Achieve Together Limited

Dyke Road Community Support Services

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
Dyke Road Community Support services is a community-based adult social care service providing personal care and social support to people in supported living settings. At the time of our inspection there were 24 people living in 6 separate supported living homes using the service.

Not everyone who lived in the different supported living settings received personal care. CQC only inspects the support being given to people who 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.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found

Right Support:
Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. People's medicine support was not being managed safely. People were not always supported to assess their needs effectively and did not always achieve good outcomes from their support. Staff had not always received effective training or supervision.

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.

Right Care:
Staff did not always communicate or support people in dignified or respectful ways. People were not always involved and included in a personalised way when being supported by staff. Relatives told us staff were not always caring and did not always encourage them to be as independent as possible.

We observed some staff in the services we visited supporting people with tasks such as meals and going out in a kind and respectful manner, offering choices and communicating with people in ways they understood.

Right Culture:
Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively to identify or resolve issues.

People and their relatives said they did not always feel involved and engaged in planning their support or being supported to do things they wanted. Staff did not always feel supported to fulfil their roles and responsibilities and raised concerns about closed cultures within homes, negative and punitive leadership and how this was not helping people to achieve good outcomes.

The provider offered immediate reassurances on request about quality and safety issues at the service identified during our inspection visits. They told us about actions they would take in response and were committed to providing resources to make any necessary improvements as quickly as possible.

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 24 February 2022) and we identified multiple breaches of regulations. 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 and the rating has changed to inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and due to concerns we received about unsafe care and staffing.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections in this report. 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 dignity and respect, safe care and treatment, abuse, staffing, good governance and notifying CQC 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 act 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

Dyke Road Community Support Services

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
This inspection was carried out by two inspectors and an assistant inspector.

Service and service type
This service provides care and support to people living in 6 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us. Inspection activity started on 14 December 2022 and ended on 9 January 2023. We visited 5 of the location's services between

15 and 16 December 2022.

What we did before the inspection
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider, the local authority and other agencies and health and social care professionals. This information helps support our inspections. 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 used all this information to plan our inspection.

During the inspection
We spoke with and observed the support of people who used the service and their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with support staff, deputy managers and managers at five different homes, the area manager, the registered manager, the provider's head of operations and the provider's 'Positive Behaviour Support' (PBS) lead. We reviewed a range of records. This included people's care and medication records and a variety of records relating to the management of the service, including policies and procedures. We spoke with and received feedback from 4 relatives of people using the service.

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 inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

Assessing risk, safety monitoring and management, Learning lessons when things go wrong

- People with risks to their health and welfare related to their complex support needs, including expressing emotional distress, epilepsy and constipation, were not always assessed, monitored and managed safely.
- Risk assessments and support plans about people's emotional distress needs contained incorrect and inconsistent details about how to safely meet their needs. This increased the chance staff would not know how to recognise and act to reduce the risk of harm to people's health and wellbeing.
- Staff at one home had not always received training to know how to support people safely if they were emotionally distressed and told us they were not confident to manage risks associated with these needs. There had been incidents where staff had intervened in unsafe ways to restrain a person when they were emotionally distressed.
- One staff said, "I would employ physical intervention techniques even though I haven't had training, but it is a concern I might get it wrong. Some staff are worried and will not even attempt this in case they are blamed for hurting someone".
- Staff and management at this home had not always acted quickly to review and agree the safest way to support people's emotional distress needs, to check their support was safe enough.
- Staff remained unconfident about how to support people with risks associated with their emotional distress. This continued to place people at potentially serious risk of harm to their health and increased the chance they may experience avoidable pain and discomfort or distress.
- One staff said, "We haven't been told how to restrain or remove people who are emotionally distressed in a certain way, so it is consistent and safe. We decided to put in place certain measures, but this was not agreed by management and PBS team. There are no structured reviews of people's emotional distress incidents and general support".
- Another staff said staff did not know how to support people and unsafe interventions may be occurring. They told us, "We need training about how restrictive we can be with people".
- Staff were not always aware of how to recognise and monitor people's epilepsy support needs to know when they might need support to reduce risks of harm to their health when experiencing seizures. A relative of a person with epilepsy support needs told us this made them very concerned about their family members safety.

●Staff had given one person their epileptic seizure management 'as and when required' (PRN) medicine despite not being trained to know how to do this safely, as directed in the person's epilepsy risk assessment. This increased the risk the medicine may not work as well to help stop the serious harmful effects the person could experience if they had a prolonged seizure.
●Staff were not monitoring people's bowel movements or fluid intake as directed in their care plans, to help support them recognise and reduce risks to their health if they became constipated. A relative told us they were concerned their family member's health was at risk due to staff not monitoring their constipation risks adequately.
●Some staff and managers were not always aware of directions in people's risk assessments to support them to have laxative medicines if they became constipated, or confirm these medicines were available and in stock for use if needed.
●At one home, staff were not carrying out mandatory fire and water safety checks as per the provider's policy. This increased the chance of a situation where emergency fire safety equipment may not work if it was needed, or water may be too hot or contaminated, placing people's health at risk of harm.
● Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not operating effectively. Staff and managers were not always recording, reporting or reviewing incidents quickly enough and sharing learning to help prevent incidents re-occurring.

Using medicines safely
● Medicines were not safely managed. People who had been prescribed PRN medicines did not always have adequate protocols or information in their care plans to direct staff about when and how to safely give them their medicines. Staff had not always recorded the reasons they had given people their PRN medicines as directed in their protocols, so it was not possible to confirm if these medicines had been given safely.
● Medicine stock control systems were not operating effectively to allow staff to know how much medicine was being kept in the service, increasing the chance of theft or misuse or people not having enough medicine.

Staffing and recruitment
●Staffing rotas were not always managed safely. There were currently unfilled support and management staff vacancies for which recruitment was on-going. The provider was employing regular long-term agency staff to cover staffing vacancies.
●People's relatives did not think there were always enough suitable staff deployed to be able to meet people's needs safely and effectively, and this made them very concerned for people's safety.
● The provider had policies and systems in operation to help ensure safe recruitment and induction practices. Pre-employment checks for potential new employees were carried out, to help prevent unsuitable staff from working in a care setting. However, permanent and agency staff were not always supported to receive regular inductions, training, supervisions or competency checks as per the provider's polices.

The provider had failed to assess, monitor and manage risks to people's' health and safety, provide safe care and treatment, manage medicines safely, deploy staff safely or ensure lessons were learnt. This is a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All of these risk management concerns were fed back to the provider during the inspection who acknowledged the issues. After our inspection visit on 15 December 2022, we asked the provider to send us further information about immediate actions they would take to address risks to people's health and well-being related to their emotional distress support needs. We received these assurances as requested.

At our last inspection the provider had failed to ensure people were safe from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes to keep people safe from abuse and improper treatment were not operating effectively. Staff had not always received safeguarding training, as per the provider's policies. Some staff did not know how to recognise, and report suspected incidents of abuse. Other staff had not reported suspected abuse situations as they felt these would not be acted on by senior management. One staff said they had tried raising safety concerns, but they were "brushed over" by managers and "things (abuse and safety concerns) aren't acted on when they are raised".

●Staff and managers at two homes raised concerns when we spoke with them during this inspection about 'toxic' and closed cultures at these settings developing since the last inspection, including neglect of people's needs and subjecting people to unnecessary restrictive practices and isolation.

●These incidents had not always been recognised as potential abuse or reported by staff at the service internally or externally, to help the provider and other agencies act quickly to keep people safe while the concerns were investigated.

●Some relatives had concerns about how well people were supported to understand and recognise abuse situations, to help prevent these occurring and to know how to ask for help and support if needed.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We raised our concerns about abuse systems with the registered manager, who acknowledged the issues and began to immediately plan actions to address these. One person said, "I feel like I can tell them anything I'm worried about".

● People we spoke with told us they felt safe from abuse at the service and liked staff. Some other relatives said they were not concerned about abuse occurring at the service.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

●We did not observe any unclean or unhygienic in areas of the homes we visited. Some people's relatives raised concerns about historical incidents of observing poor cleanliness in people's bedrooms, personal bathrooms and outside areas.

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 requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection we found staff did not have the skills and competencies to deliver effective care and support, and there were not effective systems to demonstrate all people's health needs were safely managed. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities). Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

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

- People were not always receiving consistent support to monitor and manage their healthcare needs, including issues with staff not helping people to share information with other healthcare professionals. Staff were not always aware of peoples' healthcare needs and were inconsistent in recording their formal monitoring of people's on-going healthcare needs, such as emotional distress, constipation, epilepsy and fluid intake.
- Healthcare agencies had raised safety concerns about staff not being able to locate or share information about people's healthcare records when needed, and information about people's health needs not being kept up to date in their care plans and records when their needs changed.
- Relatives raised concerns that people's healthcare needs were not being effectively met. One relative said, "They are not getting active support with personal hygiene nor teeth. Staff don't give them the prompts they need". Another relative raised concerns that their family member was not being supported to attend regular healthcare check-ups for their specific needs. Another relative said, "I know they have missed doctor's appointments due to staff issues".

There were not effective systems to demonstrate all people's health needs were safely managed. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider had developed comprehensive induction, training and supervision programmes for permanent and agency staff. However, staff across all six homes had started work without receiving or accessing any of these programmes, sometimes for extended periods. This increased the chance staff would not know how, or have support to, enable them to support people to achieve good outcomes.
- One staff member said, "The training wasn't good when I started, I had to wait for nine months for some of it". Another staff said they had started seven months ago but, "I have not done safeguarding training yet for

induction - have not done medication training. Have not done any learning disability or autism training that we are meant to. I have no idea when it is due".

●Other staff raised concerns about the quality of the training they had received and lack of regular supervisions and competency checks. We were told of how this meant they felt they, and other permanent and agency staff, did not have necessary skills or experience to be able to meet people's needs effectively. A manager said, "I don't trust that they agency can be left alone to do the job".

●Several relatives told us the high turnover of staff, new starters and agency staff had meant the staff had not always been trained to be able to effectively meet all their family members' needs. They felt this had resulted in their relatives not having the right support. One relative said, "I don't think any of them [staff] are qualified…I don't know what training they have". Another relative said because staff did not know how to effectively meet their family members needs, "It seems like I am chasing these things to get it done".

●Training records showed, and the registered manager confirmed, several staff at all homes had not received necessary training or induction support. The registered manager explained this was the result of recent high turnover of management and staff, meaning it was difficult arrange training and then to cover shifts at the service to allow staff to attend.

Failure to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform is a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People's needs were not always holistically assessed to consider what people wanted and needed from their support. People's social, mental and emotional needs or associated best practice guidance had not always been considered when delivering people's support.

●For example, some people's emotional distress needs had not been fully assessed by the provider's 'Positive Behaviour Support' PBS team, to help inform effective care plans. This increased the chance staff may not know or effectively employ preventative and positive interventions to help avoid the need for using reactive and restrictive practices when supporting people.

●Information about people's assessed needs was not always included accurately in people's care plans, which increased the chance staff would not know how to support people effectively. This chance was increased due to the high staff turnover and use of agency, who did not know people and relied on this information to know how to support them best. Social care professionals told us they had found during recent quality visits to some homes that information about people's assessed needs was difficult to locate and, on review, not always accurate or up to date.

● Several relatives raised concerns staff had not assessed people's needs effectively and did not know how to support them to achieve good outcomes. Several relatives said staff did not understood their family member's level of support needs with certain tasks of daily living, which they felt had a negative impact on these people's quality of life and their being able to learn and develop new life skills. One relative said, "They tell them they can do things themself when they can't, and they take it at face value".

Failure to assess and design care to ensure people's preferences are achieved and their needs are met is a continued breach of Regulation 9 (1) (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

●If necessary, staff had sought advice from speech and language specialist (SaLT) about people's specific dietary needs and we saw they were supported in line with their eating and drinking guidelines during our inspection visits.

● People told us they liked the support they received with eating and drinking. One person said, "The food is good. It varies…If there's something I don't like (to eat) they will change it. No problems". Another person said, "We can have written what we want (to eat) on the board. I helped with the baking the other day. I helped grease the tin". We saw other people helping to cook and prepare food they had chosen.
●Some relatives said they thought people could be supported to understand about making choices and encouraged to eat more healthy food to help make sure they maintained a healthy weight. Some people we spoke with were aware of healthy eating choices. One person said, "I need to watch what I eat really, but it's tricky".

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.

● We reviewed a sample of care plans which showed the service was working within the principles of the MCA. There were records to show some people's mental capacity to be able to make decisions about different activities had been assessed Where people had been assessed as not being able to make certain decisions, the manager understood the need to identify a person to act in their best interests and be involved in agreeing this.

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 requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection we found people were not being fully involved in their care planning. This was a breach of Regulation 9 (1) (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations. We have commented on care planning processes and continued breach of Regulation 9 (1) in the responsive section below.

Ensuring people are well treated and supported; respecting equality and diversity, Supporting people to express their views and be involved in making decisions about their care, Respecting and promoting people's privacy, dignity and independence

- People were not always supported in a way that respected their privacy and dignity, offered choices or involved in their care.
- We observed several staff at one home across two visits using disrespectful and punitive language to describe people's behaviour, choices and emotional distress directly towards people. People at this home were not always involved in discussions about planning their support for that day, even though they were present when staff were talking about this.
- Incident reports and care plans sometimes contained disrespectful and uncaring language about people and how they had been supported. In one home, people's personal care planning information had been taped to communal area walls although this was not necessary, which did not respect the person's confidentiality.
- Relatives of people living at other homes, said staff and managers did not always treat their family member with kindness or compassion or listen to their choices. One relative said, "There was one incident where the manager fired a lot of questions at (the person). They seemed annoyed, as if it was (the person's) fault. They tell people what to do rather than encouraging them. I don't feel there is any warmth from them to people".
- A person told us people at the home they lived in were not always provided with personal care support by staff of the same gender in line with their preferences. Another person in a different home said, "Sometimes I pick staff, but sometimes I don't have a choice".
- Several relatives of people living in different homes said staff often talked in non-English languages with each other when supporting people, which people could not understand and was not inclusive or respectful. A relative told us their family member, "Often complains that people don't listen to him or interrupt him. He often says, "they barge me into my room.""
- Since the last inspection, there had been safeguarding incidents where staff across the organisation had not demonstrated people were well-supported or treated with dignity and respect.

Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was made aware of these concerns during the inspection and began to put actions in place to improve and address these concerns.
●Since the last inspection, the provider had followed policy and procedures and raised concerns of safeguarding incidents where some staff had not demonstrated people were well-supported or treated with dignity and respect to ensure these were addressed.
● One person told us staff respected their privacy and independence. They said, "I have my own room so spend time in my own space. The guys pop up every so often to check I'm ok yeah. It's good that I can come and go as I please". Another person said, "I get in the shower and dress myself. I'm quite happy here".
●We observed some staff in the services we visited supporting people with tasks such as meals and going out, in a kind and respectful manner, offering choices and communicating with people in ways they understood.

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 requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

At our last inspection we found there was a lack of personalised care, communication support and structured activities for some people and people were not being fully involved in their care planning. This was a breach of Regulation 9 (1) (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

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

● Some people's care plans lacked detail about their individual preferences, emotional and social needs as well as their strengths and levels of independence. Care plans had not always been updated, or reviews of people's support taken place regularly or when people's needs had changed This increased the risk staff may be neglecting or not responding in the best way to people's personal wants and needs.

●One manager said, "I don't get the chance to sort out people's care plans and folders and keep up to date". Staff at another service said, "Paperwork is all over the shop. Needs to be really simple, but at the minute it is not easy to find important information about people's care wants and needs." Social care professionals said visits to various homes throughout the year had noted a theme of care plans notably being "in disarray". A relative said, "On the paperwork front, they couldn't find any of his records on the system. They had just disappeared."

●People told us they did not always have regular monthly care planning meetings, and records in some homes showed these meetings were only happening infrequently. This increased the chance people would not have choice and control over the support they were having or have opportunities to try new things and follow their interests and life goals.

●Staff we spoke with were not always sure of how people liked and needed to be supported. Staff and managers said there was often not enough time or staff to always help plan people's care and support them to identify and achieve new goals.

●At homes we visited we observed instances of people not being offered support with personal care and social activities and having limited social interaction with staff for long periods. Recent people surveys that had been carried out across homes identified a consistent theme of people saying they would like to go out and do more activities or try new things.

●Several relatives raised concerns about the lack of offered social engagement and activities inside and outside of the home, and the negative impact this had on people's quality of life and well-being.

●One relative said it was common to see a person undressed and unwashed late into the day, "They [staff] keep giving excuses, like "my fault, I said she could have a lazy day. They are not supported to go out when they want (during their allocated 1:1 hours), it is frustrating them.""

●Another relative said, "I've been asking them to widen communication and activities with other residents from other houses or finding a volunteer job. They are very sociable and engaging, but they are disappearing". A relative of someone in a different home said, "There is no encouragement to go on, delve deeper and find something to do. There is definitely a lack of promoting activities and getting people out".

The provider was not ensuring people received person-centred care. This is a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy but we found improvements were needed to ensure complaints were consistently well managed.

●Feedback survey response indicated some relatives were not aware of how to raise a complaint or were not confident to do so. Some relatives told us they did not feel complaints they made were always listened to or responded to well.

● Other relatives said they knew how to make complaints and when they had done so they had been happy with the response.

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 were provided with accessible information if they required this. We saw information about people's communication preferences was recorded and in use, and people were given information about their support in ways they understood.

End of life care and support

At the last inspection we recommended the registered provider reviews people's end of life wishes and records these in care plans. This recommendation was being met.

●Nobody using this service was receiving end of life care. People's care plans we looked at had basic information about their end of life needs and wishes recorded. If it were to become necessary, people could be supported to consider advance care planning to make sure they got the right support, resources and equipment to have as dignified and pain free a death as possible

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.

At our last inspection we found quality audits had not been effective in making improvements. People's records were not always complete. This was a breach of Regulation 17 (1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care, Working in partnership with others

- Across all six homes and within the provider's wider governance framework internal quality processes to review and audit service performance and quality were not operating effectively.
- Since the last inspection internal and external audits of all areas of care delivery at the service had not always been carried out consistently. Where quality audits had been completed, they had not always identified or prevented safety and quality issues occurring or continuing at the service.
- These issues included repeated safety, risk and abuse concerns not being assessed, monitored and managed in relation to emotional distress, health and well-being, social support, dignity and respect to ensure risks of harm to people's health and wellbeing were reduced or prevented as much as possible. Many people's care records were not accurate or up to date.
- Management, staff and relatives all said staff from the provider's internal organisation had not always worked well with them to ensure information and reviews about people's support needs was shared, agreed and implemented consistently, increasing risks to people's health and quality of life.
- Leadership at the service and individual homes and within the provider's wider governance frameworks had not been effective in ensuring staff at all levels were aware or able to effectively fulfil their responsibilities to provide a good standard of care. Several staff and managers told us they were not confident of how to safely and effectively fulfil their roles and had not received adequate training or supervision to support them to do so.

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

- Several staff and managers told us of issues with closed and 'toxic' cultures that had developed at services since the last inspection, with staff not supporting people in an open and inclusive way. This had resulted in unnecessary restriction and unauthorised restraint against people occurring at several homes.
- Staff at several homes also raised concerns about lack of openness and support within staff teams and

between staff and management. Two staff at one home said there had been a 'blame culture', which was not encouraging transparency or open discussions about how to make positive changes to help improve quality and safety issues.
●Other managers and staff said they felt "burnt out" and generally unsupported by the provider when they were trying to keep on top of their roles and responsibilities. One staff said, "I do not feel valued". These themes corresponded with results of recent staff surveys at some homes, which identified many staff did not feel recognised and rewarded by the provider and management.
●The provider had an Equality and Diversity Policy and a set of values outlining their commitment to embracing diversity and providing equally empowering person-centred care. However, staff were not always following policy guidelines or displaying expected person-centred values when supporting people. Recent people surveys showed staff responses such as; "They think they can't have any dreams because of their physical state", "Would like to be involved more in tasks of daily living", "Would like to be supported to be involved in the local community".
●Several relatives raised concerns about people not being supported to be engaged and involved in developing their skills and following their interests, despite them being able to. One said "They have to pay for the taxis, when staff are quite capable of getting on a bus or a train. It leaves them with very little money". Another said, "They (person's name) have not had a review of their support needs since 2017 and I am not sure actions about their life goals are happening at all".

There were continued failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection we found Statutory Notifications had not been sent to CQC. This was a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

● At this inspection we found standards of care had deteriorated since the last inspection. Multiple breaches of regulations had occurred, including continued and newly identified breaches, placing people at avoidable risk of harm to their health and well-being and impacting negatively on their quality of life. Statutory notifications had continued to not always be submitted to CQC regarding safeguarding incidents, as required by law.

Statutory Notifications had not been sent to CQC. This was a continued breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

●We raised this issue with the provider during our inspection, who acknowledged the issues and began to immediately plan actions to address these. The provider had acted to notify us about instances where notifications had not been sent as required when they had become aware of them.

●Across all six homes, since the last inspection there had been consistent high turnover of staff and managers as well as changes to the registered manager. The current registered manager was also a regional manager within the organisation and had retained their substantive posts' responsibilities alongside this additional role. These factors had all had a considerable negative effect on the ability of individual homes and the service overall to make and sustain necessary improvements.

●The service had recently recruited a permanent registered manager and we were given assurances of the support the provider was giving them to transition into the role while their registration was being processed by CQC.
●The provider's senior management team told us they were committed to making any necessary improvements across all homes under this registration as quickly as possible, including planning and carrying out more effective and comprehensive audits using a recently acquired electronic auditing and care planning system.
●Some relatives and staff told us that recent management changes at their homes had been positive and they were hopeful this would result in improvements being embedded quickly to create a better working and living environment for staff and people. Staff told us they thought their own and other colleagues' equality and diversity status was respected.
●Some people we spoke with told us they felt engaged and involved in how they were supported, and the service was run. At some homes there were regular home meetings for people to say how they thought the service could be developed. There were opportunities available for people to be involved in recruitment and quality checking roles at the service and within the provider's wider organisation.

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,
●At some homes, since the last inspection, managers had not always shared information appropriately internally and with external agencies and stakeholders when necessary. If the provider had not been aware of when things had gone wrong with people's support at the time, they had taken appropriate action to be open and honest when they had been made aware of this.
●Health and social care professionals told us staff had worked well with them in the past, including sharing information openly and transparently, but this was mainly occurring reactively after incidents had occurred. A more proactive approach was required to help work with professionals to help plan to prevent things going wrong and build on improvements when they were made.

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 Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff had received appropriate support, training and personal development to carry out the duties they are employed to perform is a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to assess and design care to ensure people's preferences are achieved and their needs are met is a continued breach of Regulation 9 (1) (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

We served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The notice requires the provider to become complaint with this regulation by 10 March 2023.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and manage risks to people's' health and safety, provide safe care and treatment, manage medicines safely, deploy staff safely or ensure lessons were learnt. This is a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The notice requires the provider to become complaint with this regulation by 10 March 2023.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The notice requires the provider to become complaint with this regulation by 10 March 2023.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were continued failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

We served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The notice requires the provider to become complaint with this regulation by 21 April 2023.