Precious Homes Limited

Precious Homes Bedfordshire

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
Precious Homes Bedfordshire (AKA Treow House) is a domiciliary care agency and supported living service, providing personal care for adults with a learning disability, autistic people and people with mental health needs, in their own homes.

Treow House comprises of 22 one-bedroom flats, with a shared communal living room and garden. Staff from the service also support individuals in their own homes through an 'outreach support in the community' service.

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 this inspection the service was supporting 24 people. Of these, 11 people were receiving personal care.

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

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

Right Support:
- Staff did not always support people to have the maximum possible choice, control and independence over their own lives.
- Opportunities to learn lessons from incidents, including those when people experienced periods of distress, were not always followed up; to see how they might be avoided or reduced in future.
- People did not always live in a clean and well-maintained environment that met their sensory needs.
- Staff did not consistently follow guidance on how to prevent and control infection.
- Although some people felt they were always involved in decisions about their care and support, staff did not consistently seek everyone's consent or follow best practice in decision-making.
- Staff did not always safely support people with their medicines, to achieve the best possible health outcome.
- Staff enabled people to access specialist health and social care support in the community the majority of

the time.

Right care:
● People's needs were not robustly assessed before they started using the service, to ensure their needs could be fully met.
● Some people told us staff were kind, caring and treated them with respect. However, other people's experiences varied.
● Staff did not always demonstrate respect or promote and protect people's privacy and dignity.
● Staff had training on how to recognise and report abuse and they knew how to apply it. However, there had been delays in some potential safeguarding concerns being reported.
● The service had enough staff, but they were not always appropriately skilled to meet people's needs and keep them safe.
● Staff could not effectively communicate with everyone using the service, because they did not have the right guidance and skills to understand some people's individual communication needs.
● People did not consistently receive care that supported their needs, aspirations, focused on their quality of life, and followed best practice.
● People did not routinely take part in activities and pursue interests that were tailored to them.
● The service provided limited opportunities for people to try new activities that enhanced and enriched their lives.
● Some staff had varying knowledge and skills on managing risk, particularly with people who expressed their needs through actions, distress or agitation.

Right culture:
● Staff did not meaningfully evaluate the quality of support provided to people, involving the person, their families and other professionals as appropriate.
● The service was not proactive in enabling people and those important to them to provide feedback and develop the service.
● The provider's systems for checking the culture, quality and safety across the service were not sufficiently robust.
● People told us a new manager had been recruited, who was approachable and had started to make improvements at the service.
● The provider also had a plan to improve the service, but they did not confirm when this plan would begin.

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 27 November 2018).

Why we inspected
We undertook this inspection to assess that the service was applying the principles of Right support right care right culture.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Precious Homes Bedfordshire' 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 monitor the service and will take further action if needed.

We have identified breaches in relation to: person centred care (including assessing people's needs, personalised care, meeting people's communication needs and social needs and interests), dignity, consent, safe care (including lessons learnt, medicines, infection prevention and control and access to healthcare services), governance and staffing.

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

In addition, and in response to areas of more immediate risk found at the inspection, we have issued two warning notices; to help keep people safe.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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.

Precious Homes Bedfordshire

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008

Inspection team
The inspection was carried out by three inspectors and a member of the CQC medicines team (pharmacist specialist).

Service and service type
Precious Homes Bedfordshire provides care and support to people living in one 'supported living' setting (Treow House), so that they can live as independently as possible. This service also provides a community outreach (domiciliary care) service to people living in their own houses and flats.

In both cases, people's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living or domiciliary care; this inspection looked at people's personal care and support.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a manager in post who was not yet registered. However, the manager submitted their application to register during the inspection.

Notice of inspection
Two of our three visits were unannounced. We gave a short period of notice for the visit carried out by the pharmacist specialist, because we wanted to be sure the manager would be available to support this.

Inspection activity started on 27 July 2022 and ended on 31 August 2022. We visited people living at Treow House service on 27 and 31 July 2022. The pharmacist specialist visited on 10 August 2022.

What we did before inspection
We reviewed information we held about the service. We sought feedback from the funding authorities and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with/or observed the support provided to seven of the nine people living at Treow House who received personal care; to understand more about their experience of the care provided.

We also spoke with four relatives, one professional who works with the service and twenty members of staff including: the head of quality, the manager, two deputy managers, four senior support workers and twelve support workers.

In addition, we received written feedback from a further four professionals.

We reviewed a range of records including care, risk management, financial and medicine records for ten people using the service. We also looked at a variety of records relating to the management of the service, including policies and procedures, staff files in relation to recruitment and staff supervision, complaints and compliments, audits and meeting minutes; so we could corroborate our findings and ensure the care and support being provided to people were appropriate for them.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to 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.

Using medicines safely

- Medicines were not always managed safely or administered as prescribed.
- We saw medication in one person's flat at 3.30pm, which was due to be given at 2pm. Staff told us the person they were prescribed for would sometimes refuse them, so after an hour they would remove the medication and record the refusal on the administration records. This had not happened.
- According to the person's records staff had sought pharmacy advice regarding their regular refusal of prescribed medicines. The advice was to phone the person's GP but this did not happen for a further 14 days, when an appointment was made. We found no record of the appointment outcome and noted the person was still refusing their medicines during our inspection, almost six months later. This placed the person at risk because they needed their medication to manage a significant health condition.
- Some people were prescribed medicines to be taken on a 'when required' (PRN) basis. Guidance in the form of PRN protocols was in place, however, protocols did not always include person specific information. For example, protocols lacked details of signs and symptoms that people could present with to inform staff when to administer the PRN medicines. This meant that staff may not administer medicines consistently, reducing the effectiveness of the medicines.
- When PRN medicines were administered, staff did not always record the date, time and reason for administration on the medicines administration record (MAR), as per the provider's medicines policy.
- Topical medicines administration records (TMARs) were not always available for all topical medicines. Those that were available, did not always describe where the product should be applied, state the frequency or when additional professional advice should be sought. Application of topical medicines was not consistently recorded on TMARs or the daily records. Therefore, we could not be assured that topical medicines were being applied as prescribed.
- Some people were administered medicines covertly (this is when medicines are disguised in food or drink for example, without the consent of the person receiving them). Although the service followed the Mental Capacity Act 2005, there was a lack of evidence to demonstrate that family members or other advocates were involved in the best interest meeting with healthcare professionals.
- Medicines related care plans were in place for people. However, they did not always have up to date information about people's current medicines. For example, we saw one person's rescue medicines protocol had been changed by a specialist doctor in February 2022. However, care plans and PRN protocols had not been updated to reflect the changes. This placed the person at potential risk of harm because staff did not have clear guidance on how to administer their medication in an emergency.
- Management carried out regular audits of MARs and medicines. However, audits did not always identify the gaps or concerns we had identified during the inspection.

Preventing and controlling infection

● The service did not have effective infection, prevention and control measures to keep people safe. We saw a number of staff during our visits that were either not wearing face masks or were not wearing them properly. Current Government COVID-19 guidance states face masks should still be worn by all care staff. This was concerning because there had been a recent COVID-19 outbreak at the service so this placed people, staff and visitors at risk of cross infection.

● People were not always supported to live in an environment with a good level of cleanliness. For example, one person had damaged their furniture, fixtures and fittings which would make effective cleaning difficult. Although fixtures and fittings would be the responsibility of the person's housing provider, records showed some of the damage had been present for almost two years. The person would not have been able to report the damage to the housing provider without support from staff. The manager said some items had been reported and replaced, but further damage had occurred. This did not evidence effective communication between staff and the housing provider; to explore more durable options.

●In addition, during our first visit, we found an unacceptable level of dirt, including faeces, in one person's flat and on their duvet cover. It was the responsibility of Precious Homes Bedfordshire staff to support the person with cleaning their flat. When we showed the soiled duvet to staff, they simply placed it back onto the person's bed.

Learning lessons when things go wrong

● The service did not consistently manage incidents affecting people's safety well. Gaps in records such as incident reports, showed missed opportunities to routinely learn lessons and improve safety across the service; through reviewing incidents and events. An example of this was one person's incident records which showed out of five incidents, only one contained information that could meaningfully be used to learn lessons from.

● Some incidents had not been recorded at all, so there was no information to review and learn from.

The unsafe management of medicines, poor infection control and lack of learning from lessons were all breaches of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● Relatives and professionals felt people were kept safe from avoidable harm, because staff knew them well and understood how to protect them from abuse. One professional told us, "I have recently been allocated a safeguarding enquiry where the provider raised the alert regarding the concern. The provider has worked with me to try to reduce the concerns."

● Staff told us they had training to recognise and report abuse and they knew how to apply it. One staff member said, "Always follow the golden rule that if we see or hear anything of concern we report it straight away."

● However, records showed there had been delays in some safeguarding concerns being reported in a timely way; both to us (CQC) and the local authority safeguarding team. This could have placed people using the service at risk, by not acting swiftly and enabling an independent review to take place.

Assessing risk, safety monitoring and management

● Generally, relatives and professionals felt people lived safely and free from unwarranted restrictions, because the service assessed, monitored and managed their safety.

● However, one professional told us that staff had varying knowledge on managing emotional distress and implementing proactive strategies to manage this consistently. This feedback echoed some of our own observations during our visits, in terms of how staff engaged with people who used non-verbal ways to

communicate, or expressed their needs through actions, distress or agitation. Some staff did not understand why people might express themselves in this way and did not know the best way to manage this. A number of people lacked any real structure and purpose to their day as well.

● Some of the language used by staff in records infantilised people, or it promoted a culture of inequality and negativity. For example, describing one person as "aggressive, agitated and grumpy," when they had been visited by a dentist. This did not demonstrate an understanding of why the person had presented in this way or explore whether they were actually frightened, confused or anxious. There was no information either to show that staff had adequately prepared the person for this visit in advance.

● Written guidance was available for staff on how to support people expressing distress and anxiety, but this was often quite generic and lacked sufficient detail to be effective and provide consistency of support.

● In addition, some people's sensory needs had not been recently assessed to understand why they might express themselves in these ways. It would be difficult to provide effective guidance for staff with proactive strategies on how best to support them, if their actions are not properly understood.

● Records for restrictive practices, such as physical restraint, were in place but they contained brief information and did not demonstrate the involvement of the person these related to.

● The Head of Quality acknowledged improvements were needed and shared information about a strategy being rolled out across all services run by the same provider. The aim of the strategy is to develop practice, focussing on improving people's quality of life.

Staffing and recruitment

● The number of staff matched the needs of most people using the service. One person required two staff to transfer from one position to another. The manager told us they had taken action to ensure current staffing levels did not limit them from taking part in activities how and when they wanted.

● People told us they mostly received support from the same staff, which provided them with consistency of support. One person told us, "They (staff) will give me choices of times of support if I want time by myself….We do have the same ones (staff), but sometimes we get new staff in and try them out, so it's quite good really."

● The provider carried out background checks to make sure staff were safe to work at the service, including Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● We found some gaps regarding required background checks which must be undertaken before new staff begin work. This included unexplored gaps in employment history and verifying reasons for leaving previous care positions. The manager told us they would be addressing this with their recruitment team, to ensure all required checks were in place in future.

Requires Improvement

Is the service effective?

Our findings

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

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

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

- People's needs were assessed prior to them using the service. However, assessments varied in content and detail; in terms of establishing the support people needed to meet their individual needs. This meant support plans, which were developed using this information, did not always reflect a comprehensive understanding of people's holistic needs and aspirations.
- For example, some sections of the assessment forms, which would have provided valuable information, were completely blank. Functional assessments had not been completed, to help staff know what to do when people expressed their needs through actions or distress.
- There was also no evidence that people and those important to them, had been included in the assessments we saw.
- Compatibility with other people living at the service had not been considered sufficiently. For example, two people talked about noise levels in their home and how this disturbed them or kept them awake at night. Records showed a third person was regularly awake at night too. High and intense noises can have a severe impact on some Autistic people and this wasn't adequately taken into account during the assessment process.

This shortfall in assessing people's needs thoroughly 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

- We observed people were not consistently supported by staff who had received relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have. Training records we saw had lots of gaps for both new and refresher training.
- This included training for some staff to administer rescue medication to people who experienced epileptic seizures. They told us they would need to call a senior if this was needed. Where training had been provided, staff were not always confident to utilise it. In the event of someone having a seizure and requiring rescue medicine, one staff member told us they would, "Probably panic and call for help." They were also unable to tell us the meaning of 'seizure codes' being used on one person's epilepsy monitoring chart. The manager told us they were in the process of arranging training for support staff, as they were aware not all staff were trained in this area.
- At our last inspection we found staff competency was not being routinely monitored. The point of this would be to check staff were competent and knowledgeable to do their jobs well. During this inspection we

found this was still not happening consistently. We were told competency assessments were completed for medication, and questions of knowledge in other areas were asked within individual supervision sessions. However, records we saw showed some staff had not received their annual medicines training and competency assessments. We also received mixed feedback about how regularly staff supervisions were carried out. We were unable to verify this information as the supervision matrix we saw was not up to date.
● Staff meetings were being held, but there was no evidence of how important messages were being cascaded to staff who were unable to attend these. Some of the meeting minutes referred to areas requiring improvement identified through this inspection, but there was no evidence these messages had yet been received and understood by the whole staff team.

These inconsistencies in the support and training provided to staff were a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; and Staff working with other agencies to provide consistent, effective, timely care
● We received mixed feedback about people being referred to health care professionals, in a timely way to support their wellbeing and help them to live healthy lives. One person told us, "Staff support me with appointments, I have only just started to go to the dentist as I didn't like them." However, a professional told us, "I have had to remind them (staff) to get follow up appointments for the GP for physical health screening if behaviour has deteriorated."
● During this inspection we found delays in healthcare professionals being contacted for advice too. For example, when people regularly refused their prescribed medicines.
● In addition, we found no recent evidence of dental check-ups for one person. Staff told us they didn't need to see a dentist because the person did not have any teeth. This did not demonstrate a good understanding of the importance of screening check-ups to monitor for signs of other ill health.
● Daily records did not demonstrate people were routinely and effectively supported to maintain good oral hygiene. One member of staff commented on how it was, "Impossible" to support another person with cleaning their teeth. They did not know how to support the person with this, or the plan to improve the person's daily oral hygiene routine going forward.
● People had health actions plans (HAP). The purpose of these plans is to provide a record of a person's health, and what that person needs and wants to do to stay healthy. The plans we saw did not include sufficient personalised information regarding people's health needs and goals. For example, one person's HAP referred to them needing an epilepsy monitor at night. But there was no further guidance on how to use it. There was also no information about the type(s) of epilepsy the person experienced and how to monitor this to keep them safe.
● Another person had spent a significant period of time living with their family during the COVID-19 pandemic. There was no evidence of a handover taking place when they had returned to their flat; to establish any updates and changes in their healthcare needs, and to know when their next routine healthcare appointments were due.

This was a failure to ensure safe care and treatment with the assistance of other professionals, and a further breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People, relatives and professionals provided positive feedback in terms of how staff supported some people to make their own decisions in line with relevant legislation and guidance.

● However, we found this was not consistent across the service, particularly for those people who lacked capacity to make some of their own decisions. For example, we found staff had locked one person's bathroom, with no clear explanation for doing so. On another occasion, a staff member had taken laundry detergent paid for by one person to use for another person, with no evidence of consent.

● We also saw information and photographs of people living at the service on a group WhatsApp chat, used by staff, on their personal mobile phones. WhatsApp is a messaging service that allows people to share written, audio and picture messages. Records did not demonstrate people had provided consent for their photographs to be used in this way, or that they understood the confidentiality implications of this. The manager acknowledged our findings and told us they had taken immediate action to ensure no staff member used WhatsApp in this way in future.

● Capacity assessments were in place for people who needed support with making decisions, but these were often brief in content and did not demonstrate how staff had tried to help the person understand the decision being made.

● In addition, where decisions had been made on people's behalf, using the Best Interests principle, there was limited evidence to show who else had been involved, such as family members and relevant professionals. Some of the decision records we saw had been completed and signed off by one member of staff only, which is not in line with the MCA.

This meant people's consent to care and support was not always sought in line with legislation and guidance. This was a breach of Regulation 11 (need for 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

● Staff encouraged people to eat a healthy and varied diet to help them to stay at a healthy weight. A professional told us, "Staff have developed strategies to overcome issues with food / drink which enable [person] to have choice and eat healthy, balanced meals of their choice."

● However, not everyone was involved in choosing their food, shopping, and planning their meals. Although one person told us, "Staff have to make sure we have enough food, and I do the shopping with them and they help you to cook." We observed other people being given drinks and food by staff, with no consultation.

● Care records contained guidance for staff on how to support people with complex eating and drinking needs. However, the records for one person who had problems with swallowing food, were overdue for review by six months. There was no evidence the person had come to harm as a result, but it would be important to check the current guidance was still correct.

● People's enjoyment of mealtimes had been considered with steps taken to ensure they were not interrupted and room temperatures were comfortable. We identified further improvements to enhance the

experience for more people using the service, including the presentation of blended food and equipment to aid independent eating and drinking. In addition, one person did not have access to a table to eat at, and we saw them having to eat a meal whilst sat on their bed.

● Staff understood the importance of flexible mealtimes, arranged around people's individual routines and preferences, and we saw this happening.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Staff did not always follow best practice standards which ensured everyone using the service received privacy, dignity, choice and independence in their tenancy.
- One person told us, "Staff treat me with respect and you have to treat them with respect." We could see too, from other people's appearances, that staff supported them to look their best and uphold their dignity. However, this was not the case for everyone.
- One person looked uncared for in terms of their personal appearance. Staff provided reasons for this. They said they had discussed it with the person's social worker to plan a way forward; to promote their dignity and wellbeing. Despite this being an issue for a while, it had not yet been resolved.
- Another person came into the office naked. They were visible to other people living at the service and to some extent members of the public; through the main entrance gates. Staff tried to prevent this from happening but were not successful. They confirmed this was a regular occurrence, so it could be anticipated. Yet nothing was in place to protect the person's dignity, such as a sheet or dressing gown that staff could grab.
- Some people's flats didn't always provide them with dignified surroundings. We observed a lack of storage, clutter, continence pads in living areas and being generally run down and dirty. A visiting professional commented on this too.
- There was a lack of clear information regarding goals for helping people to increase their independence and daily living skills. For example, one staff member told us they did one person's food shopping online. However, this person enjoyed going out and may have benefitted from seeing more grocery options if they had been supported to go to an actual shop.
- When we asked staff if another person was going to help them with the day's household tasks they just replied, "No." There was no explanation for why not, despite having all day to try to engage the person in such activities.
- Similarly, another staff member told us a further person also did not engage with any household tasks, apart from occasionally putting a bin bag outside. They were not aware of plans to work with the person on furthering their skills and independence in any other tasks.
- Staff did not always respect people's privacy and confidentiality. Aside from photographs we saw of people living at the service on a staff WhatsApp chat group, a staff member talked to us about using their personal laptop to keep on top of their work - due to a lack of available IT equipment at the service. This arrangement placed people at further risk of confidentiality breaches and did not promote a good awareness of, or compliance with, the General Data Protection Regulation (GDPR). The GDPR sets out clear guidance and controls regarding how people's personal information should be used. The manager told us

they had ordered sufficient IT equipment to ensure this did not happen in future.

Inconsistencies in how people's privacy, dignity and independence were promoted were breaches of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People mostly received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. One person told us, "They (staff) are quite caring and kind really, they come to work and support us and interact with us and do things we want to do." A relative described staff as, "They are brilliant, really lovely people."

● We observed a number of positive interactions between people and staff during our visits, which echoed this feedback. When one person became upset, staff provided verbal reassurance and a hug. They listened and took action, to alleviate the person's concerns. This approach quickly created an easy and relaxed atmosphere.

● Other people appeared calm and relaxed in the company of staff. We saw people actively calling out, smiling and waving at staff as they passed by. It was clear that some harmonious and respectful relationships had been established.

● However, we also observed occasions where staff did not treat people with kindness and compassion. Their approach was task based and they did not support people in a way that was caring or showed the person that they mattered. For example, we observed a staff member providing food and drink to one person for more than 20 minutes, without speaking to them. During this time the person was heard screaming and shouting; indicating they were distressed.

● Other staff spoke passionately and were knowledgeable about people they supported. They knew them well and understood how best to support them in a caring and meaningful way. This was often reflected in how people's support was provided; following established routines that people understood, helped to manage their anxieties and feel in control. One professional told us, "Staff know people really well. I can't fault the staff."

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

● Staff were seen respecting people's choices and wherever possible, accommodated their wishes. For example, staff advised one person on removing some outer clothing due to the warm weather but respected the person's decision to keep this on.

● When asked if staff offered people real choice and control a relative told us, "Yes they do. [Name of person] won't do anything they don't want to." We heard staff telling people, "It's your choice," and people were also heard saying similar statements such as, "It's up to me;" indicating this was said often and reinforced by staff. Another person told us, "I like living here because we can do what we want to do within reason, so long as it is not dangerous for us."

● However, we found this approach was not consistent across the service, particularly, but not exclusively for, those people who lacked capacity to make some decisions. For example, one person told us, "Night staff decide when to lock the communal room and we are allowed in if we can't sleep." This did not demonstrate an understanding that staff were supporting people in their own homes.

● We also witnessed staff doing tasks for people, with no consultation. This included handing them food, drink and wiping their nose. There were no attempts made to help people understand the options available to them, or to encourage people to do things for themselves. Although staff seemed generally kind and well-intentioned, this demonstrated a culture of inequality; not seeing all people as equal adults with the same rights.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed 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

- Support plans did not contain sufficient guidance to ensure people consistently received personalised, proactive and co-ordinated support. We found important information missing as well as generic statements such as, "[Name of person] to form relationships," but there was no further detail on how staff should go about supporting the person to do this.
- People's daily records often lacked personalised information; instead providing brief, task focused accounts about the support provided to them. Where staff had taken time to make a record of how someone was feeling such as, "[Name of person] got up from bed, started banging, slamming and screaming," there was no further information about the actions taken to find the cause of the person's distress, or to try to alleviate this.
- People had not been supported to identify meaningful goals that would enable them to increase their independence, follow their interests and achieve their aspirations. For example, "[Name of person] needs support surrounding his personal care." There was no further information on how they might be supported to achieve this. When asked, staff were not aware of any goals for some people living at the service.
- Although one person told us, "I review my care plan. I did it completely and staff help but I type it on the laptop." There was no evidence of support plans being meaningfully reviewed for everyone in this way. Some of the reviews just stated, "No change." There was nothing to show people had been involved, along with those important to them.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Staff did not always have the right skills and understanding of people's individual communication needs, or how to facilitate communication when people were trying to tell them something. We observed variations in how well staff communicated with people. Some did this very well, but some staff did not engage in a meaningful way at all.
- People did have communication support plans. But these lacked sufficient detail to provide staff with effective guidance on each person's preferred methods of communication; including the approach to use for different situations. One person's plan contained a number of suggested actions, such as using picture cards, to support with enhancing their communication. However, it had not been reviewed for at least 18

months. This meant there were no recorded updates to show progress with these actions. Staff told us these had either been tried and dismissed, or only recently introduced.

● People did not always have access to information in formats they could understand. Despite staff talking about recently introduced communication tools such as the picture cards, we did not observe staff using any individual communication methods or tools with people. In addition, people's support plans had not yet been produced in an easy read or accessible format. The manager told us they aimed to introduce these for everyone within the next four months.

● One staff member talked about a version of a Makaton sign used by one person. Makaton is a language that uses symbols, signs and speech to enable people to communicate. Another staff member, who was supporting the person in question, did not understand this sign at all. It had also not been described in the person's communication plan. Despite the person having knowledge of at least one Makaton sign; with potential to increase their use of this language, training records showed there were many staff who had not yet received any Makaton training.

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 were not consistently supported to participate in social and leisure interests, on a regular basis. There were no structured activity plans in place and records showed a number of people did not leave the Treow House site regularly.

● Activity support plans were in place but were not being followed. One person's activity support plan referred to them being given a choice of activities daily. However, they had only been on four outings, outside of their flat, in three months. Staff were not aware of what the person might like to do beyond going for a walk or a drive round the block.

● People were not routinely supported to broaden their horizons and develop new interests. Staff spoke about ideas to increase a second person's social and leisure interests, but they also told us the person needed two staff to help them move from one position to another, which limited opportunities for accessing activities off site.

● Neither of these people had left the Treow House site between our first and second visits, with the extent of their activities recorded only as walking around the grounds or sitting in the garden.

● We observed people using the communal garden, which people and staff referred to as the 'smoking area'. We observed staff regularly using this area to smoke in. A professional commented on the garden not being suited for people with increased sensory needs. They told us, "The communal and garden areas appear to be set up for the clients who enjoy loud spaces and the staff… Although some clients seem to enjoy these social areas, this is quite a loud environment and does not meet the needs of all of the clients, as this can be a challenge for some with more sensory needs."

● A third person's support plan stated, "Staff need to engage [person] to participate in activities in the community as [person] is unaware of local activities which take place." There was no further detail to guide staff on how to do this. People told us there had been a local Carnival, but this person had not attended. Staff confirmed the person enjoyed going out but had not been ready on time. Records did not evidence what staff had done to explain and prepare the person for the Carnival in advance; in a way that would have been meaningful and understood by them.

Inconsistencies with providing personalised care or meeting people's communication and social needs were further breaches 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

● Records did not evidence how concerns and complaints were handled. Where a concern had been logged,

we found no further information to demonstrate how this had been dealt with, the outcome and any lessons learnt.

● Despite this, the majority of people, and those important to them, told us they could raise concerns and complaints easily. One person told us, "I would go to the manager as she's quite good." A professional echoed this by adding, "I have worked closely with both the manager and deputy regarding a customer and they have been very responsive."

End of life care and support

● Staff confirmed there was no one currently using the service who was in receipt of end of life care.

● Records showed attempts had been made to consider people's individual preferences and choices for their end of life care, should they become unwell. However, this had not always been done in a meaningful way, with the person or those important to them. For example, one person's records stated their wishes were to be respected but did not go onto say what these were.

● Another person's records said they were unable to inform staff of their wishes, so staff would need to consult with those closest to the person in the event of them becoming unwell. Although not everyone may wish to do so, understanding and considering people's needs in advance can improve their quality of life; particularly if they were to be come unwell unexpectedly.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- Systems were in place to check the quality of service; to identify potential concerns and areas for improvement. Audits and checks were being carried out however, these did not fully consider or address all the areas we (CQC) look at when we inspect registered care services, including improvements important to people to live full and meaningful lives. For example, person centred care, dignity and respect, need for consent, safe care and treatment, good governance and staffing.
- There was limited evidence the provider routinely sought feedback from people and those important to them, to develop the service. A relative told us they had never been asked for feedback, "No, no questionnaires or surveys." When we asked to see the most recent analysis of feedback from people, relatives, staff and professionals, it was not provided.
- This was the same with tenants meetings for people living at the service. We were told these had taken place regularly prior to COVID-19, but not since.
- In addition, although the manager was very aware of the importance of a positive service culture, they confirmed there had been no recent checks to assess this. The purpose of this would be to provide assurances about the care and support provided to people, and whether this was person centred, inclusive and empowering. The manager told us they planned to focus on providing staff with the skills and knowledge to achieve good outcomes for people using the service.
- The head of quality arrived during our inspection as they had planned to carry out a new style audit for the service, on behalf of the provider. The inspection delayed this happening and although we requested an update on this, no timescale for this audit to be rescheduled was confirmed.
- However, the head of quality and manager both acknowledged improvements were needed. They shared information about the provider's plans to develop staff practice and focus on improving people's quality of life. The plans did address many of the areas we found in need of improvement, but the timescales for implementing this were not confirmed at the time of this inspection, despite us requesting this information.

This meant quality monitoring systems were not yet robust enough to identify and drive continuous improvement across the service. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We received mixed feedback about whether the management team were visible, approachable and took a

genuine interest in what people, staff, family, advocates and other professionals had to say. One person living at the service told us, "We can always go straight to the office and speak to anyone there." A staff member echoed this with, "I can talk to the manager if concerned. She is friendly and listens to us."

● Other staff told us they did not feel respected, supported and valued by senior staff. They felt disheartened and did not yet feel the management team were effective; in terms of listening and bringing about positive changes. Comments included, "Often too busy" and "[Name] comes once in a while but they are not approachable and doesn't talk to us."

● Similarly, the feedback about staff motivation and collaborative working varied. Whilst we did observe some great team working, with strong communication and a focus on people's needs. We also found inconsistencies in how people were supported.

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

● A new manager had been recruited who had been in post around six months prior to this inspection.

● We found no evidence of any incidents occurring during this time that would have required duty of candour to be applied. The duty of candour requires registered providers and managers to act in an open and transparent way with people receiving care or treatment from them when things go wrong.

● The manager confirmed they kept up to date with current guidance and legislation in several ways, to ensure their legal responsibilities were understood and met. However, we did find some areas requiring better understanding and swifter action to demonstrate legal requirements were being consistently met by both the manager and the provider. This included reporting potential safeguarding concerns and notifying us (CQC) of changes in management arrangements at the service, in a timelier way.

● Despite this, feedback we received indicated an improving picture with a manager who was committed to delivering a quality service for people; with more time and the right support. One professional told us, "[Name of manager] works her socks off; so lovely to see someone who cares. There is care there, they do care."

●This echoed our own findings. The inspection was carried out using recently enhanced methodology, which included the 'quality of life' tool. The purpose of the tool is to really find out what life is like for people with learning disabilities and autistic people; in terms of the quality and safety of the service they receive. It was evident the provider had a clear vision for the direction of the service, which demonstrated ambition and a desire for people to achieve the best outcomes possible. However, they acknowledged there was more work to be done to demonstrate how they consistently meet the needs of everyone using the service, in line with current best practice. This includes the 'Right Support, Right Care, Right Culture' guidance.

Working in partnership with others

● The service worked with a range of different professionals to meet people's assessed needs. Generally the feedback we received from professionals was positive, with a few areas for improvement such as developing staff skills for managing people's emotional and sensory needs consistently, and ensuring people are always referred to relevant health care professionals as required and in a timely way.

● The service worked with advocacy organisations too, which helped to give people using the service a voice and improve their wellbeing.

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 People did not consistently receive personalised care that met their needs and individual preferences. Regulation 9(1) People's care was not always designed to make sure it met all their needs, including social needs and interests. Regulation 9(3)(a)(b) People's holistic needs and aspirations were not comprehensively assessed prior to them using the service. Regulation 9(3)(a)(b)(d) Attempts to involve people in making decisions about their care and support - by providing information in formats they understood - were inconsistent. Regulation 9(3)(d)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not consistently supported to make decisions in line with current legislation and guidance. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were inconsistencies in the support and training provided to staff, to enable them to carry out their roles effectively. Regulation 18(2)(a)