruitment and training records as well as quality assurance systems.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• People were at risk of harm as risks were not always mitigated and effectively managed.
• Risks associated with people's care which were identified, such as arson or self-harm were not fully considered and management plans were not robust or consistently implemented by staff. This meant that people were not adequately protected from harm.
•Incidents were not always responded to appropriately or safely. We saw that a person had a fall and had sustained a head injury but there was no evidence of any additional checks being completed or follow up to check for any deterioration in the persons wellbeing
• Environmental risks in people's homes were not always identified or reviewed in a timely way and we found an unused swimming pool, an open gate and cleaning products stored in an unlocked cupboard, all of which presented risks to people's wellbeing. There were fire safety risk assessments in place but had not been reviewed since 2019 and the health and safety documentation did not consider the individual circumstances of each supported living service. We did not have confidence that the systems in place kept people safe and the provider met their responsibility to ensure the environment was safe to provide personal care.
• Staff supported people to raise maintenance shortfalls to their landlord but the arrangements in place did not work effectively to manage risks in the properties. One person was sleeping in a bed alongside a wall which was covered in mould and in another property the fire doors had not been closing for some time, placing people at risk if there was a fire. We asked the agency to immediately raise this with the landlord and they subsequently confirmed that the fire doors had been repaired.
• People's positive behaviour support plans varied in detail and quality and staff were not always confident in being able to support people who were showing signs of distressed behaviours.
• Despite the issues we identified some relatives spoke positively about how their relatives were kept safe.

Learning lessons when things go wrong
• Safety monitoring was ineffective and did not ensure that lessons were learnt to reduce the risk of reoccurrence.
• Incidents and accidents forms were poorly completed, there was little information on how staff intervened in an incident or what techniques they used to defuse the situation. Reviews of incidents were not always timely, and we did not always see evidence of follow up to identify learning. A member of staff told us, "We do not keep a log of incidents. The forms go back to head office. They keep them. We don't have copies here."
• Incidents had taken place where staff had been physically assaulted. These incidents were normalised, and staff reported that they had been 'brave', and the incident was part of 'relationship building' with the individual. We could not see that staff received an effective debrief or a thorough review of what happened to enable reflection and learning.

• The provider did not have a system for the collation of incidents to identify patterns and monitor safety related information although they told us that they intended to put this into place.

Using medicines safely
• Shortfalls in medication systems meant that there was a risk that people may not be supported to take their medicines safely. People medication plans were inaccurate and risk assessments were either absent or incomplete and did not fully consider the risks around people's medicines.
• 'When-required' (PRN) medicine protocols were available for medicines that were no longer prescribed which could have been misleading. Some lacked accuracy and detail which could have led to the medicines being given to people inappropriately and we noted that for people prescribed more than one pain-relief medicine there was a lack of written guidance establishing their overall pain-relief strategy.
• Medicine Administration Record (MAR) charts were written inconsistently and some medicines that were prescribed were not included and being recorded. In addition, some entries referred to the contents of pharmacy- prepared packs and did not record each medicine separately in line with national guidance so the records were unable to provide further information about these medicines that were given to people.
• For some people, staff used both electronic and hand-written paper records to record that they received their medicines. This could have led to confusion and error. We also noted that there was a lack of recorded accountability to show that staff always checked the charts for accuracy before use. When people did not have their medicines given to them staff were sometimes using codes inaccurately leading to confusion and so there was a lack of records explaining why the medicines had not been given.
• For people prescribed medicated skin patches records there was a lack of records about the removal of previous patches needed for safety. In addition, records did not show that the sites of application of the patches to their bodies had had appropriate intervals of time before repeating the site of application to avoid the potential for irritant skin reactions.
• For a person who was unable to consent to taking their medicines and would otherwise refuse them they were deemed to be able to have their medicines given to them concealed in food or drink (covertly). However, we found that in making this decision the service had not consulted with a wider group of persons in line with national guidance. In addition, when people were given their medicines placed in food or drink records did not confirm that advice had been taken from an appropriate healthcare professional about each medicine prepared in this way to ensure it was safe to do so.

The shortfalls in the management of risk and medicines are a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staffing and recruitment
• The service did not have sufficient numbers of staff in either the domiciliary or the supported living service to meet the needs of the people they supported.
• People and relatives expressed concerns about staffing and the impact on their support. One person told us, "Staff take me shopping and take me out to where I want to go but there is rarely staff on the rota who drive, so I cannot go out." Some staff reported feeling overworked and we saw some were working excessive hours. We could not see that this had been adequately risk assessed. Staff told us and we observed that they did not receive regular breaks.
• People did not always receive the contracted hours for which they had been assessed as requiring. People's one to one hours were put on a centralised staffing rota, but not always on the rotas maintained in the supported living properties. We were not assured of their accuracy as it was not clear the times of support provided. Staff did not always complete the handover forms, so it was not clear who was supporting who and when. Clearer accountability was necessary.
• People and their relatives also described issues in the domiciliary service, such as late or missed visits. One told us, "The agency is short staffed. Last week I only had one carer for my relative in the morning when I

should have had two." Despite the staffing shortfalls the domiciliary care service were continuing to accept packages of care. Staff told us that they had regular rota changes and shortfalls meant that they were cutting visits short and arriving late to support people.
• Staff recruitment processes were in place and showed references and disclosure and barring checks (DBS) were undertaken on newly appointed staff. The agency provided support to young people but were not checking that those staff working with children and young people had the correct level of DBS check. Agency staff were organised centrally by the provider but no on arrival checks were completed to check the identity of staff.

There were not enough staff effectively deployed to meet people's needs and this was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from abuse and improper treatment and we received inconsistent feedback about the effectiveness of safeguarding and whistleblowing processes.
• Staff did not all have confidence in the systems in place and a number had raised whistleblowing concerns to CQC. Some staff told us that when they had previously raised concerns these were not taken seriously. One said, "I emailed the office, but I did not hear anything back…I know now I would go to safeguarding." Others told us that they did not have confidence as the management did not respond to the issues that they had previously raised.
• We found that incidents were not always recognised as safeguarding and therefore correctly reported internally and externally to the local authority safeguarding team where required. Several relatives told us that they had raised concerns, but there was no record of these being investigated or logged as a safeguarding concern. Although, most relatives told us that when they had raised issues, the agency had responded by stopping the member of staff attending. None the less this did not meet their responsibility to take immediate action to refer concerns of abuse immediately.
• Staff were not always provided with consistent messages about safeguarding and how issues should be dealt with. For example, in a risk assessment it was recorded that if a person makes an allegation about a staff member an incident from should be completed and depending on the allegation advise the safeguarding team.

During the inspection we raised a number of safeguarding concerns regarding the management of incidents, the environment and medicines which had not been identified by the provider and these shortfalls are a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Preventing and controlling infection
• People were not always supported to live in a clean and hygienic environment. Areas including food preparation areas were not always clean and staff did not always fully understand their responsibilities to support people to maintain a clean environment and reduce the risk of infection.
• People told us, and observations confirmed that staff wore Personal Protective Equipment (PPE).

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
• People's rights under the Mental Capacity Act had not always been respected and the act was not fully understood.
• We saw in an incident report that staff had recorded that they had held the person after they had become distressed, but this was not viewed as restraint and staff told us that they did not restrain people. Mental Capacity assessments were in place for some people; however, this was not consistent across the service which meant that staff did not have clear information on what decisions people could make for themselves.
• Restrictions were not always questioned and reviewed to ensure that they were always proportionate or least restrictive. We found blanket rules, such as everyone using plastic cups in one supported living service. Staff could not explain to us how this was proportionate or in line with the principles of right care, right culture, right support. In an incident report we saw that staff had recorded that they had told a person 'not to go to their room'. This did not demonstrate that people had choice control or independence
• There was some monitoring of restrictive interventions, such as the use of PRN medicines but this was not undertaken in a systematic way. Some people were under constant supervision and we could not see that a Deprivation of liberty application had been made. Where the court of protection had made authorisations, the service was not clear about the nature of the authorisation and what they were for.

The shortfalls we identified are a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff support: induction, training, skills and experience;
•People did not always receive safe or effective care as staff did not always have the knowledge needed to support people with a wide range of complex needs, across all age groups.
• We identified shortfalls in staff knowledge in areas such as medicines, dignity, mental capacity act and end of life care. We also received inconsistent feedback about staff skills and experience with some people telling us that staff were skilled and knowledgeable, but others said that further training was needed. One person told us, "I think they need to train staff more on Mental Health and Learning Disability. Staff do not have the experience and understanding of my needs. I have to tell them what I want and need."
• Staff confirmed that they received training to develop their skills which included a combination of online and face to face training, as well as refresher training. Newly appointed staff received an induction to prepare them for their role. There were some arrangements in place within rota management to ensure that staff had the right skills to support people's individual needs, however it was not robust. We found that the staff supporting people with health conditions such as Parkinson's and Multiple Sclerosis did not have training in this area.
• Staff told us that they would find more specialist knowledge useful and most told us that they learnt from other staff what works. The service has an inhouse trainer and on occasion they had been asked to review positive behavioural support plans for people using the supported living service. There was no specialist for staff to refer to and referrals for psychology or mental health support were made through GP referral. We identified areas where staff would have benefited from more specialist knowledge.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture, which promotes a good quality of life and includes key principles of choice, control and independence.
• In the Domiciliary care part of the service the registered manager carried out an assessment of people's needs before they began to use the service to ensure that they were able to meet the person's needs. The assessment included people's physical, mental and social needs.
Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives told us that they received the support they needed with meals. A relative told us, "My relative gets the food they like. Weetabix for breakfast and in the evening, they heat up a meal in a microwave. They can't always stay until they finish but will write it up." Another told us, "They only have to give my relative a meal on odd occasions, but they always have a choice and they do ensure they have plenty to drink."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare.
•Where applicable Health Action plans were in place and people were supported by staff to attend health care appointments. Information following appointments had been documented in care records and we saw some examples of collaborative working.
• Relatives told us that people had access to healthcare when people's health deteriorated. One relative told us, "They have called an ambulance for my relative when they had chest pains and stayed with them." Another told us, "Carers would speak with me if my relative was under the weather. A chest infection was picked up by them and reported to me."
• People's oral health needs had been assessed and their care plans set out the levels of support needed to maintain good oral care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• People were not consistently treated with respect and compassion.
• We observed some poor interactions and some of the ways staff described people and their support was not respectful. We were told within hearing of a person, "Not to shake hands as you don't know where they have been." A member of staff told another staff member, again within hearing of the person that they," have been prn'd" referring to the fact that they had been given their medicines.
• Staff did not always demonstrate caring behaviours. We observed a member of staff eating strawberries in front of people when they were waiting for their meal. People were not offered any strawberries and watched the member of staff eating. Some people told us that staff did not always offer comfort and empathy when they were upset. One person told us, "I get told we are not here to support your mental health we are support workers….. When I am feeling low and suicidal, they just give me a number to call – Samaritans, suicide numbers, I feel suicidal at times and they tell me to phone up the numbers."
• At other times we found staff treated people with kindness and were well meaning in their approach. They took time to make sure people were comfortable and were enjoying what they were doing. We also observed positive engaging interactions, where people and staff were clearly fond of each other.
• We also received positive feedback from relatives some of whom described staff as kind and helpful. Comments included, "The staff are very kind and compassionate and have formed a good bond with my relative." Another said, "Carers are sensitive to my relative's dignity. They don't rush and give them the time they need.", "They always close the doors and pull curtains before starting my relatives' personal care. I feel they would protect their modesty."

The shortfalls we identified are a Breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to maintain relationships with friends and family, and we saw that there were a variety of arrangements in place reflecting people's individuality.
• People told us that they were consulted and involved in helping making decisions about their care. One relative told us, "My relative is very pleased with the care they get. We were involved in the content of the care plan and got what we felt was required. I am not 100% sure if we have had a review but if we did there are no changes required." Another relative said, "They do listen to my partner about how they want their personal care done and if they say they are not up to having a shower for example they will wash them

instead. They don't rush, and we work well together."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 did not receive care that was planned to be person centred, proactive and well-co-ordinated. They were not always supported to have meaningful lives.

• Peoples long term objectives were not always clear and there was in some supported living services complacency and a lack of ambition. One person had not had access to a shower or a bath for some time and while a referral had been made to occupational health this had not been undertaken in a timely way. A relative expressed concern that their relative had been given continence aids rather than investigating the issue and exploring more creative solutions.

• Whilst opportunities had increased following the pandemic other factors such as staffing were impacting on what people had access to and their ability to follow their interests and participate in meaningful activities. A relative told us, "My relative only goes out one a fortnight if he is lucky in his mobility car, as there are not often drivers available."

• Care plans were inconsistent in quality and level of guidance provided to staff. In domiciliary care the provider was in the process of transferring to an electronic care system, but the staff told us that plans did not contain the level of detail they needed to support people. One member of staff told us, "I have to turn up not knowing anything… completely blind. I have to rely on people to tell me what they need and ask them to help me."

• In the supported living part of the service care plans were more detailed but they were not easy to follow as the old and new care plans were stored together making it difficult to know what was current. There was lots of repetitive information which presented challenges for staff, some of whom told us that while they read the care plans as part of their induction, they largely learnt people's routines from colleagues. This was a concern given some of the disrespectful comments made about people, that we observed during the inspection.

• Daily notes were completed by staff and reflected the personal care provided and the activities undertaken but handover sheets were not always completed in line with the provider processes.

End of life care and support

• Peoples preferences and choices for their end of life care were not clear. There was a lack of understanding among staff in relation to last wishes, end of life planning and Do not attempt cardiopulmonary resuscitation (DNACPR) decisions.

• One person had been identified as being at the end of their life but there was no end of life plan in place and staff told us, "'Relative to be informed. They will make arrangements." We were told by staff that another person had a DNACPR in place but there was no record of this at the persons home. We asked the staff to

follow this up with the persons GP to clarify the position.

The shortfalls in planning to meet people's aspirations and preferences is a breach of Regulation 9 (Person centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• People had communication plans in place, and these reflected their preferred methods of communication. Staff had undertaken training in Makaton, and we observed staff communicating well with people. Staff knew people and their preferences and worked hard to provide people with choices. One member of staff described how they understood what the person was asking for by the different pitch they used when they spoke.
• In the supported living service, we saw evidence that people were supported to undertake activities that they liked to do. People had pictorial options in their care plans for them to use to make choices.

Improving care quality in response to complaints or concerns
• Feedback on the management of complaints was inconsistent.
• There was a complaint procedure in place. People told us that they knew how to raise concerns, and, in the domiciliary care part of the service, most people told us that the agency had responded appropriately. One relative told us, "I spoke to the agency because some carers were trying to rush my relative with feeding and they took notice of me when I asked them to slow down." Another relative said, "A carer turned up once and stayed in the car having a smoke and then was in and out in 10 minutes. I reported it and it has been sorted out."
• In the supported living service, the feedback from relatives and people using the service was variable. Some people told us that complaints were not handled well, and they did not always receive an outcome. There was not always a correlation between what concerns people told us that they had raised and the records at the agency.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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
At the last inspection we found that there had been a failure to operate an effective quality assurances system to assess, monitor and mitigate risks. The systems and processes required for the timely ordering and administering of prescribed medicines had not always operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that not enough improvement had been made and the provider remains in breach of Regulation 17.

• People did not receive safe effective person centred care. We have found continued shortfalls and a lack of consistency across both the supporting living part of the service and domiciliary service. The service has been rated as requires improvement in well led at the last three inspections and oversight has not been effective at identifying and addressing shortfalls.
• Concerns in the environment had not always been recognised, risk assessed and escalated in a timely or urgent manner. Incidents and accidents forms were poorly completed, and we could not always see that learning had taken place or a system in place for the collation of incidents to identify patterns and learning.
• The provider did not have sufficient staffing and people told us that this impacted on their care. Staff told us that it also impacted on them and their wellbeing. There was a management structure within each supported living service, but some posts were unfilled due to staffing vacancies, impacting on leadership.
• There were on call arrangements in place to support staff out of hours however there was no formal system for recording and we were unclear about how this fed into overall governance.
• The systems in place to support people with the management of their medicines was not safe.
• There was a culture of staff reporting concerns to CQC rather than internally as they did not have confidence in the reporting systems.
• The Mental Capacity Act was not fully understood, and restrictions were not always questioned to ensure that they were the least restrictive.
• The provider had a system in place to assess the quality and safety of the service which included spot checks, audits and regular meetings however the systems in place had not identified failings in the service or yet delivered on improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Outcomes for people were not consistently good and staff did not always demonstrate caring behaviours.

People's dignity was not always promoted and support was not in line with the principles of right support, right care and right culture.
• Staff feedback was contradictory, some reported they felt supported, but others told us that management were not visible, morale was low, and they were not able to give people the care they needed. One told us, "You can be stuck on someone's doorstep not able to get in or you need support but it's just not there….. it's not just occasional but often."
• We saw that staff had previously raised concerns about accessibility and support, but these had not been taken seriously by management. Staff were largely well meaning but needed more direction and professional input to meet the wide ranging and complex needs of the people they were supporting.
• Since the last inspection an organisational safeguarding has been upheld. The organisational safeguarding was raised following concerns being raised about management and leadership, staffing, hygiene and cleanliness of the environment, the management of risk and care delivery.
• Following the organisational safeguarding the provider produced an action plan setting out the actions they intended to take to address the shortfalls. Some changes had been introduced, but we could not see that they these had yet made a significant impact and many of the issues identified as part of the safeguarding had not been fully resolved.

The shortfalls we identified are a continued Breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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 two registered managers were aware of their responsibilities regarding safeguarding and had made notifications to CQC. They gave us examples of the actions that they had taken when issues were identified. However as outlined previously we received conflicting information about safeguarding's having been raised about which we had not been notified.
• Following the findings of the organisational safeguard the provider had been working with the Local authority on reviewing people's needs and strengthening quality across the whole service. This was a work in progress. Where improvements had been identified these need to be sustained, maintained and fully embedded into the culture of the service.
• The senior management team responded to the inspection in a positive way and took some immediate actions to mitigate risks we had found.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Staff worked with health and social care professionals for the benefit of people using the service.
• Arrangements were in place to gather the views of staff and relatives about their experiences of the service. Questionnaires were sent out at regular intervals and the results collated to identify learning. The registered manager told us that responses from staff had been low and they were looking at ways to increase participation. The results of the most recent survey of the domiciliary service had been reviewed and an action plan was in place setting out how changes would be implemented.

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 People were not consistently treated in a way which promoted their dignity

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The mental capacity act was not fully understood by staff