Poppy Cottage Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Poppy Cottage Limited is a supported living service. The service provides personal care to people living in five supported living settings, so that they can live as independently as possible. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection 18 people with a learning disability and/or autism used the service.

People's experience of using this service and what we found
People's care and support was not always provided in a safe or clean environment. Systems were not always implemented to ensure people were protected from abuse and poor care, or the safe management of medicines. In general people and relatives told us felt the service was safe, however, they were concerned about the impact of poor staffing levels and inexperienced staff upon people's safety and quality of life. People's risks were not always assessed regularly in a person-centred way. People were not involved with managing their own risks whenever possible. Systems to report and learn from incidents, including where restrictive practices were used were not implemented effectively.

People's care, treatment and support plans, did not fully reflect all of their sensory, cognitive and functioning needs. People did not receive care, support and treatment from trained staff and specialists able to meet their needs and wishes. People who had behaviours that could challenge themselves or others had care plans in place, however these did not always include proactive plans to reduce the need for restrictive practices. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice.

People were not always supported to be independent and identity or achieve their own goals. Where people were supported by staff who knew them well, and understood the support they required, people told us they experienced caring and positive relationships with staff. People did not always have care from staff that protected and respected their privacy and dignity.

People's communication needs were not always met, and information shared in a way that could be understood. People were not always supported to take part in meaningful activities which were part of their planned care and support. People and those important to them, were not actively involved in planning their care. Care plans were not always reviewed to ensure they were up to date and accurate.

People were not supported by staff who understood best practice in relation to learning disability and/or autism. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs. People and those important to them, were not fully involved with leaders to develop and improve the service.

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 model of care and the setting did not always show how people's choice, control and independence were maximised.
Right care:
• Care was not always person-centred and did not always promote people's dignity, privacy and human rights.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives.

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

Rating at last inspection
The last rating for this service was Good (published 3 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, medicines errors, an allegation of abuse and poor management. A decision was made for us to complete a focused inspection to review the key questions of safe and well-led. However, during the inspection we found wide-spread concerns and decided to complete a comprehensive inspection to include all key questions.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Poppy Cottage Ltd on our website at www.cqc.org.uk.

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 people's safe care and treatment, safeguarding from abuse and improper treatment, person centred care, dignity and respect, need for consent, sufficient numbers of skilled staff, fit and proper persons employed, governance systems and reporting events to CQC when required.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Poppy Cottage Limited

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The onsite inspection was completed by two inspectors on the first evening and one inspector on days two and three. An inspector and an Expert by Experience made phone and video calls to people and their relatives to gain their feedback. 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 five '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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The day to day running of the service had been delegated to a manager, who had applied to register but withdrew their registration prior to our inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 8 July 2021 and ended on 26 July 2021. We visited the office location on 9 and 13 July 2021.

What we did before 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 seven people who used the service and seven relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, manager, operations manager, senior care workers, care workers and the registered manager who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. During our inspection we also received online feedback from ten anonymous sources who told us they were staff members.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at six staff files in relation to recruitment checks. 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, staff rotas and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• People were not safe from abuse. The provider did not always work well with other agencies to protect people from abuse. The manager did not maintain a log of safeguarding concerns to monitor multidisciplinary outcomes and agreed actions. They could not show us any evidence of reporting or correspondence with the local safeguarding authority in relation to allegations of missing medicines, an alleged medicines over-dose, or an allegation of physical abuse.
• We found the manager's investigation into an allegation of abuse was not robust and was inappropriate in its methods. For example, the manager failed to interview other staff as part of the factfinding process, which meant conclusions were not based on all potential lines of enquiry.
• In response to a previous safeguarding concern the provider had reported to CQC that no male staff were deployed to one setting. However, we found in practice male staff were allocated and were expected to be the second member of staff to support a person with personal care, with a less experienced female member of staff.
• The provider did not always have the legal authority to or deprive people of their liberty. Some people needed continuous staff supervision and in one case staff told us they locked the exit at a person's home for their safety. The provider told us they were not aware of staff practice to lock the person inside their home and said they would take action to review the person's needs.
• Another person was subjected to seclusion in their bedroom. The person did not have a positive behavioural support plan to prevent the need for this restrictive practice and there was no evidence of the person's consent or best interest decision, required under the Mental Capacity Act 2005.
• Staff recorded incidents where people's distress and behaviour could challenge themselves or others. However, restrictive interventions such as seclusion was not always recognised by staff or management and there was no meaningful analysis of incidents to offer debriefs to both the person involved and their staff team. Learning from this was not actively taken forward to reduce the likelihood of incidents reoccurring.

Systems and processes were not established or operated effectively to prevent abuse of service users and people were potentially deprived of their liberty without lawful authority. 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.

We shared information with the local safeguarding authority who have the statutory duty to investigate allegations of abuse. The operations manager agreed to take responsibility for overseeing safeguarding concerns to ensure systems were followed and action was taken to reduce risk to people's safety and to uphold people's human rights.

• People and their relatives generally felt the service was safe, with comments such as, "I feel safe. Overall. If I didn't I would speak to a carer or to management" and "I have never had any concerns about [family member's] safety. I just feel that the younger staff maybe need a little more support and encouragement from the more senior staff who never seem to be around."

Assessing risk, safety monitoring and management; Using medicines safely
• The provider did not effectively identify or mitigate risks to people. For example, there was no care plan or risk assessment for the care and treatment of a person's pressure ulcers, or instructions to staff about repositioning to avoid further damage. The same person's daily records showed inconsistent blood glucose monitoring in relation to diabetes, which put their health at risk. Staff responsible for monitoring a person's blood glucose monitoring were not trained or assessed as competent to do so and might not be able to identify when medical assistance was required.
• One person's epilepsy risk assessment did not provide any guidance to staff about when to seek emergency medical attention in the event of an epileptic seizure. Another person's risk assessment for choking did not refer to, or include safe measures identified in the person's swallowing guidance by a qualified therapist. This meant staff who were new to the service did not have enough information to support people safely.
• Health and safety checks and actions such as water safety checks to prevent scalding and legionella bacteria were not always implemented by staff.
• Fire drills to test evacuation procedures were not completed at all at one setting in the past 12 months and only once at another setting. No night-time drills were completed where the risk was higher due to people's level of dependency and a reduction in staffing levels. The provider had not addressed all time-specific actions identified in fire risk assessments across settings, to reduce risk. For example, a required fire door guard (to hold fire doors open safely) had not been fitted on the kitchen door at one setting and was kept propped open. We found the lounge door, which did have a fire guard, was propped-open with a magazine rack and prevented the door from automatically closing in the event of a fire. The provider had failed to address this practice with staff or liaise with the landlord to rectify door guards in a timely manner.
• Medicines were not managed safely. We found numerous medicines recording gaps for three people's medicines administration records (MAR) between May and July 2021. Most gaps were not reported by staff or investigated by management, which meant no action was taken to check whether medicines were administrated, or to seek medical advice about the potential impact upon people's health.
• On one occasion in May 2021, a person's MAR indicated to us there had been a potential overdose of a medicine. Management were unaware of this; the operations manager checked their records and advised there had been a change in prescription the same day. The manager said one tablet had been in a blister pack and the other was kept in its original packet. Therefore, there was potential risk that both tablets were administered by staff. However, due to the elapse of time, there was no way for management to check medicines stock in order to reach a conclusion.
• Another person's medicine stock was disorganised with multiple open boxes. We found a loose tablet in one box, which management were not aware of and there was no stock control system in place to monitor correct administration.
• Staff practiced secondary dispensing for one person's tablet, against legislation and best practice guidance. The manager told us the person's social worker had agreed to secondary dispensing, as requested by the person's relative, however there were no written records to support this. When we checked with the social worker directly, they advised us they had not discussed this issue with the manager.
• When required medicines protocols were not consistently in place. For example, there was no protocol for a person's sleeping tablet or another person's pain relief. We found one person's topical medicines were not always recorded on MAR charts.

The provider failed to adequately assess and mitigate risks, which put people at increased risk of harm. This

was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would take action to review people's risk assessments and implement health and safety checks.

Staffing and recruitment
• People and relatives consistently told us they were concerned about staffing levels and the lack of experience of staff supporting people. "I see lots of different [staff] faces - they change a lot", "Staff levels are bad at the moment…They work as hard as they can. I say to them 'slow down'. I feel bad for them, if you need help they are so busy. The turnover is very rapid at the moment all across the board- management as well" and "[Staffing levels] are not so good. They have quite a change of staff and it takes time for [family member] to get used to them."
• Staff consistently told us the service was short of staff which resulted in permanent staff being constantly moved around the settings to cover, where they were not familiar with people's needs and felt this contributed to medicines errors.
• The service had a high level of staff turnover, carried a high number of vacancies and relied upon agency staff to provide cover. During our inspection we spoke with three agency staff had not received sufficient inductions and were not fully informed about people's needs or safe procedures.
• Rotas and other recorded systems such as staff signing-in books, handover documents and staff clocking-in technology were inaccurate and unreliable. We received information of concern the staff rota did not always reflect staff allocation in practice. We found this to be the case on the first day of our visit. We received information of concern and a staff member told us they had supported people with personal care when they were not permitted to do so. We raised our concerns with the operations manager who told us they would take action to investigate and prevent this from reoccurring.
• We received information of concern people using the service had been left unsupervised and unsupported, against their care plans. We asked management about this and they disclosed one recent occurrence, which they had not reported to CQC. The manager's account that people were only left for 5-10 minutes differed from staff accounts and an incident report written by night staff which indicated people were left for 20 minutes until their arrival.
• The provider had reduced staffing during the day from three to two at one setting, due to a fifth person being in hospital. However, the person in hospital did not receive one to one staff support all day when they were at home; by removing a member of staff all day meant the remaining four people did not receive the agreed staffing levels.
• The provider only deployed one member of staff in each setting at night where several people required physical assistance or verbal prompting to evacuate safely in a timely manner.

The provider failed to ensure there were sufficient numbers of suitably skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acknowledged issues with staffing levels which they felt had been impacted by COVID-19. They informed us they were in the process of interviewing candidates.

• One member of staff was employed and supported people unsupervised without a criminal record or barring list check (government list of people who are not legally permitted to work in a regulated activity with children and/or vulnerable adults). One of their social care employment references had not been verified by the provider and appeared to be completed by a previous colleague rather than the employer.
• Agency staff profiles were not consistently obtained by the provider prior to them working to check they

had the required recruitment checks and right to work in the UK.
• Recruitment interview documentation was incomplete; scoring methods were left blank and there was no explanation about whether candidates met the provider's required standard for employment.

The provider did not always obtain the required checks to make sure staff were of good character prior to employment. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to make sure the missing criminal and barring list check was applied for and issued and provided evidence of this.

Preventing and controlling infection
• The provider was not promoting safety through the layout and hygiene practices of the premises. We found opened food without date labels in people's fridges at all three settings we visited. Some food was out of date and some was visibly spoiled with mould growing on it, which posed a risk of harm to people. At another setting numerous flies were in the kitchen; the window and external door were open for ventilation without any form of fly screens. Staff belongings such as personal bags were stored on the kitchen worksurface. The operations manager advised us staff were expected to store their personal belongings in the 'staff' toilet, which was also used for general storage of household items. This was not hygienic practice.
• Staff did not consistently implement the infection prevention and control (IPC) policy. Provider IPC audits were infrequent and did not identify the concerns we found during our inspection.
• The provider had not consistently risk assessed whether people were at higher risk of COVID-19 infection and needed to shield.
• Staff did not always dispose of used PPE masks safely. In one setting used PPE was disposed of in general kitchen waste and was not double-bagged. At another setting the lid of a PPE bin was broken and hanging off, this was situated in the lounge next to the TV and easily accessible to people.
• Staff did not consistently follow health screening procedures for visitors. During the first day of our visit staff did not ask us if we had completed same day testing and received negative results prior to entry. Staff implemented the procedure to take visitor's temperatures but did not ask other health screening questions about symptoms, travel abroad or close contact with positive cases in line with government guidance.

The provider did not take effective action to detect or prevent the risk of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager added these concerns to an action plan for the provider to address.

• The provider was accessing testing for people using the service and staff and facilitated visits and community access in accordance with the current government guidance.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

• Care and support plans were not always holistic or reflect people's needs and aspirations. For example, communication, sensory, oral hygiene, pressure area and skin integrity assessments were not completed to identify people's needs or inform care plans.

• The service did not take the time to understand people's signs of distress and what may be causing them. No functional assessments were completed for people who needed them. The operations manager informed us a referral was made to other professionals for positive behaviour support in response to our inspection.

• The service did not implement a national screening tool to assess people's risk of malnutrition or monitor people's weight to make healthcare referrals where needed, in order to support people's health and wellbeing.

The provider did not consistently carry out assessments of people's holistic needs and preferences in collaboration with relevant others. This was a breach of regulation 9 (Person centred care) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

• The provider had not established a robust mandatory or specific staff training programme to meet people's needs. We found numerous training gaps and recent training delivered by the manager to staff new to care and existing staff, covered 22 topics in only one day, such as medicines administration, moving and positioning, health and safety, basic life support, infection prevention and control, behavioural support, staff breakaway techniques, values, and job role.

• We raised concerns about the quality of the training and asked to see the content of the courses. The operations manager failed to provide this to us without explanation; they only submitted the 'challenging behaviour' training material, which we found provided inappropriate guidance. For instance, in response to continued 'verbal aggression' staff were advised to, "Tell the individual you will leave them alone and will return in 5 minutes." This kind of blanket policy did not consider people's individual needs or risk assessments and meant people were at risk of being supported inappropriately. The training content did not reference any national guidance, there was no way to find out where the information was sourced or evaluate whether it was relevant.

• No staff were being supported to achieve any vocational qualifications at the time of our inspection and

the provider did not support staff new to care to achieve the Care Certificate, which sets standards for the induction of adult social care workers. The provider's alternative induction was not equivalent to the Care Certificate as not all the expected standards were covered, such as nutrition and hydration, privacy and dignity or equality and diversity.
• No induction forms were completed for agency staff prior to our inspection. We found some agency profiles in relation to training and experience, were not obtained prior to them supporting people. Where profiles had been obtained, we found training was out of date and did not cover areas such as epilepsy to meet some people's needs.

The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager told us they were taking action to reduce to number of training topics in one day and had employed a new trainer to review training needs and delivery.

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 had not always received initial or refresher mental capacity act and deprivation of liberty training and did not demonstrate they fully understood principles of the code of practice. For example, staff consistently stated they would gain people's consent by reading their body language and facial expressions, rather than referring to MCA assessments and best interest decision processes.
• The provider did not maintain a tracker to monitor people's deprivation of liberty status. The operations manager initially told us that no one had a court of protection authorisation. After the inspection they updated us to say one person had a court of protection authorisation in place, dated 7 April 2021 and agreed to add the conditions to the person's care plan and risk assessment, which had not been done.
• The provider had not ensured their MCA and deprivation of liberty policy and procedure was understood and implemented by all managers and staff. Staff had not consistently notified people's commissioning authorities where they suspected people who potentially lacked capacity to consent, were being deprived of their liberty.

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

Supporting people to eat and drink enough to maintain a balanced diet
• People's dietary requirements were identified and recorded in their care plans and people were supported to shop and plan their own menus. However, we were concerned that in one setting most of the food in the fridge was out of date and not fit for consumption.
• One person's care plan stated staff must monitor and record their fluid intake. However, we found this was recorded infrequently and no daily target was indicated.
• People told us, "I like food. Like all kinds of food- I go shopping for it", "It is nice food. I get Iceland deliveries. Sometimes I choose what I have to eat" and "We sit down and plan menus the night before and I go shopping every week with staff. I am happy with this".
• People's relatives consistently fed-back their family members had put weight on since joining the service with comments such as, "We were constantly asking for healthy food for [family member]. They had put on so much weight", "[Family member] eats very well. They have put on weight so we are encouraging to eat healthily and have more salads", "Food wise [family member] is happy- but put on weight since they have been there. They are slowing down now and I'm not sure whether it is due to his health or lack of stimulation and exercise" and "I am not happy [family member] is getting a balanced diet. I had a quick look in the fridge and there wasn't much there. They hadn't had a proper food shop for three weeks and there was an old out of date menu on display".

We recommend the provider takes action to ensure staff follow people's nutritional and hydrations needs.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff consistently used disrespectful terminology when describing people to us such as, "Naughty", "Bad" and "Lazy." One person's distress was described by staff as tantrums.
- A person's care plan, care notes and staff feedback raised concerns the person was viewed as and treated like a child. For example, staff told us they would tell the person's parent about their 'negative behaviour' to refer back to them. There was no consideration about whether this was appropriate or in accordance with the person's wishes or best interests.
- We found a written account by staff of the same person's behaviour to be disrespectful and indicated staff support escalated the person's distress. The staff involved had not received any feedback in relation to how they supported or treated the person and there was no review of the person's care plan. When we raised concerns with the manager, they said they were not surprised and agreed action was needed in that particular setting to address staff values. However, there was no evidence of the manager or provider monitoring or addressing these concerns with the staff team to improve people's treatment.
- The service did not protect people's privacy. For example, people's medicines records were accessible to others in communal areas in all the settings we visited.
- Staff had not received communication training, which meant they did not have the skills to consistently enable people to express their wishes and decisions about their care.
- People's care plans did not indicate whether people and others important to them were involved in reviewing their care. Care plans were written in the first person, however, people's needs meant it was sometimes doubtful information was their true voice.

Care was not always provided in a compassionate or supportive way. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People we spoke with told us they got on well with staff and their key workers with comments such as, "Staff are all fine. They are kind – I know them well. I have a laugh with them", "The staff are absolutely fantastic, they get on with you. I would like the old staff back though 'cos they worked fantastically. [Staff name] is my key worker she is my favourite" and "When I ask, they do everything. I appreciate them and adore them for everything they do. I have a good relationship with staff past and present. It is hard for them to carry out all the tasks with a shortage of staff".
- Some staff spoke about and to people with respect and kindness and provided people with explanations

and reassurance.
• At one setting we observed staff interaction with people was warm and positive. Staff provided verbal information to people to encourage them to make their own informed choices and decisions about planning their food shopping and menus. Staff provided gentle advice to a person to make sure they understood another person's rights and treated them fairly.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• Care plans did not always support people to achieve positive outcomes, such as improving their emotional health and wellbeing or learning new skills. For example, a person's care plan stated they should receive staff support to learn new skills, however, there were no specific goals or outcomes agreed with the person to aim for.
• Care plans were not always easy to read or follow. One person's care plan stated, "I need staff to be clear with me about making good choices", however, there were no explanations or examples of what this meant, or how staff should support the person to make choices.
• One person said other people did not always receive their one to one support due to staff shortages. Staff consistently told us people's engagement with meaningful activities and community access was restricted due to being short staffed. One staff member told us, "No one can go out one to one. It has to be group activities day to day." They explained that staff from another setting would sometimes support in order to drop people to an activity, however, they said this meant staff levels and opportunities in those settings were negatively impacted.
• People told us, "I don't do much. The staff take me outside, maybe once a week I'm not sure", "I still can't see my friends. I go for walks with the staff to the shops" and "I do walking and stuff. If I walk outside I need staff. I go to the Day centre three times a week. I'm going to a concert at Wembley in August with my key worker." One person said they had to give a week's notice to staff if they needed to access the community using their own car due to a lack of drivers.
• A person's care plan stated they should follow a full activity planner, however there was no plan in place. Daily care notes for June 2021 showed limited activities such as walks, a drive with staff (no purpose or destination), one occasion of a drive with staff to drop off another service user, one occasion of using the garden trampoline and paddling pool and numerous occasions of using their tablet device to watch YouTube. During our inspection visit on the 8 and 13 July 2021 the person was supported to visit the cinema and dinner at a restaurant, by agency staff who were new to the service the same week and did not know the person. A staff member told us these activities only occurred as the person's funding authority had raised concerns about the lack of activities the previous week.
• Another staff member told us the lack of meaningful activities had led the person to become dependent upon their tablet device. They felt the person's behaviour had changed, including signs of distress due restrictions placed on the use of their tablet device, without meaningful alternatives. The service had not reviewed the person's care plan to respond to this change.

The service did not consistently provide people with care to meet their needs and reflect their preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 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.
• The provider understood its responsibility to make sure people were given information in a way they can understand, but this was not always implemented. For example, staff did not use one person's preferred methods of communication such as pictorial symbols and signs alongside speech. Staff told us the person communication symbols book was lost and staff no longer signed key words since the previous manager of the service left approximately two years ago. The person's one to one allocated staff told us they had read the person's care plans but were not aware of their communication needs.
• Another person's communication care plan stated the objective was, "To ensure aids are available to promote communication and socialisation" but did not explain what aids were to be used. An additional person did not have a communication care plan, despite having difficulties with speech. There was no information about whether this was linked to the person's physical disability or how staff should support the person to enable communication.

The provider failed to ensure reasonable adjustments to enable communication were consistently identified or implemented by staff. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We observed staff members supporting one person were able to understand and interpret their speech to enable communication, because they knew the person well.

Improving care quality in response to complaints or concerns
• There was an appropriate complaints policy and procedure and people and their relatives told us they knew how to raise concerns.
• The service kept a log of complaints and outcomes, however, there was no evidence of the provider monitoring complaints over time, to look for trends and areas of risk that may be addressed.

We recommend the service develops a system to monitor complaints in order to respond to trends and areas of risk.

End of life care and support
• The service had previous experience of supporting a person at the end of their life. There was an appropriate end of life policy and procedure. The operations manager informed us they intended to assess one person's end of life needs before they were discharged from hospital.
• Staff training in this area was not established to make sure staff understood how to plan and support people well at the end of their life. The operations manager told us they were arranging training as a priority and planned to seek support from the person's local authority and healthcare professionals to assess their needs.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection we made a recommendation for the provider seek advice and guidance from a reputable source about quality assurance systems and put this into action. At this inspection the provider had not made enough improvements.

• Our findings from the other key questions showed governance processes were not effective to keep people safe, protect their human rights or provide good quality care and support. The service did not design the service to promote the right support, care or culture for adults with a learning disability or autistic people, or ensure people's tenancy rights were upheld. For example, people's own lounges were used as staff offices, which encroached upon people's space and privacy.
• The current manager who commenced their role in February 2021 had recently withdrawn their application to register and was leaving the service in August 2021. The registered manager who was also the nominated individual told us they were recruiting candidates to replace the manager.
• Audits to monitor the safety and quality of the service were infrequent and had not identified the concerns we found during our inspection. We asked to see the last three audits for two settings for health and safety, quality assurance, medicines and finance. Only one infection control audit dated June 2021 and one finance audit dated March 2021 for each of these setting, completed prior to our inspection visit, were provided. The finance audit identified that staff did not have a clear understanding of service user finances or implement the provider's procedure to ensure receipts were obtained for each transaction. Staff training was identified as an action within 3 months, however, this had not been achieved and no dates were planned. There had been four safeguarding referrals in relation to the mismanagement of people's monies in the past 12 months, the most recent in July 2021.
• Staff consistently told us they did not feel supported or valued. The provider did not offer staff training to promote equality and diversity. Some staff felt they were treated unfairly, pressured to work extra hours and to cover-up staffing issues. They were concerned about speaking up for fear of reprisal from the provider. Other staff said management did not act upon concerns and improvements were not made. Staff told us, "At present staff morale is at the lowest I have ever seen. And no don't feel supported, as explained staff are stretched, not enough staff, and not enough good and qualified staff", "Don't feel they listen enough and would like more support", "Management and communication is poor" and "I would appreciate [management] keeping us in loop and for us all to be on same page".

• Systems to assess and manage risk were not established. Reviews of incidents were only completed in response to our enquiry during the inspection. These were incomplete as several people's incidents were excluded. Incidents were categorised as 'aggression' and 'behaviour' which was non-specific and derogatory. There was no exploration of people's emotional state, how staff had supported people, or which staff were involved. This meant the review was not able to effectively identify and respond to themes or emerging risk.
• Records in relation to the management of the service and people's records were not always accurate, complete and contemporaneous, or stored securely. The operations manager told us they could not find the majority of staff medicines competency records, which they said had been filed away by a previous manager. The provider's electronic systems were unreliable. We were unable to access electronic management or care records on day two of our inspection. We asked to see staff entries on the electronic care system for the night shift 8 July but were told none were made as the system was down. Shortly after our inspection the operations manager informed us printers were off-line in response to our request for information. A member of staff told us this was a frequent occurrence and impacted upon their ability to do their job.
• The manager told us they did not implement the provider's procedure of recording their review and follow-up actions in response to incidents on the electronic system, as they felt this did not protect people's privacy. However, no alternative system was in place.

Systems or processes were not established and operated effectively to ensure compliance with regulations. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had not notified CQC of numerous incidents in relation to concerns of neglect and abuse, or the outcome of an application made to a court to deprive a person of their liberty.

The provide failed to consistently notify CQC of events where required. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

The provider developed an action plan to address the concerns identified. However, this was not time specific and did not set out how the service would monitor and sustain improvements. The local authority is supporting the provider to ensure their action plan is robust.

• The nominated individual recognised staffing issues had been a challenge but felt that some concerns raised were malicious and unfounded. They told us they were committed to improving the leadership and governance of the service to achieve positive outcomes for people. We saw they had arranged gifts for staff and planned a pay rise to recognise staff contributions and improve morale.
• One member of staff praised a care lead who they described as brilliant in their attitude, support for staff and care for people. Another member of staff told us they received support from management whenever they needed it and felt appreciated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• People, and those important to them, had limited opportunities to work with managers and staff to develop and improve the service. Household meetings with people were not facilitated. Since our last inspection only one out of 14 people who received personal care, had been supported to complete a service quality questionnaire, dated June 2021. The operations manager thought others may have been done, but they had not collated these to review people's feedback. People's relatives told us they had not been asked for their feedback and were not consulted on the running of the service. Two relatives reflected they used to

attend meetings and coffee mornings prior to COVID-19.
• We received mixed feedback from people and relatives about the management of the service, with comments such as, "[Family member] is happy there and we are happy. It could be better – we don't get any information from the service. We always have to contact them", "It is well managed apart from the staffing", "When [the manager] is not stressed I get on well with him really well" and "I have had some dealings with [the manager] and the office and communication was good."
• The provider had completed a staff survey to gain their feedback in May 2021, which showed improvements were needed. For example, 57 % of staff said they would not recommend working for the care provider. The nominated individual informed us in response to this they had focused on initiatives to value staff, which they were planning to implement in July 2021. 'House' staff meetings were not generally facilitated. We were provided with evidence of one meeting, in one setting dated November 2020 where staff discussed safe COVID-19 measures and rotas, which included a comment from the care lead, "We may need to still step up and take on extra shifts until this is over." At a management team meeting, dated May 2021, a care lead provided feedback that some staff could not do over time and it was difficult to cover shifts. Also, a concern was raised about breaks being deducted from staff their pay. No follow-up actions to address these points were included in the meeting minutes.
• The provider did not always share information with other agencies effectively; there was a lack of collaborative working with the local safeguarding authority to liaise about enquiries and seek feedback.
• We received feedback from two health and social care professionals that responses from the management team to co-ordinate assessments of people's needs were not always timely. Also, people were not always supported to their health appointments on time.

The provider did not always seek and act on feedback from relevant persons and other persons to continually evaluate and improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider had an appropriate duty of candour policy and understood their responsibilities. There was no evidence of specific notifiable incidents. However, we were concerned the underpinning principles to promote an open, honest and transparent culture was not being achieved by the provider. Rather, we raised concerns there was evidence of closed culture developing which created a risk to people's welfare.
• There were occasions where the manager's account of when things had gone wrong, was not supported by records and differed from the accounts of staff, and a health and social care professional. A senior member of staff, who was entrusted by the management team to oversee the staff rota with the manager, directly lied to us about the deployment of staff during our inspection.

We recommend the provider takes action to develop and sustains a positive, open culture to uphold people's welfare and to underpin its duty of candour responsibilities.

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 provide failed to consistently notify CQC of events where required.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always obtain the required checks to make sure staff were of good character prior to employment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not consistently carry out assessments of people's holistic needs and preferences in collaboration with relevant others. Staff did not consistently provide people with care to meet their needs and reflect their preferences. The provider failed to ensure reasonable adjustments to enable communication were consistently identified or implemented by staff.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care was not always provided by staff in a compassionate or supportive way.

The enforcement action we took:

We served a warning notice.

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

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess and mitigate risks, which put people at increased risk of harm.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established or operated effectively to prevent abuse of service users and people were potentially deprived of their liberty without lawful authority.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance with regulations. The provider did not always seek and act on feedback from relevant persons and other persons to continually evaluate and improve the service.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.

The enforcement action we took:

We served a warning notice.