# The Regard Partnership Limited

# Uxbridge Road

## 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? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Uxbridge Road is a supported living service and is registered to provide personal care for up to nine people with learning disabilities, mental health needs, autism spectrum conditions and behaviours that may challenge. At the time of the inspection seven people were living at the service. The service accommodates people in a main house and a large bungalow annex located in the garden. People have their own self-contained flats and share communal areas, such as a kitchen and living room in the main house and a kitchen and living room area in the annex.

Six people who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not always kept safe. We found concerns with the safe management of risks to people including risks associated with medical conditions such as epilepsy, and where people have behaviours that may challenge others. People were also not always protected from the risks arising from weak safeguarding procedures.

There were not enough staff deployed to meet the individual needs of people living at the service and some staff did not have a good understanding of people's needs. We found limited evidence of supervisions being conducted with staff to allow them the opportunity to talk about their work and to share information in a one to one setting.

Staff were using restrictive practices to limit the movement of some people living at the service. The provider did not ensure that staff had the necessary training and experience needed to manage and reduce behaviours that challenge. We identified concerns with overall levels of staff training. Role specific training was not available to support people with specific health conditions such as epilepsy and not all staff had training in the Mental Capacity Act 2005.

Staff had not always supported people to attend their healthcare appointments, some appointments were missed, and we found poor management oversight to ensure that people had regular health assessments in line with best practice.

People were not supported to undertake activities that were meaningful to them. We found staff did not always actively engage with people, who were often left without any therapeutic interventions.

Staff were kind and relatives confirmed they believed people were happy, although they felt there had been a lot of management changes and a high turnover of staff, which had an impact on people's wellbeing.

Care plans did not always promote personalised care and lacked information for staff to meet people's needs safely.

At the time of our inspection, there was no registered manager in post. A registered manager for another of the provider's services had been supporting the service on a part time basis. A senior manager was supporting the service in order to make immediate improvements.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

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

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

Right support:
The provider had no effective systems in place to ensure that people's voices were heard. People were not always supported in the least restrictive manner and their choice and independence were limited. People were not always supported by enough staff who had received the full training required to appropriately meet their needs.

Right care:
People using the service did not receive planned and co-ordinated person-centred support. Care was not always delivered in a way to ensure that people's human right and dignity were respected. Staff used restrictive practices to limit the movement of people and there was a lack of understanding of people's needs. Best practice was not sought when supporting people to maintain their dignity.

Right culture:
We were not assured that the provider had made the necessary changes needed to improve culture within the service. Senior management had begun to take action to address shortfalls in communication between care workers and management, but this still required improvement. We found interactions between people and staff were task focused and staff did not activity seek to improve the quality of people's lives by providing activities that were meaningful.

People's wishes and preferences about end of life care were not consistently explored with them. We have made a recommendation about involving people in decisions about their end of life care.

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

Rating at last inspection
The service was registered with this provider in December 2020 and this was the first inspection since then.

The last rating for the service under the previous provider was requires improvement, published on July 2019.

Why we inspected
The inspection was prompted in part due to concerns received about the quality of people's care and support, staffing, the way people were being treated and safety and governance. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all the key question sections of this full report.

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

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

We have identified breaches in relation to safe care and treatment, person-centred care, safeguarding service users from abuse, good governance and staffing 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 for 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 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?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Uxbridge Road

**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 was completed by two inspectors. An Expert by Experience also supported the inspection by telephoning relatives of people who used the service. 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 provides care and support to people living in a supported living' setting, 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.

There was no manager registered with CQC at the time of our inspection visit. The previous registered manager had left the service in February 2021. A registered manager  similar to the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The service had a registered manager from another service who was providing support alongside a senior manager. They had been at the service for six weeks at the time of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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.

We reviewed information we had received about the service since the last inspection. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We met six people who used the service and spoke with four, while carrying out observations between people and staff to help us understand the experience of people with whom we could not communicate . We spoke with five members of staff including a senior manager, a registered manager for another service and three support workers. We reviewed a range of records. This included three people's care records and medication records. We looked at three 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 staff records and quality assurance records. We spoke with the relatives of four people who used the service via telephone and we raised a safeguarding alert about some of our findings.

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 for 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

● Risks to people had not been fully assessed or mitigated. One person had a habit of picking up items around the home without understanding whether these posed a danger or not. Staff told us the person would eat or drink things they believed to be food. We saw examples of this when they tried to eat food items which were not designed for raw consumption. Within their home environment they had direct access to items which could pose a serious risk to their safety, such as cleaning products and sharp knives as well as a variety of food items, some of which should not be consumed without cooking.

● The person also had a habit of reaching out and taking items which may not be suitable or safe. Within their home there was an exposed electrical meter cupboard and electrical wires hanging loosely under a television. While the provider had arranged for this person to be supported by a staff member on a one to one basis, we saw instances where staff presence did not reduce the risks in this person's environment to ensure their safety. Therefore, the provider had not adequately assessed and mitigated the risks that could arise if the person were to pull on these items which may cause them harm.

● Assessments of the risks to people's safety and wellbeing had not always been recorded so staff did not have clear guidance on how to manage these risks. For example, one person had mental health needs and they regularly refused to engage in any social activity and slept for most of the day. Whilst their health plan identified this was a trigger for contacting medical professionals for support there was no other identified measures about how to manage this risk and support this person.

● In order to support one person to prevent them hurting themselves or others, staff used physical interventions and restrictions. There was no assessment of these types of interventions or plans for staff which had been approved by specialists. This meant the person was put at risk from staff carrying out unsafe interventions which were not part of their plan.

● On arrival at the service the inspection team found the front door of the main house left ajar. This posed a potential risk of unauthorised individuals gaining access to the premises. This also meant that people may have been able to leave the home when it was not safe for them to do so as the home is located on a busy main road.

Failure to assess and mitigate risks to people's safety and wellbeing was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the above concerns with the management team at the service and after the inspection they assured us they had taken action to mitigate some of the immediate risks to people within their

environment. They explained they were in the process of reviewing and developing recorded risk assessments and risk management plans.
● Personal emergency evacuation plans (PEEPs) were in place for each person living at the service, which identified potential hazards and detailed the staff support required for safe evacuation procedures for different times of the day.

Staffing and recruitment
● Some of the relatives we spoke with told us about concerns regarding staffing. Comments included, "There have been lots of staff and managers coming and going. Would have liked to have been kept informed", and "All known staff have left, staff changes have always been an issue. [Person] gets to know them, then gets upset when they go. It's a difficult journey. Sometimes there are bank staff. They don't know [people using the service as well as they do]".
● Not enough staff were deployed to meet people's needs and keep them safe. On the day of our inspection, there was not enough food for two people and the staff told us this was because no one was available to go to the shops to buy this for or with these people. People told us they did not have enough support when they needed this for escorting them in the community and to support them with activities within their home.

● One member of staff told us they had to come to work at short notice because they were the only staff trained to administer medicines. One person was prescribed a medicine to be administered in the event of a seizure. Only a small number of staff were trained to administer this. There were times this person was being supported by untrained staff alone and outside of the service. This meant the person was at risk because they may not receive their medicine if they needed this in an emergency situation because of the provider's failure to deploy suitable staff in this instance.
● The staff supporting people were not suitably qualified or trained to do so safely. Some staff had not received the necessary training to understand people's healthcare conditions, communication needs or how to safely support people. One member of staff explained they had received no formal induction, no training and did not have experience working in the care sector. However, shift planners stated this staff member was allocated to support people with high needs on several occasions and also allocated as 'shift leader' on a rota basis. This meant the provider had not always deployed suitably qualified and experienced staff to meet the needs of people using the service.

Failure to deploy enough suitably qualified and experienced staff was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Staff were recruited appropriately. The provider ensured that staff had the correct pre-employment checks before any new employee started work. These included obtaining reference checks from previous employers and disclosure and Barring Service (DBS) checks.

Systems and processes to safeguard people from the risk of abuse
● The systems and processes to safeguard people from the risk of abuse were not operated effectively. Staff told us they had not undertaken training in safeguarding adults from abuse and only had a limited knowledge of what to do if they suspected abuse. The training records confirmed this as not all staff had received this training or had a date scheduled to undertake it. Staff did not routinely discuss safeguarding or whistle blowing procedures with each other or managers, and the management team said they were not aware of the lack of staff knowledge in this area.
● The staff used restrictive practices in their support of one person. These included physically intervening to stop the person from doing things they wanted. This had not been assessed or planned for and the management team were unaware these interventions were classed as restrictive practices. The staff had not

been trained to do this safely and appropriately. We raised our concerns about this with the local authority safeguarding team.
● There was limited information available to ascertain what actions the provider had taken in relation to learning lessons when things went wrong. Outcomes were not documented, and risks had not been analysed to identify trends to help reduce the risk of recurrence. There were no examples of reflective practice or that this information was being discussed with staff.

The systems for safeguarding people from abuse were not operated effectively and 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.

● Notwithstanding, managers have reported safeguarding incidents where these had occurred without delay to the local authority and/or the police for investigation.

Learning lessons when things go wrong
● We also looked at learning when safeguarding incidents had occurred and found limited information available to ascertain what actions the provider had taken in relation to learning lessons when things went wrong. Whilst immediate actions were taken to protect people and keep them safe, outcomes of the investigations were not always documented, and concerns had not been analysed to identify trends and patterns to help reduce the risk of recurrence. There were no examples of reflective practice or that this information was being discussed with staff to ensure learning took place.
● The provider confirmed that no accidents or incidents had occurred at the service.

We were not assured lessons were learnt from incidents which had occurred. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The staff did not always record when and where (on a person's body) medicated creams and topical medicines were administered. For example, we witnessed staff applying medicated cream to a person's injury, although this was not recorded and there was not a clear plan for when and how this should be administered. There was no evidence the administration was inappropriate but without clear records there was a risk people may not receive medicines as prescribed or directed.
● We found that people generally received their medicines as prescribed and in a safe way. The management team had reviewed how medicines were managed and made improvements which included introducing detailed medicines profiles for people, protocols and improving systems for checking and recording medicines administration.
● The staff responsible for administering medicines undertook relevant training and were assessed as competent to do this by members of the management team.

Preventing and controlling infection
● The service was following infection prevention and control procedures to keep people safe and we saw that staff supported people to maintain their personal hygiene.
● Since the start of the COVID-19 pandemic, the provider had reviewed their procedures to make sure these were suitable and in line with government guidance. The staff wore personal protective equipment (PPE) and this was also offered to people using the service who could wear it if they wanted. The staff and people had regular COVID-19 tests and had been encouraged to have vaccinations against COVID-19 and flu.

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 under the new provider. 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

● People were being cared for by staff who did not have the skills, experience and training so they know how to care for and support people with a learning disability in the right way and safely. Three staff members told us they had not been given thorough inductions. One member of staff had no experience of care work prior to being employed at the service and said they had learnt through following the custom and practice of others, and they had not had guidance and direction from managers. They explained they had not had training, their competencies had not been assessed and they had not had meetings with the managers to discuss their work. Another member of staff echoed this, telling us that although they had previously worked at another care home, they had not had any form of induction at this service.

● The staff had not received the necessary training to care for people safely. They provided care to people with healthcare conditions which caused seizures but had not had training in how to support them in the event they had a seizure or in basic first aid. They also worked with people who could not communicate verbally but had not had any training to help them understand how these people communicated and so they could communicate with them.

● Staff training was not up to date in all cases, particularly for that of new starters as role specific training was not always delivered or available. Training records confirmed that several staff members had not received training with person-centred care, safeguarding, mental capacity, and fire safety.

● Staff did not feel supported. We spoke with three support workers who told us they did not have clear direction or guidance from managers. They explained they were asked to work at short notice and carry out tasks they were not confident with. We raised this feedback with the manager on the day of the inspection. We were told that, ''[staff] were employed under the previous manager and that is the first time I have heard about that''. There was a lack of management oversight in ensuring that staff had the relevant skills and confidence to support people safely. Competency observations had not been conducted and regular supervisions were not happening with staff. This meant opportunities to manage staff performance and to make sure the right culture was created for them to deliver care and support to people had been missed.

Failure to ensure suitably trained, experienced and qualified staff were deployed was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager left earlier in 2021 and there had been several changes in the staff team. The new temporary management team were aware this had impacted on staff communication and support. They told us they had started to plan for more staff training.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff did not have the knowledge to ensure laws and guidance were followed and people were not deprived of their liberty. The staff we spoke with had not had training about the Mental Capacity Act 2005 and did not know what this was or how it applied to their work. Additionally, they were using restrictive practices but had not been trained in this area.
● The management team had started to carry out assessments of people's mental capacity relating to specific decisions. We saw some of these assessments. They had also made referrals to the relevant authorities for them to be assessed regarding the deprivations of their liberties.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat and drink and were nutritionally stable but at times they did not have sufficient quantities of food and drink available between their main meals. Two people living at the service needed full support from staff to plan, shop for and prepare food. On the day of the inspection, the staff explained they had not been able to do food shopping and showed us the fridge and cupboards did not have any fruit or snacks for people. One person showed the staff they were hungry and wanted food, but there was nothing to offer them. We explained this situation to one of the managers so they could address this shortfall immediately.
● People were responsible for purchasing their own food, some with the support of staff (as described in the example above). The staff supported people to prepare meals which reflected their individual tastes and dietary needs. However, a relative told us that staff did not support a person to discard expired food, which resulted in the person having an upset stomach from consuming food products past their expiration date.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access health care services. However, on the day of our inspection a person missed a healthcare appointment. The manager was subsequently made aware of this and informed the inspection team of this oversight and had begun to put systems in place to help make sure this did not happen again.
● Previously risks associated with people's care and treatment had not always been identified and referred to in a timely way. For example, one person who was at risk of choking was last assessed by the Speech and Language Therapy team in 2014. There was no evidence that consultations or reviews had been arranged since and this was only addressed by the management team this year.
● There were other instances where health care professionals needed to be sought in relation to concerns

with people's dental hygiene. For example, in November 2020 an oral health assessment determined that a person needed to have a dental examination every six months. However, there was no evidence this had taken place and no record of any appointment being arranged.

● Staff had recorded plans about people's healthcare needs and any specialist support they required. The manager told us they had updated and improved some of these, so the information was clearer. Guidance from healthcare professionals was included in people's plans. A relative we spoke with told us that they were kept informed of healthcare appointments, "If they take [Person] to the GP they tell us afterwards".

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

● We saw instances where staff carried out restrictive practices to limit the movement of a person who lived at the service. The provider did not have restrictive intervention reduction plans in place and the management team did not recognise that staff methods constituted restrictive measures. This goes against National Institute of Clinical Excellence (NICE) guidelines on Violence and Aggression.

● People's needs were assessed before they moved to the service. We saw examples of detailed assessments which identified people's needs and the level of support they required. The assessments also included a profile of their likes and choices.

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 under the new provider. 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.

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

- Whilst we witnessed kind and polite interactions from staff, the service did not ensure people were always well treated, cared for or supported. For example, the provider had not planned their care well enough and staff were using restrictive practices on people without having had the training to make sure this was always carried out in a person-centred way and appropriately. Furthermore, people were not always safe and the staff were not trained or skilled at caring for them.
- Staff interactions were mostly task based and did promote the ethos of the right culture, right care and right support. For example, staff supported people with personal care, cooking and household jobs but they did not spend time engaging in leisure or social activities with people. We did not witness staff asking people about their wellbeing or asking what they wanted to do and how they wanted to spend their time. People told us they were sometimes bored.

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

- Care files evidenced that some people had the opportunity to express their views through sessions with care staff. However, this was not consistent across all settings.
- Relatives told us that communication with the service had not been sufficient and that more could be done to provide updates to families. When we asked relatives if the service have provided the information they needed, one relative said, "Not very often, I normally find out when I ring weekly or two weekly. When I phone, I speak to different people, they don't tell me who they are and what they do. They don't keep in touch very much," and another relative said, "We get no communication from the home. Updates would be nice".
- Notwithstanding the above, relatives told us that people were happy and that their physical needs were met. A relative commented that "[Staff] do listen to me and are always nice. The manager comforts and reassures me…", and "They needed time to get to know [person], learning what [person] needs. I think [person's] needs are being met now. There are no carers [person] doesn't get on with. [Person] is happy".

Respecting and promoting people's privacy, dignity and independence

- People's privacy and independence was respected. People could choose what they wanted to do with certain limitations and were supported by staff to make their own routines. For example, people were involved with elements of preparing their own meals and shopping for items of their preference.

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

- People did not always receive personalised care which met their needs and reflected their preferences to ensure they were supported to have a good and meaningful life, every day. Two people received individual staff support throughout the daytime. However, records showed the care which had been provided demonstrated they did not participate in many meaningful activities. For example, during April 2021, records showed that they had only left the service once to go on a car ride and had used their garden less than five times. On the day of our inspection, one person spent the majority of their time sitting on a sofa, sometimes looking at an electronic tablet. The other person walked around their home with no structured activity. The staff reported this was typical of most days. There were only a few resources for people to use, such as some building blocks and toys. The staff reported they did not regularly use these.
- Furthermore, there was no planned activities or structure for the staff to follow when supporting people to follow their interests and to take part in their local community. As a result, their needs were not always being met.
- The records for a third person showed that they had spent the majority of April 2021 alone in their bedroom, with staff recording the person was asleep regularly throughout the day. There was a basic timetable of activities designed for this person to follow in their care file, however, this had not happened and the person was not supported to take part in the activities planned for them. The only activity for most days was cooking and eating their food.
- We spoke with four other people who lived at the service. One person told us they were not supported to take part in any structured activities, follow their interests or to be part of the local community. We saw that for most of the day people sat in their rooms, the garden or lounge. The majority of interactions they had were with each other and members of the inspection team. At one point a staff member took a board game (designed to be played by two people) and placed it in front of a person but did not play the game with the person or suggest others played the game.
- Feedback received from relatives was largely negative in relation to the lack of activities and engagement at the service. Comments included, "I put [person] in supported living for [person's] benefit. I hoped [person] would learn to manage [person], be more independent. It didn't happen, [person] sits in front of the TV, [person] should have a programme. I feel let down", another relative said, "Stimulation has always been an issue. It hasn't lived up to its name of supported living. It's like a care home. I hoped [person] would learn some skills and independence. There is no development".
- People told us they did not have assigned keyworkers to support them in planning and meeting their needs. One person told us they used to have a keyworker but this member of staff no longer worked there.

Therefore, people did not have regular opportunities to discuss their needs with a member of staff and plan how these would be met. Staff were not reviewing how care and support was working for people. For example, one person's file contained monthly reviews of care, however the last one had been completed in November 2020. Records of care for this person indicated their needs had changed significantly since this time, although their plan had not been updated to reflect this.
● Care plans did not contain personalised plans to support people with behaviours that can challenge. No assessment had been conducted to provide guidance for staff to help identify, monitor and manage these behaviours, which resulted in staff not able to effectively support people to improve their quality of life. Following the inspection, the provider confirmed that an urgent referral had been made to the relevant healthcare professionals to create a personalised plan of support for people which would include guidance for staff to help understand and manage behaviours safely.

Failing to provide care which was personalised and met people's needs was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to stay in touch with friends and family. Relatives told us that although they had been able to communicate with their loved ones, the provider had only facilitated this on behalf of their request and did not actively make contact with them, "The old Manager rang regularly, not so much now. No one volunteers information. I ring and ask staff to ask [person] to ring me. We do video, WhatsApp calls". The provider supported garden visits and one person had a planned barbeque for their birthday with their family member attending. A relative of this person confirmed that they are planning to attend.

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

● People's communication needs were not always met. Five of the seven people could communicate verbally and express their needs and wishes. However, two people could not and communicated in other ways. The staff had not been trained to understand these needs and there were no plans to show how people needed support. The staff had not been trained in Makaton (sign language) and did not use picture, photos, objects of reference or any other method to support their communication with people.
● There was no planned approach to understand people's communication needs. The staff told us they made guesses about what people were trying to tell them from known actions, such as a person getting a plate or spoon when they wanted to eat. But without a clear plan to reflect a person's preferred means of communication, there was a risk that communication might not be effective and staff may not be able to respond to the person's individual needs and requests for support.

Failure to meet people's communication needs was a further 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
● There was no record of any concerns or complaints being raised. The manager told us this was because the provider has not received any complaints about the service.
● The provider had information and guidance for people in relation to making complaints. A complaints policy was available in an easy read format and displayed on a notice board at the service.

End of life care and support

● The service was not supporting anyone at the end of their life. Most people living at the service were younger adults and did not have life limiting diseases and staff did not receive training in this area. We found that the service did engage with a person about their end of life needs and their choices and wishes were recorded, however this was not consistently reviewed or explored for all people living at the service.

We recommend the provider consider National Institute of Clinical Excellence (NICE) guidelines in relation to end of life care.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection under the new provider. This key question has been rated requires improvement.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The culture at the service was not open or person-centred and did not reflect the values around CQC guidance on Right Culture, Right Care and Right Support . People did not always receive personalised care which met their needs or reflected their preferences. For example, the staff did not understand people's communication needs, people were not supported to follow their interests and did not take part in meaningful activities and their access to healthcare was at times compromised because healthcare appointments were sometimes missed.
- The lines of communication within the service among staff, including management staff were not always effective. Staff told us they had not been given clear directions, did not always understand how to care for people and had not had the training and support they needed to carry out their roles. There was limited evidence of staff having had supervision or reflective practice conversations. We discussed this with the management team and they explained they had not had the opportunity to give the training and support needed to staff since they started working at the service six weeks before the inspection. One of the managers explained there were problems with the culture at the service, with staff following custom and practice that was not always in people's best interests.
- The provider's systems for assessing and mitigating risks were not operated effectively. We identified risks to people's safety and risky practices where staff were physically restricting people's movement without proper training, planning or assessment.
- The provider had not always maintained records to demonstrate the management and oversight of the regulated activity. For example, they had not ensured records relating to staff suitability and recruitment were in place.
- Systems for monitoring and improving quality were not operated effectively. There were widespread failings at the service which were the result of poor staff training and support, lack of direction and guidance for staff and a poor culture. Whilst the provider had recognised some of these failings, they had not taken enough action to make the necessary changes and as a result people were receiving a service that did not always meet their needs, preferences and interests.
- The provider had recently implemented regular audits in relation to health and safety and the management of medicines. We saw that audits conducted in March 2021 identified that new employees had not yet completed elements of fire safety training and in April 2021 this had been recorded as being

completed. However, training records revealed that not all staff had undertaken this training or had this training booked. Therefore, audits were not effective as they did not identify this issue.
● The provider's systems for gathering information from people and their relatives about their experience of the care provided were not operated effectively. There were no records of any meeting's held with people or surveys being sent out. This meant the provider did not seek to gain people's feedback and did not present people with the opportunity to discuss different aspects of their care.
● Following the inspection, the provider continued to keep us updated with any actions they had taken or had arranged to make the necessary improvements.

Failing to operate effective systems to monitor and improve the quality of the service and mitigate risk was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team had started to introduce some changes at the service. These included challenging poor practice when they identified this and updating some people's support plans and risk assessments.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The service has had no registered manager in post since February 2021. In the absence of a permanent manager, a registered manager from another service and a senior manager were managing the service on a temporary basis. They had both been undertaking management responsibilities for six weeks prior to our inspection. We have seen improvements in the running of the service since they have been in place and we have been provided assurances that the concerns identified will be addressed. However, there are still significant improvements that need to be made to improve staff knowledge around regulatory requirements as described throughout the report and to ensure people received appropriate and safe care and have as fulfilling a life as possible.

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 has been working closely with the local safeguarding authority to address shortfalls in people's care and support. The provider attends provider concerns meetings and is open and transparent about their finding's and how they intended to put things right to improve the service. The provider's engagement and willingness to make improvements has also been demonstrated in their service improvement plans that are disseminated weekly to CQC and the local authority.

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<br><br>The registered person did not ensure care and treatment of service users were appropriate, met their needs and reflected their preferences.<br><br>Regulation 9(1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered person did not ensure that care and treatment was provided in a safe way for service users.<br><br>Regulation 12(1) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered person did not ensure systems and processes were established and operated effectively to prevent abuse and improper treatment of service users.<br><br>Regulation 13(1) |

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 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person did not effectively operate systems to assess, monitor and improve the quality of the service or to assess, monitor and mitigate risk.<br><br>Regulation 17(1) |

**The enforcement action we took:**

We issued a warning notice telling the registered persons they must make the required improvements by 30 June 2021.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the needs of the service users.<br><br>Regulation 18(1)(2) |

**The enforcement action we took:**

We issued a warning notice telling the registered persons they must make the required improvements by 30 June 2021.