The Cube Disability Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Cube Disability Ltd is a domiciliary care agency providing personal care to people whilst they are in holiday accommodation. The service provides support to people living with a learning disability and/or autism. At the time of our inspection there had been 8 holidays in the UK in 2023 for 48 people of which 6 people received personal care.

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.

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:
People's risks had not been formally assessed and staff did not have all the information they needed to mitigate the risks relating to people's care, travel, activities and accommodation. Staff relied on verbal handovers and feedback from families to understand people's needs.

People's families were involved in people's preparation for their holidays, providing managers with information about people's needs and how to manage people's anxieties. Staff did not have this information available to them in written form; the information did not reflect people's protected characteristics under the Equality Act.

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. People's mental capacity to make decisions had not been assessed and there were no systems to hold best interest decisions.

People did not receive their medicines in a safe way.
Staff ensured they asked consent from people before supporting them. Staff understood people's rights to refuse care.

Staff understood safeguarding procedures and knew how to protect people from potential abuse and harm.

Right Care:

The provider failed to ensure staff received the training they needed to provide person centred, safe care to people.

People did not have care plans or behavioural support plans for staff to refer to. Staff did not have the information they needed to always know how to provide safe care or mitigate risks. People's records were not always reviewed when people's needs changed. Staff did not record daily notes to demonstrate people received their care as planned.

People received care from staff that were of good character that were recruited using safe recruitment practices.

Staff showed kindness and treated people with dignity and respect.

Right Culture:
The provider failed to have all the systems and processes in place to assess, monitor and mitigate risks, or make improvements to the service. There had been a recent change in management whereby they recognised the changes that were required to improve the service.

People were involved in choosing the types of holidays and activities they wanted. People were cared for by staff who knew them and shared their holidays with people they knew from the day centre.

Staff adapted activities to ensure all people could take part in the activities they wanted.

People, relatives and staff had been asked to feedback on the service, the information was used to drive improvements.

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

Rating at last inspection
This service was registered with us on 1 October 2020 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to risk assessments, care planning, person centred care, consent and management at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Cube Disability Ltd

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 1 inspector and an Expert 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes and in holiday accommodation.

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 48 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 3 July 2023 and ended on 6 July 2023. We visited the location's office on 3 July 2023.

What we did before inspection

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 1 person who used the service and 7 relatives about their experience of the care provided. We spoke with 6 members of staff including care staff, the registered manager and the nominated individual The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's care records and medicine administration records and 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management and oversight of the service were reviewed including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The provider failed to assess all of people's risks or have care plans to mitigate risks.
- People did not always have risks assessments, care plans or behavioural support plans for their health conditions, anxieties or for new activities. This meant staff did not always have the information they needed to provide people's care or mitigate risks. For example, staff did not have information on how to provide care for 2 people living with epilepsy.
- The provider failed to sufficiently risk assess the travel arrangements or holiday accommodation. There was no information for staff to understand how to secure the wheelchair in the vehicle, or contingency plans in case of breakdown of the vehicle. There was no system to check the holiday accommodation for risks such as blocked fire exits and security.
- Personal emergency evacuation plans did not reflect people's mobility, verbal comprehension, or likeliness to comply with evacuating the holiday accommodation. This meant the emergency services would not have enough information to assess people in the event of an emergency.
- Staff did not have information to provide to emergency services in the event of a person going missing. Staff did not have a photograph of each person or information about how they communicated. This meant if a person went missing, the emergency services would not have enough information to find them or know how to communicate with them to gain their trust.

Using medicines safely

- The provider did not have adequate systems in place to ensure people received all their medicines as prescribed. Not all staff who administered medicines had received training in medicines management.
- People's medicine administration records (MAR) did not contain all the information staff needed to give people their medicines safely. Not all people had been assessed for their ability to manage their own medicines safely. Not all allergies and GP information were recorded. There were no photographs of people on the MAR charts to identify which person the MAR chart referred to.
- The provider failed to have a system to record and evaluate 'as required' medicines. People received medicines that had not been prescribed or provided by families. For example, medicines for allergies and laxatives.
- People's MAR charts did not indicate what the medicines were prescribed for, the side effects experienced by people and the times the medicines were due. People did not always receive their medicines in a timely way. For example, one person was given their medicines too close together as staff administered their tablets late evening and at night, placing them at risk of unmanaged symptoms.
- Staff recorded they gave people's medicines, but the dosage and times they recorded did not always

match what people were prescribed. This had not been identified by staff, manager or the provider and the stock had not been recorded or checked to establish if this was a recording error, or whether people had not received their medicines. People were at risk of not receiving their prescribed medicine.
● The provider failed to have a system to monitor the safety of the medicines management; they failed to identify the missing information or potential medicines errors.

The provider failed to assess all risks relating to the health and safety of people or doing all that was reasonably practicable to mitigate any such risks. The provider failed to manage medicines safely. This placed people at risk of harm. This was a breach of regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had met with two families before their holidays to gain a better understanding of their mobility and medicines. One family told us, "[Staff] follow the care plan really well. They have photos of how [person] has their supportive pillows." Another relative told us, "[Staff] have taken a lot of time to understand [Name's] needs. They worked out the care plan with me."
● People's families provided information about people's needs through conversation or via emails in the weeks running up to the holidays, however, these were not recorded adequately to provide a plan of care. One relative said, "They ask lots of questions via email, about [Name's] daily routines to reduce their anxiety." Staff told us they met with families an hour before the holiday to provide information on changes in care and medicines, but these had not been recorded.
● People's health conditions were listed. A brief description of what people liked to talk about to alleviate anxieties was recorded. Staff received a verbal handover about people's care; staff knew people from providing care and supervision in the day centre. One family told us, "[Person] gets anxious when they go away and [staff] know how to calm and reassure them."

Staffing and recruitment
● There was no system to calculate the number of staff required on each holiday. There was no provision for staff breaks or contingency for managing people's care during journeys or emergencies. People were at risk of not receiving their care at times when staff were not available.
● The provider had not always recruited staff in a safe way as they had not always followed their recruitment policy. The registered manager had identified this and had an action plan to rectify the issues and prevent future incidents.
●The provider carried out Disclosure and Barring Service (DBS) checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff told us they enjoyed taking people on their holidays and had not encountered any problems with staffing. Records showed there had not been any accidents or incidents.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems to report and respond to safeguarding concerns. The safeguarding policy provided staff with guidance on how to recognise abuse. Safeguarding posters containing information on how to report abuse were displayed in key areas. The provider needed to incorporate how to report abuse into their policy.
● Staff told us how would identify and report safeguarding concerns.
● There had been no safeguarding concerns reported or evidence of any safeguarding concerns.

Preventing and controlling infection
● Staff received infection prevention and control training as part of their induction.

● Staff used personal protective equipment (PPE) when providing personal care.

Learning lessons when things go wrong
● There were not enough systems in place to record and analyse the planning, risk assessment and outcome of the care received by people during their holidays to learn from or improve the service.
● The provider had a procedure to record and review accidents and incidents. The registered manager told us, and records available showed there had not been any accident or incidents at any of the holidays.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

● The provider did not ensure all staff had the training and competence to assess people's mental capacity to consent to care. This meant not all staff understood the principles of MCA and there was a risk that people would not have the opportunity to make their own decisions.
● The provider did not have systems in place to ensure all mental capacity assessments had been recorded, or systems to arrange for best interest decisions. Staff had recorded that one person did not have the mental capacity to make decisions for themselves, but there was no record of a best interest decision for their care, travelling, going on holiday or activities. This meant people were at risk of receiving care they had not consented to without the proper safeguards in place.

The provider failed to ensure care to people was provided with the consent of the relevant person. This placed people at risk of harm. This was a breach of regulation 11 (1) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were no people receiving care that had restrictions placed upon them by the Court of Protection.
● Four relatives told us staff asked people for their consent before providing care or taking part in activities. One relative told us, "[Staff] have a lot of respect for all of the clients. [Staff] can encourage [Name] to have a shower but won't force them. They do not like washing or doing their teeth."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider failed to record how people and their relatives had been involved in the assessment process. People's records did not reflect people's needs and choices.
● The provider's pre-assessment of needs was not comprehensive as they had failed to gather sufficient information from relatives and relevant professionals. People's protected characteristics under the Equality Act 2010 including age, disability, gender reassignment and religion had not been recorded. People's choices, preferences and routines had not been recorded; people's notes did not reflect their individual goals and aspirations.
● People's needs had not been assessed in line with national guidance and best practice. The provider did not have risk assessments that were evidence based and their policies and procedures did not always reflect relevant legislation. For example, people receiving personal care did not have their skin assessed.

Staff support: induction, training, skills and experience
● The provider did not ensure all staff had the training, skills and competencies to meet all people's needs. The training records showed not all staff had received training and refresher training in medicines management, catheter care and epilepsy. This meant people living with epilepsy or with a catheter were at risk of not have their needs met.
● The provider did not ensure all staff had the training they required to manage the safety of people whilst they were on holiday. Not all staff had received training or refresher training in first aid, fire safety, challenging behaviour, control of substances hazardous to health, safeguarding, moving and handling and infection prevention and control.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider failed to ensure people's nutritional risks had been assessed or care plans created to inform staff how to maintain people's safety. Staff did not have all the information they needed to understand and manage people's risks such as food allergies and intolerances.
● The provider failed to ensure all staff had training in food safety including the consistencies of food and drink to prevent choking.
● The provider failed to ensure all previously known risks about food intake were documented in current information. For example, old documentation recorded the risk of choking for one person and described how staff were to cut their food into smaller pieces and supervise them when eating. The current records did not mention this as a risk, but stated the person liked large portions of pizza and cake. Staff did not record the actions they had taken at mealtimes; it is not known if staff consistently cut up the person's food and supervised them eating.

The provider failed to ensure staff had the skills, competence and experience to provide people's care safely. The provider failed to ensure people's risks were assessed and risks mitigated. This placed people at risk of harm. This was a breach of regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had been involved in choosing the types of holidays they would like to have and chose to go on holiday. People chose what they liked to eat, one relative told us, "When they have gone out for dinner [Name] has had the opportunity to pick what they would like."
● Relatives told us they had been asked about people's preferences, but these were not always recorded in people's records. One relative said, "[Before the holiday], I get something [a form] that asks what [Name] likes and doesn't like." Two people's relatives said their relative preferred female care staff to provide personal care; this was not recorded in people's notes.
● Staff had received training and support to develop the skills required to care for people with a learning

disability and autism.

● Staff received support in the form of regular supervision where they had the opportunity to discuss their performance and development.

● All staff had undergone an induction which included the completion of the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

● People's care records contained brief information about people's medical history and their current health care needs. There was no supporting information from health professionals on how to manage people's health care needs.

● Staff had information they needed to seek medical advice. Staff had recorded the contact details of people's GP and sourced the localities of walk-in health centres near the holiday locations.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People received care and support from staff who knew them from the day centres they attended. Relatives described the positive relationships people had with staff, "[Staff] just get [Name]. They understand [Name] so well", "[Staff] are honestly amazing. [Name] really likes the carers" and "I think [staff] are lovely people with big hearts. They are lovely with [Name], they make [Name] feel happy."
- Staff spoke about people they cared for with dignity and respect. One staff member recalled how proud they were of people's achievements and how much they enjoyed being with people when they experienced new activities on holiday.
- Staff had received training on equality and diversity and showed compassion and awareness of people's diverse needs. Staff knew people well and what was important to them, such as family and cultural needs.

Supporting people to express their views and be involved in making decisions about their care

- Relatives told us staff were patient and allowed people time to express themselves. One relative told us, "[Staff] know [Name] needs time to think about what they want to say." Some people required routine in what they ate; staff ensured people were offered familiar food and offered other choices too. One relative said, "It's important that [Name] has those choices away from home, [to keep] the same routine."
- People had chosen which holiday and activities they wanted to attend. Families told us they were kept informed. One relative told us, "Staff give the itinerary for the whole week so I can explain [to Name] what is happening and where they are going. [Name] didn't want to do the boat trip so their one-to-one [staff] stayed with them. They are still involved and can go on the holiday." Another relative told us, "[Staff] keep in contact every day. They send a quick text and photos."

Respecting and promoting people's privacy, dignity and independence

- People received care and support that promoted their independence. People who required prompting to go to the toilet were encouraged to do so by staff in a dignified way. One relative told us, "They will encourage [Name] to go to the toilet in a casual way."
- People received care and support that respected their privacy and dignity. Staff spoke respectfully about how they maintained people's dignity when providing personal care, giving examples of how they had achieved this.
- Relatives spoke positively about how staff respected people. One relative told us "[Staff] always include [Name] client in conversations."
- Staff understood the importance of keeping information safe and secure and had undertaken training in data protection and confidentiality.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- The provider did not have assurances that people received care and support that met their needs. There was no recorded information to demonstrate people had been involved in planning their care or had choice and control over their care.
- People's records did not always reflect people's current needs and did not include the protected characteristics for staff to provide person-centred care. People's records were not comprehensive, as they did not cover all aspects of people's lives such as health, independence, goals, skills and abilities, and did not guide staff on how best to support people. Staff did not have sufficient written information about people's sensory needs.
- There was no reliable system to review the information about people's care needs to ensure the records were updated as people's needs changed. Staff did not record in people's daily notes how they had provided people's care.

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's communication needs were not recorded; staff and emergency services did not have all the information they needed to communicate effectively with people. Where people had specific individual communication needs, for example, by using Makaton, staff had not received training in Makaton, or had information about particular signs people used to express themselves. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate.
- The provider was not meeting the Accessible Information Standard for people's care. Information was not always available in different formats. The provider had not provided people with accessible information in formats such as easy read or pictures about the arrangements for their holidays.

The provider failed to carry out collaboratively an assessment of needs and preferences with people about their care or have information in formats that met their needs. This placed people at risk of harm. This was a breach of regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff providing care received verbal handover about people's communication needs. One relative told us, "[Name] has idiosyncratic language. 'This sound means that'. I have sent a list so [staff] know and understand their communication. [Name] has limited signing. [Name] uses objects of reference." There was no written plan of care for staff to refer to.
● People's relatives told us staff understood how to communicate with their relatives. For example, one relative said, "[Staff] know they can't give [Name] loads of information at once. They break it down into small sentences. It is very personalised."

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 had had group discussions about the types of holidays they would like. The provider had researched and arranged holidays in line with these suggestions. People had the opportunity to attend these holidays with others they knew from attending the day centre.
● The provider met people's aspirations by sourcing various types of holidays such as activity centres, camping, theme parks and travel abroad. One relative told us, "On the last holiday they had a tennis coach which was brilliant so [Name] got to try tennis with all their friends. They sent me photos. They went on a safari at a zoo which they loved. [Name] is getting experiences that they would never [normally] get."
● Staff were familiar with people's interests, hobbies and aspirations. One relative told us, "[Staff] have got a lot of energy and are fun. Whatever they organise [Name] is up for it." One person had been supported to climb Snowden, their relative told us, "I was worried about it as [Name] has physical limitations. Some people went to the top [of the mountain] whereas [Name] went to the point to where they could. So [other] people could be challenged who could."
● People were supported to take part in the activities on the holidays in groups. Where activities were not accessible such as for people using wheelchairs, staff found other ways of ensuring people could take part in the activity. For example, one relative told us, "On one of the holidays there was a hot tub but [Name] can't use one of them because of the risk of infection, so [staff] took a paddling pool instead and [Name] went in that."

Improving care quality in response to complaints or concerns
● The provider had learnt from concerns relatives had raised in the past. They had used the information to make improvements to the quality of service. One relative told us, "I raised an issue last year after a holiday…..it was fine this time. I don't have any qualms about speaking to anyone. I know they will listen."
● There had not been any complaints recorded this year.
● The provider's complaints policy and procedure had been shared with people and relatives in an easy read format.
● The management team were responsive to feedback during and after the inspection visit and worked towards continuous improvement of the service they provided.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to have adequate systems to assess, monitor and mitigate the risks of people's health and personal care needs, or to make improvements to the service. They failed to identify that people did not have risk assessments, care plans, behaviour support plans, mental capacity assessments and best interest meetings, or safety checks of the transport or accommodation. This meant people were at risk of harm as the information staff needed was not always recorded, current or sufficient enough for staff to know how to provide care that met people's needs.
- The provider failed to have systems to monitor and improve the management of medicines. They failed to identify staff had not accurately recorded the medicines they had administered and did not have systems in place to give 'as required' medicines safely.
- The provider failed to monitor and assess the staffing levels to manage people's care whilst travelling, during staff breaks or emergencies.
- The provider failed to have systems to monitor staff training to ensure staff had the skills, competence and experience to meet people's needs. This meant people were placed at risk of harm as not all staff had received all the training they required to manage people's healthcare needs, medicines and emergencies.
- The provider failed to have sufficient policies and procedures in place to mitigate and manage the risks of travel, accommodation, activities, missing persons, and medicines management.
- The provider failed to have systems to ensure their policies were followed as staff failed to complete pre-assessments, care plans, outbound risk assessments and positive behaviour plans, or complete training in first aid, in accordance with their Holidays Policy and Procedure.

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

- The provider failed to have systems to provide accessible information to support people to understand and be involved in the planning of their holidays. This meant there was a risk people would not be prepared for, or consent to taking part in the travel and activities. For example, a member of staff described how one person refused to get on the transport to go on holiday; there was no evidence this person had been sufficiently involved in the planning or prepared for the journey.
- The provider failed to have systems to record people's equality, diverse and cultural needs. People did not have support plans that described how they wanted to be supported.
- The provider failed to have systems to work in partnership with other health professionals and agencies to improve their skills and knowledge in risk assessments and person-centred care planning.

The provider failed to have adequate systems to assess, monitor and mitigate the risks of people's health, safety and personal care needs. This placed people at risk of harm. This was a breach of regulation 17 (2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had recently reviewed all the systems relating to the risk assessments and care planning required for people attending the holidays. They had identified some areas for improvement, but the plans for improvement were in their infancy. They required further input and resources from the provider to make the changes required to ensure all areas of risks had been assessed and mitigated and staff had all the information they required to provide person-centred care. The provider told us they were committed to providing this support.
● The provider had recently changed the responsibilities within the management team. The registered manager had communicated with people and their families about the changes. One relative said, "They keep us very involved as parents. They are very honest. There were changes in management and they were good with telling us about that."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● Relatives had been asked for feedback through surveys, the information had been used to improve the service. One relative told us, "They do questionnaires and we do a review every year. We sit with the staff and chat about what's going on."
● People and their relatives knew the staff that organised the holidays and found them to be approachable. One relative said, "I love [Staff name] because you can tell they love what they do and has genuine affection for all the people and wants them to have a good time. [Staff name] sees beyond the learning disability." Another relative said, "I think [Staff name] is very approachable, very responsive. The pre-trip information has improved."

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
● The provider understood their legal responsibilities. They notified CQC about significant events which they are required to tell us. This helps us to monitor the service.
● The provider understood their duty of candour responsibility. They were open, honest and acted on concerns raised by relatives, commissioners and staff.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to carry out collaboratively an assessment of needs and preferences with people about their care or have information in formats that met their needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care to people was provided with the consent of the relevant person.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess all risks relating to the health and safety of people or doing all that was reasonably practicable to mitigate any such risks. The provider failed to ensure staff had the skills, competence and experience to provide people's care safely. The provider failed to manage medicines safely.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 18 August 2023.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have adequate systems to assess, monitor and mitigate the risks of people's health, safety and personal care needs.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 18 August 2023.