Achieve Together Limited

Dyke Road Community Support Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Dyke Road Community Support Services is a supported living service providing personal care to 19 people with a learning disability, autism, behaviour that may challenge, and mental ill health at the time of the inspection.

Dyke Road Community Support Services is based near Brighton and is made up to three supported living houses. People had their own bedrooms and shared a communal kitchen and staffing. The Care Quality Commission inspects the care and support the service provides to adults but does not inspect the accommodation they live in. CQC only inspects where people receive personal care, this is help with tasks related to personal hygiene, medicines and eating.

People's experience of using this service and what we found
The service is made up of three supported living houses and we found serious concerns in one house, other concerns in a second house and no concerns in the third house.
Risks were not being safely managed in relation to choking and people's behaviours that others may find challenging. People were not consistently being protected from the risks of abuse.
Medicines management was not safe in all the supported living houses as we found important guidance for as required medicines missing or not in place. One person did not receive their medicines when they needed them.
Staffing levels in one of the houses frequently failed to provide people's allocated hours, and staff and relatives told us that there were not enough staff to support people safely, as some people needed one to one staffing which they were not receiving at times of low staff.

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 consistently support this practice. Some people who were unable to consent to restrictions did not have these assessed under the Mental Capacity Act 2005 as required. We have made a recommendation about how decision are made for people.
One person did not have access to the medical appointments they needed as staff were unaware of the need. Staff had not received the training and support they needed with people's behaviours that may challenge. Staff told us they needed the training and felt unsafe at times.
People were having sufficient food and drink to maintain good health.

Not all people were involved in planning their care and some people had not been responded to in a caring way when they experienced distress. Some language used in incident forms was not person centred.
We did see some caring support from staff and people in two of the houses told us they liked their staff and could talk to them if they needed.

People did not always receive person centred care and support. There was a lack of planned individualised

activities for people in one of the houses, and one person had not been supported with things such as blood tests in the way they needed to be. Staff were not trained to communicate with some people.
Complaints were not being managed consistently and end of life care had not always been care planned.
We have made a recommendation about planning peoples end of life care.

Governance systems were not effective in identifying or putting right the shortfalls we found at this inspection. We found one incident that had not been notified to CQC. Risks were not being safely managed and this left people exposed to the possibility of harm. Governance systems had not ensured that any lessons learned improved the services people received.
The culture in one of the houses was not positive or person centred and staff told us they had concerns about safety especially around some behaviours that may challenge.

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

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

Right support:
• Model of care and setting did not always maximise people's choice, control and independence. One of the houses had staff shortages that meant people did not always have the support they wanted.
Right care:
• Care was not consistently person-centred. Some people had not been supported to communicate effectively.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives. Some relatives feedback expressed concerns about one house and staff told us that the culture was not positive.

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)
This is the first rated inspection of this service under the new provider.

Why we inspected
This was a planned inspection due to the length of time the home had not been inspected since the change of provider. The service had been under the new provider since September 2020.

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.

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.

Since the inspection, the provider has taken action to mitigate the risks to people around constipation,

choking and management of expressions of emotional distress.

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

We have identified breaches regarding the management of risk and the safe management of medicines, and abuse; management of health needs and staff training; personalised care; and management oversight of these issues, and in relation to failing to notify CQC of an event.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always well-led. Details are in our well-Led findings below.	**Requires Improvement**

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 Care Act 2014.

Inspection team
The inspection site visits were carried out on both days by two inspectors. A third inspector supported the inspection after the site visit by speaking with relatives on the phone.

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

The service did not have a manager registered with the Care Quality Commission. This meant that the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
We gave a short notice period of the inspection because some of the people could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

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

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the regional manager, senior service managers, senior care workers and care workers. We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, care plans and quality assurance records. We also spoke with some relatives.

Inadequate

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 for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- People were not being protected from avoidable harm and risk. One person had choked and the provider had failed to review and assess the risk after the incident. We met with the provider after the site visit to ensure the risk was safely managed. Some people were at risk of skin breakdown and were sleeping on air mattresses. Air mattresses are used to prevent skin pressure damage and have different settings depending on each person's individual needs. People with air mattresses did not have these included in their care plans. Staff confirmed that the correct settings were not recorded and were not being checked. When we checked people's mattresses, we found that one was faulty. This put people at risk of skin breakdown.
- Government guidance states people with a history of challenging behaviour should be supported in accordance with the principle of positive behaviour support. However, people's PBS plans were either not in place or were out of date, as people's presentations had changed. PBS is an approach that seeks to understand the reason for inappropriate or challenging behaviour and reduce the behaviours.
- We observed staff intervene in one urgent situation. One person was in the habit of grabbing hot drinks and staff had to physically intervene. There was no written guidance around prevention and risk of this known behaviour. Staff were not confident in managing people's behaviours. One staff told us they needed PBS training. A second staff said there was no process for de-briefing after incidents and a third staff told us of times they did not feel safe working in the service due to people's behaviours.
- Constipation care was not being safely managed. One person was diagnosed with constipation and had 'as required' medicines to treat this condition. There were times when they had not received their medicine as required. The same person's care plans and risk assessments did not specify what was an unsafe amount of time between bowel movements, for example, more than three days. Another person did not have their bowel charts completed since December 2020. We checked with staff on duty and they confirmed that no bowel charts had been completed. This left the people at risk of health complications from constipation.

Learning lessons when things go wrong

- Incidents were not being managed to ensure lessons were learned and safety was improved. One incident from May 2021 outlined a head injury to a person. The section on the form for managers comment or remedial action had been left blank. The incident had not been reviewed asper the provider's policy. The manager told us that incident forms had not always been reviewed.
- Other incidents dating back to 2020 showed that forms of restraint were being used in one of the supported living houses. These had not been analysed and there was a lack of action following incidents. This meant the same support continued for people and staff did not have additional training they might need to manage people's behaviours.
- One person's care plan noted the need to avoid orange colourants in food. Staff we spoke with told us this was a matter of preference. However, we found documents from the person's previous care provider stating

this was due to these colourants causing an overactive thyroid. A previous review had linked thyroid levels to an episode of psychosis. Staff not knowing that orange colourants could lead to changes in thyroid levels for the person put them at risk of developing psychosis.

Using medicines safely

● People's care plans did not always contain the correct and up to date information around their prescribed medicines. One person was prescribed an 'as required' medicine to treat anxiety. Their doctor had written to change the dosage and minimum time between doses. However, their risk assessment did not have this change and left the person at risk of receiving too much medicine.

● Other people had been prescribed 'as required' medicines. These medicines were prescribed in order to be given under specific circumstances and should have care plans for their use to set out any side effects, what action to take if the medicines were not effective and how the person prefers to take the medicine etc. However, we found no guidance or care plans for their use. This left people at risk of not receiving their medicines as directed.

● We spoke with the manager of the supported living house and were told there were not any in place as the service was waiting for the GP to sign them off. This meant that staff did not have the guidance they needed to administer 'as required' medicines. This was a particular risk as there were lots of agency staff working in the house, so staff needed to have the correct guidance.

Medicines were not managed safely. The provider failed to identify assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse

● People had not been protected from the risk of abuse or neglect. We saw incident reports where people had been restrained or were injured because behavioural support during incidents was poor. The restraint was not assessed or mentioned in care plans. There was no capacity assessment for people to agree to be restrained. There was no guidance about holding people, physical interventions, or restraining people and therefore no review of this.

● Physical intervention was directly observed during our inspection, and also recorded in incident reports, and in discussions we had with staff. We discussed the issue of restraint with the provider who had asked their PBS practitioner to review people's plans. The provider had decided that people did not need any forms of restraint.

● We found people had not been supported proactively with behaviours that may challenge others, due to a lack of staffing and also a lack of staff training. For example, one person was distressed and vocalising during our site visit as they were unable to go out when they wanted due to not enough staff. Staff did not have the correct training, experience and knowledge to meet all peoples individual needs. For example, one person had not received the medical support they required, as staff were unaware of the need to support them to an important medical appointment. Missing this medical appointment meant that their condition was at risk of developing.

● We shared our concerns with the local safeguarding adults team and were told that during a recent review 16 incidents at one supported living house had not been shared with the local authority. At another supported living house, we found a Statutory Notification should have been made to CQC relating to an incident of suspected abuse, but this was not sent. We have reported on this in the Well led section of this report.

People had not been sufficiently protected from the risk of abuse because systems to safeguard people were not effective. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels were not consistently safe and people were not receiving their assessed staffing hours. For example, in one of the supported living houses the staff rota for September 2021 showed 30 shifts that had not been covered from the monthly allocation. The provider had told us about several instances before and after our site visit where one of the supported living houses had reached critical staffing levels.

● We spoke with staff whether risks were being safely managed for people at the supported living house they worked in. The staff told us they felt they needed better training and they didn't feel confident due to a lack of senior staff and training.

● The provider confirmed that people were not always receiving their assessed hours. The provider had tried to cover shifts with agency staff, but this was not always possible. Staff told us there were not always enough staff to provide peoples allocated hours and records confirmed this. They said this led to people being in distress.

● One person enjoyed going out and had a planner that was kept on their bedroom door. Staff told us that that the person hadn't been going out as much recently. Staff commented, "[the planner] probably hasn't been done this week as we're short staffed. I think the planner got forgotten after [staff] left."

● We raised these concerns with the provider who told us they were working with a recruitment team to introduce new staff and there were new staff joining so there would be full capacity in two of the supported living houses. However, for the third supported living house we still received statutory notifications for critical staffing levels in the weeks following our inspection.

There were not always sufficient numbers of suitably qualified, competent and skilled staff to meet the needs of the people using the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

● We were not assured that the provider was accessing testing for people using the service and staff. One supported living house was not conducting weekly PCR tests. The provider had ordered PCR tests and all staff would then be asked to complete one PCR test and two lateral flow tests every week. Following our inspection, we were assured this had been implemented.

● We were somewhat assured that the provider was using PPE effectively and safely. One staff member started their shift whilst wearing a cloth face mask, instead of a surgical face mask in line with guidance.

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

● We were assured that the provider was meeting shielding and social distancing rules.

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

● 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 were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

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.

Staff support: induction, training, skills and experience

- Not all staff had the training and skills they needed to carry out their roles. We spoke with staff who commented that they were not behaviour trained or health and safety trained but were left in a supported living house, to support people with behaviours that challenge with only agency staff. Records showed a staff had turned their back on someone and had been attacked. The staff did not know they were not to do this as they had not been sufficiently trained. People's care plans did not have details about what to do if people were distressed in the community and staff confirmed they would not know what to do in this situation.
- Another staff member confirmed they had not had training on how to support people with behaviours that may challenge. We asked them how they would support someone if they hadn't received the training and were told, "I didn't know there was any guidance on how to deal with it. [Name] goes for you: I knew from a family member you're supposed to use arms open and down movement."
- Incident reports had shown that staff were supporting people with a history of behaviours that may challenge. One incident report showed a staff had not worked with a people previously and did not understand their communication which led to an incident.
- Staff supervision had not consistently been happening. Staff we spoke with told us they had not had regular supervision and the manager confirmed there had been no supervisions since July 2021, when staff should receive these every six weeks. If staff had been involved in incidents supervision can be used to speak through their concerns and ideas for improvement.

Staff did not have the skills and competencies to deliver effective care and support. This was a breach of Regulation 12 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their

liberty. We checked whether the service was working within the principles of the MCA.
● People in one of the supported living houses did not have mental capacity assessments completed for some decisions that they would not be able to consent to. This left people at risk of having restrictions imposed that were not in their best interests. For example, whether their front and rear door were locked all the time.
● Some people were living in a service with a keypad on their front and back door, but there was no capacity assessment to show whether people could consent to this. Some people were stopped from going out by this restriction. During our inspection we saw some people could not consent to care plans but did not have a capacity assessment for a coded door lock.
We recommend the provider reviews decisions made on behalf of people in line with current best practice guidance on capacity.

Supporting people to live healthier lives, access healthcare services and support
● Not all health needs were being managed effectively. One person was diagnosed with epilepsy. Their seizures needed to be recorded on a seizure chart so that an accurate record was kept and could be used to analyse the efficacy of medicines or other treatments. Seizure charts were not accurate and one seizure had not been recorded on the charts. Accurate seizure records should be kept for neurology reviews, so professionals can gauge how effective epilepsy medicine is for each person.
● The person had been prescribed a rescue medicine to be given during a prolonged seizure. The emergency intervention plan for this medicine stated, "Please refer to [initials] care plan for further information". Staff we spoke with told us that further information would be in the person's care plan, but there was no further detail about the use of this medicine in any care plans. There was no information for staff to refer to about when and how to give this medicine and where it was stored.
● One person required specific support to help them give a blood sample. This had not happened and we spoke with staff who were not aware of the special instructions on how to support the person to give a blood sample. Had the set of instructions been followed the person may have been able to supply a sample at a special clinic as requested
● Night checks were not happening with the frequency outlined in the person's care plan. In addition, hourly night checks for epilepsy did not mitigate the risk. For example, if the person had a prolonged seizure a couple of minutes after a night check, they wouldn't be checked again for almost an hour. There had been no consideration of night-time monitoring checks such as sensory mats that would alert staff to a seizure.

There were not effective systems to demonstrate all people's health needs were safely managed. This was a breach of regulation 12 (Safe Care and Treatment) 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 who moved into any of the supported living houses were given a pre-admission assessment. We reviewed the last one completed and it was thorough with a range of needs assessed, including autistic needs and behaviours.
● However, some sections of people's care plans had not been completed effectively, such as sensory profiles. These described whether people had a good sense of smell or taste, but not what would cause anxiety or describe the person's sensory needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People were given sufficient food and drink to maintain good health. Where people preferred food to be served in a certain way, such as cold, this was respected by staff to ensure people ate and drank good amounts.

● One person had a food diary with food and drink recorded for each day and calories counted with a total. People made their own food planners and were supported to go out weekly to buy whatever food they needed. People were supported by staff to cook their own food where possible.

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

● When people moved in or out of the service there is a robust transition process. One manager told us how they introduced a new person moving in, "We planned it with a carer; we informed all people in the house, and the person came over for an hour or two. We see how they interact, then gather feedback from the people already here." This process was then followed by a transition where the person could come and stay for short times.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Not all people were actively involved in planning their care. We spoke with managers of two of the supported living houses and were told that people were not yet actively involved in care planning. Some people also had limited family involvement so would only have plans written by staff despite being able to participate if supported with communication. Care plans had not been reviewed by people and some were not reviewed within the providers own timescales to ensure they were accurate and up to date.
- Some people communicated by using Makaton. Makaton is a language programme for people with communication difficulties that uses signs and speech together. Some staff we spoke with were unaware that people used Makaton. Other staff were aware but had not been trained to use it. One staff told us, "Makaton would be great, both [name] and [name] speak it. It would be great to have that."

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

- People were not always responded to appropriately when they were experiencing distress. One person had a characteristic that was described in their care plan as indicating they were in distress. The person was engaging in this action and staff did not respond to them. After a while the person's distress escalated and they started shouting before staff intervened.
- One agency staff said they would just walk away from people in distress displaying behaviours that may challenge. The staff had not been trained in challenging behaviours and said they did not want to risk injury.

People were not being fully involved in their care planning and people in distress were at risk of not having the support they need. This is a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- Some language used to describe people was not person centred. Incident reports had referred to people experiencing distress as 'kicking off'. Another incident report had referred to supporting an adult with their continence needs as 'putting a nappy on'. These were not dignified ways of referring to people.
- We raised this with a manager who told us, "Some of the language used or detail [in incident reports] is not correct. It is important to recognise that our quality has dropped and we need to improve."

We did see some caring support from staff who were dedicated and working hard to care for people. One supported living house had good caring interactions. One person told us, "I'm doing well here. They are looking after me well."

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

- Personalised support had not always occurred. One person had a communication plan that said they should be introduced to any visitors to their house, to reduce risk. When we visited as part of our inspection, we were not introduced to the person. The person was later showing signs of being upset.
- Monthly key worker assessments had not been completed in one of the supported living houses since March 2021 and in another supported living house since May 2021. These assessments would be meetings with people to review their goals and achievements, as well as arrange activities.
- Some people's care plans had sections that had been left blank that were relevant to them, such as the life goals part. Other care plans for people did not have sufficient information in them to be personalised. For example, one stated the person liked TV and should be supported to watch their favourite shows, but not what these were.

Meeting people's communication needs

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

- One person, who did not use speech and is autistic, had a suggestion in their communication profile that picture boards might work well for the person to communicate their needs. However, there was no follow up of this and no reference to picture board in their communication guidelines. We asked a staff about this and was told, "No [name] hasn't got a now and next or communication board. It might help." This person had a high number of incidents where they used behaviour as a means of communication.
- Another staff told us of how they struggled to support a person with their communication due to a lack of written guidance or personalised information.

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 living in one of the supported living houses did not have planned individualised activities. One person told us, "[There is] not much activity inside. I like listening to my music, or to read something." Activity planners had not been completed since June 2021 and one staff told us they were not aware of the need to complete them. Another staff told us, "I've never seen any activities except taking [people] out." The same staff commented, "We used to have activities, but since COVID hit not so much…we just ask people what they fancy doing. No plans as such."
- One relative told us of activities, "We bought [name] a large paddling pool for them to use there. They

didn't have a hosepipe or pump to set it up so I went down with mine. There seems to be no budget for stuff and activities."

There was a lack of personalised care, communication support and structured activities for some people. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people in two of the other supported living houses had good access to activities that were person-centred and planned. In one of the supported living houses there was a handwritten activity plan that was written during a house meeting and then displayed in the lounge.
● One person told us that although some activities had been cancelled due to the pandemic, other activities had been put in place. The person said, "We used to have lots of singers…we used to have a massage lady. Now we have a lady with violin session. We still have yoga and violin classes [online]."
● Some policies and important notices had been displayed in the houses in accessible format.

Improving care quality in response to complaints or concerns
● There was a mixed response to complaints. We spoke with a manager, in one supported living house, who told us, "We don't have a complaints folder, I just respond to emails. We have easy read forms which are available for people. I would only have the emails parents have sent in; we don't keep a folder of these." This approach may make it more difficult to track complaints and any themes.
● Other supported living houses kept a complaints file and had responded to complaints in line with the provider's policy.

End of life care and support
● People being supported at Dyke Road Community Support were younger adults and nobody was currently receiving end of life care. Some people had a funeral plan with basic information, but other people's end of life care plans were left blank.

We recommend the registered provider reviews people's end of life wishes and records these in care plans.

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 Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered provider had failed to a send Statutory Notification to CQC. Regulations of the Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service, or the people using it, are notified to CQC. There was an allegation of abuse in October 2021 where an incident was reported to the local authority safeguarding team. The registered provider had not notified CQC of this.
- There was no registered manager in post at the time of our inspection. An area manager had been overseeing the service but since our site visit, we were told they had left the organisation. Following the inspection, the provider told us that a manager had been recruited and is in the process of applying to register with CQC.

Statutory Notifications had not been sent to CQC. The failure to notify CQC of significant incidents is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

- There were not robust governance systems in place to ensure that care and support was safe, effective or high quality. Shortfalls we identified had either not been highlighted by audits, or effective action to remedy them had not been taken. Audits had not reflected the concerns of staff or some relatives, such as a lack of specific training for behaviours, or the risks around choking and constipation found at this inspection.
- For example, in one supported living house we found issues with a person's constipation care. The audit for that house had not identified there was a constipation risk or shortfall to address this, and the action plan did not contain any action to put this right.
- The provider was not able to accurately assess monitor and improve service delivery in some supported living houses as some people's daily notes had been incomplete for some days. The daily notes provide an overview of each person's day including what they did, how they were and food and fluid intakes.
- People's care plans and records were not completed or were inaccurate. Parts of care plans had not been completed with the necessary level of detail to explain people's support needs, and people's daily notes had not been completed for entire days in one house. Daily notes are used to record the support people are given each day.

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

- One of the supported living houses did not have a positive culture that ensured good outcomes for

people. Staff working in this service told us there were times they were not confident working with people. Some staff said there were times they did not feel safe. We observed that there were times when people were distressed as they were unable to access the community. One person showed signs of distress but was not responded to by staff.

● We spoke to the service manager about this and was told, "It's been a very difficult time overall. We're working it out. The internal PBS team are supporting us. A manager is now in post. Hopefully things will improve."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff, people and relatives were not being fully engaged in the service. Relatives told us that they had not received any questionnaires or feedback forms about Dyke Road Community Services.

● Some relatives did say they felt able to speak to managers, but that there had been a high turnover in management and staff.

● The provider told us that for one supported living house they were reliant on longer term staffing to guide other staff on how people like to be supported. One manager told us, "Old staff say what could be better and what's needed."

● In two of the supported living houses there was no evidence of people being engaged and involved with their service. One person told us, "We don't really have residents meeting [I would like these], because if someone had a problem they could talk to management. We need to negotiate about having meetings, so we can give feedback."

Quality audits had not been effective in making improvements. People's records were not always complete. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the supported living houses had a very positive culture and people and staff told us they were happy living there.

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. Working in partnership with others

● Relatives told us they had been informed when things went wrong. However, not all incidents had been shared openly with the local authority in one supported living house. There were 16 incidents where the local authority had not been informed of issues, including people's behaviour.

● Information was being shared securely between the provider and other professionals on a need to know basis. Encrypted services were used to send documents such as care plans and other personal data to local authorities.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to Notify CQC of all significant events and incidents.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that people were being fully involved in their care planning and people in distress were at risk of not having the support they need. The registered provider had failed to ensure people received personalised care, communication support and structured activities.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that people were kept safe from risks and they had safe access to medicines. The registered provider had failed to ensure that effective systems were in place to demonstrate all people's health needs were safely managed. The registered provider had failed to ensure that staff had the skills and competencies to deliver effective care and support.

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to ensure that people had been sufficiently protected from the risk of abuse and that systems to safeguard people were effective.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to ensure that quality audits were effective in making improvements; that people were supported in a person-centred culture; and that the registered manager and provider understood the requirements of their roles.