Independence Homes Limited

Active Care Group Supported Services

Inspection report

Quadrant House
Croydon Road
Caterham
CR3 6TR

Tel: 01883331777
Website: www.activecaregroup.co.uk

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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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Active Care Group Supported Services provides support for autistic people, people with learning disabilities, physical disabilities or mental health needs. People's care and housing are provided under separate contractual agreements, although we have highlighted within this report that the separation between these two elements had not been made clear to people. The Care Quality Commission (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 providing support within the regulated activity of personal care to 36 people across six 'supported living' settings. The settings included accommodation in both small shared houses and larger blocks of flats.

People's experience of using this service and what we found
People were not always supported to have maximum choice and control of their lives and despite staff having a good understanding of people's capacity, support was not always delivered in the least restrictive way possible and in their best interests; the policies and systems in the service did not consistently support best practice.

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.

Right Support:
The quality of support that people received across the different settings was not consistent. At one setting, people did not always receive the care they needed to live safe, happy and fulfilling lives.

There were not always enough staff on duty. In addition to staffing shortages, some of the settings relied on high levels of temporary staff who did not always have the skills and experience to meet people's needs and expectations. Recruitment processes were safe, and the provider was taking active steps to increase number of staff and ensure that staff were deployed effectively.

Staffing issues had a significant impact on the way people received their care. People and their families told us that staff did not always have the time to provide support in a way that increased people's skills and promoted their independence.

There were systems in place to support people with their healthcare needs, and managers were working hard to build more positive working relationships with other professionals to ensure people received the

care they needed.

Right Care:
People did not consistently receive care that was person-centred. Whilst staff understood the importance of individualised support, the challenges with having enough experienced staff meant that often they had to prioritise the needs of the group, rather than the individual.

People at one setting told us that some staff had not treated them with respect or kindness. Where those individuals were able to be identified, immediate action was taken to ensure people were safeguarded. Other staff were praised for their commitment and dedication to doing the right thing.

Right Culture:
The culture varied across the settings. At one setting, people did not feel listened to or valued. They told us they had given up raising complaints because nothing ever changed. At other settings, despite the staffing challenges, people felt engaged and informed about what was going on. This led to the feeling a greater sense of control over their lives.

The new registered manager and senior leadership team were working hard to change the culture across all settings, they were already aware of many of the issues people raised with us and were working hard to implement the changes that were needed.

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

Rating at last inspection This service was registered with us on 11 November 2021 and this is the first inspection.
The last rating for the service under the previous provider was Good published on 27 November 2020.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the safety of people's support. As the service had not previously been inspected under the new provider a decision was made for us to carry out a full inspection to provide a rating.

We found evidence the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The provider fully engaged with the inspection process and has already provided evidence of immediate action that has been taken to mitigate the risks identified.

Enforcement
We have identified breaches in relation to person-centred care, safeguarding, the safety of medicines, management of risks, staffing and good governance. Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Active Care Group Supported Services

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of 4 inspectors, a specialist advisor with professional experience in the management of medicines and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
This service was providing regulated care and support to people living in six '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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection a new manager had been in post for four months and had applied to register. Since the inspection, this person has successfully completed the registration process and is now the registered manager.

Notice of inspection
We gave the provider 24 hours' notice that inspection activity was commencing. This was because we wanted to meet with people living in their own homes and we needed to understand people's level of capacity to be able to consent to this. We made both short notice announced and unannounced visits to the settings across a twenty-four-hour period.

Inspection activity started on 2 November 2022 and ended on 7 December 2022.

What we did before the inspection
We reviewed information we had received about the service and sought feedback from the local authority and other professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited 5 of the 6 settings where people received a regulated activity. We visited some settings multiple times to follow-up on specific issues or concerns. This included an overnight visit to one setting. During the course of our inspection activity, we spoke with 26 people and 18 relatives about their experiences of using the service. Some people we met were not able to verbally communicate with us and we communicated with them using a symbol-based communication tool to tell us of their experience. We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use this symbol-based communication tool. We checked that this was a suitable communication method, and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves.

We also interviewed 23 members of care staff, including the service managers at each setting. We undertook a remote review of recruitment with the provider's onboarding manager and spoke individually with two managers from the organisation's quality team. We communicated regularly with the registered manager and nominated individual during the inspection period. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a range of documentation relating to people's care and the management of the service. These included the medicine records and support plans for 9 people and the recruitment records of 6 staff. A variety of records relating to the management of the service, including incidents and accidents and audits were also viewed.

After the inspection
We continued to seek clarification from the provider to corroborate our findings. We also spoke with our colleagues in partner agencies to ensure appropriate safeguarding measures were in place where people had raised concerns. On 7 December 2022 we had a video call with the nominated individual to discuss our inspection findings and received assurances about the immediate and short-term actions that had been taken in response to the concerns that had emerged at the beginning of our inspection activity.

Requires Improvement

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- People did not consistently feel safe in their homes. Whilst it was not everyone's experience, many people described situations where they were or had been scared by the behaviour of other people they lived with. At one setting people also told us they did not feel safe with some of the staff that supported them.
- People and staff at one setting told us that some staff were "Unkind," "Spoke sharply" and did not treat them with respect. A family member of a person living at that setting also told us, "I do not feel that [Person's name] is safe with the night staff, they can be so disrespectful." Likewise, a relative expressed, "[Person's name] is safe with the day staff but I do not feel nor does [person] that they are safe with the night staff."
- At this same setting, another person told us, "There is so much screaming and shouting, night times are the worst. I hear [Person's name] regularly attacking staff, how can we be assured we are safe when staff aren't even safe themselves?" Similarly, a further person said, "I don't feel safe in my own flat, I keep telling them, but nothing gets done and it's not fair."
- At another setting, people weren't able to verbally express how they felt, but families and staff explained people expressed heightened anxieties which suggested they did not feel safe in their surroundings due to the way another person using the service behaved. For example, one relative told us, "I am concerned as to whether he is safe from another client." The relative went on to describe a number of incidents with another person that their loved one had witnessed. We also observed that the person was quite withdrawn and took themselves to back to bed in the afternoon. A staff member expressed, "[Person's name] has changed with everything that has been going on here, they do seem to spend a lot more time alone in their room now. We do try to engage him in things, but he is a lot more withdrawn now."
- Staff knowledge of safeguarding was variable, whilst staff had received training in this area, this learning was not always reflective in their practice.

The failure to have systems and processes which consistently protected people from abuse and improper treatment 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.

- In light of the specific concerns raised we shared our information with the safeguarding team at the local authority and contacted the provider for immediate assurances. The provider confirmed that they had also recently identified that staff were not consistently following safeguarding policies and procedures and shared the improvement actions they had in place to address this.
- Prior to the conclusion of our inspection activity, a number of immediate steps had been taken by the provider to better safeguard people across the whole service.
- Some staff we spoke with had an excellent understanding of their roles and responsibilities in respect of

keeping people safe from abuse and were able to confidently describe the steps they had taken to report and safeguard people from harm.

Assessing risk, safety monitoring and management

● Risks were not always appropriately understood and managed across the settings to ensure people were consistently kept and felt safe.

● People at one setting repeatedly told us that they did not feel safe living there. One person said, "I hate it here, I don't feel safe and I want to leave."

● People and their relatives consistently raised concerns about the impact staffing issues had on supporting people safely. In particular, the impact of people having to wait too long for staff support when they had complex medical needs, or high levels of anxiety.

● Relatives of some people raised concerns about staff's ability to meet people's specialist needs and the risks this posed. For example, several relatives raised concerns about people being seated safely in their wheelchairs. One relative told us, "I have visited and [Person's name] is slumped in their wheelchair almost falling out." Likewise, another family member stated, "I have been in several times and [person's name] is almost slipping out of their chair."

● Care records reflected that where risks to people had been assessed, staff did not always have the understanding, skills or time to implement the risk mitigations in place. For example, some settings were relying heavily on the use of temporary staff who were unable explain the key support needs and therefore risks associated with the people they were supporting. Two people told us they relied on the support of other people using the service to summon help when they were unwell or in distress.

● Each person had a Personal Emergency Evacuation Plan (PEEP) in place which outlined the support they would need in the event of a fire. At one setting, some people and relatives raised concerns about the fire alarms sounding regularly, and staff not responding appropriately. People told us that this left them feeling unsafe about the risk of fire.

The failure to ensure risks to people's safety and well-being were effectively assessed and acted upon was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In light of the specific concerns raised about risks to people we contacted the provider during the inspection. Prior to the conclusion of our inspection activity, a number of immediate steps had been taken to improve the way risks were being managed. Ongoing improvement in this area is directly linked to the need to recruit and train a core team of staff who know and understand people well.

● The registered manager also provided assurance that whilst there had been a specific issue with one person repeatedly triggering the fire alarms, this had now been resolved. They also provided evidence of more recent fire safety training and drills for staff as well as professional servicing of fire equipment. We reminded the registered manager of the importance of staff communicating to people the outcome of the fire alarm sounding so those people who have remained in their flats are not left wondering whether there is a fire or not.

● We saw that where people were supported well by staff who knew them, the management of risks had enhanced their independence. For example, one relative told us, " When [Person's name] was in hospital they were very risk adverse, here they have encouraged him to try and walk something he couldn't do after a long spell in hospital and its worked I am very grateful to them as he is mobile again." Likewise, another family member commented, "My daughter has received travel training from the staff so she can now walk down to the town to do her own shopping, there is a risk but she so enjoys it and knows to take her mobile with her."

Staffing and recruitment

● People across all settings repeatedly told us there were not enough staff to meet their needs. For some people this resulted in them waiting for their personal care. One person said, "They are often short-staffed which means waiting for your care. Sometimes I go to bed much later than I would like to, because I am waiting for staff to come and help me."

● Other people and their families highlighted the impact of staffing shortages on their mental well-being. For example, one person told us, "My mental health has declined since being here. I put that down to social isolation and unmet needs." Likewise, a relative informed us, "[Person's name] doesn't get enough support and that is detrimental to her mental health."

● At one setting we were told, "They are short-staffed most of the time with managers constantly scrabbling around for agency staff to cover shifts. Lots of people are being deskilled by the lack of support for example in respect of meal preparation. This is leading to poor diets and a lack of exercise."

● At settings where people's basic needs were being met, staffing challenges had prevented them accessing activities and working towards goals to achieve independence. One person told us, "Sometimes I feel like our trips out are rushed. This makes me sad as I used to love going out lots."

● Staff and managers across settings consistently raised concerns about staffing levels and morale was low as a result. Staff described daily frustrations of working excessive hours and the need to support high numbers of temporary staff.

● Our concerns about staffing levels were in addition to the recognised staffing challenges across the wider health and social care sector. This was because there was a lack of clarity about what staffing levels people were funded for in addition to an inconsistent approach towards the effective deployment of staff.

The failure to ensure suitable and sufficient staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely, and appropriate Disclosure and Barring Service (DBS) checks and other relevant recruitment checks were completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● The management of medicines at one setting was not always safe. We found that these medicines were not being stored, administered or recorded in line with the provider's own policy or best practice.

● People described occasions where they had been or nearly been given the wrong medicines. One person told us, "A medication error completely undermined my trust in them. Now I check everything for myself."

● People at this setting told us that sometimes they had to wait for their medicines. We also observed this to be the case. Staff administering medicines were constantly interrupted which meant that there was a delay for some people, and they did not receive their medicines in a timely way. Medicines such as insulin were prescribed to be given at set times and not doing so risks them working effectively.

● Where people required occasional medicines (PRN), there were not always clear protocols for staff to follow. For example, the guidelines in place for one person living with diabetes had not been devised in conjunction with a relevant health care professional. Furthermore, the information for staff made reference to a PRN medicine that was not available within the service.

● A relative also informed us, "Sometimes she has to wait for support, that can vary from 20 minutes to 2 hours, that can be a problem as she is on PRN medication for pain and has to wait too long sometimes."

● Medicine Administration Records (MAR) highlighted that medicines had not always been given as prescribed. For example, one person had been prescribed eardrops for 7 days, but staff continued to administer it for 11 days. A relative of a different person highlighted that the same mistake had occurred for

them, "[Person's name] was down to have medicine for 2 weeks but they managed to carry on giving it long after they should have."

The failure to ensure the proper and safe management of medicines is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had completed their own medicine audit at this setting a couple of weeks prior to our visit and identified the majority of the issues we did. There had not been sufficient time to fully implement the actions from this audit by our first inspection visit, however the provider had been able to provide evidence of appropriate steps being taken prior to the completion of the inspection. This included a further full medication audit by a clinical expert on behalf of the provider and twice daily management checks to ensure all medicines had been appropriately given and recorded. The diabetes protocol had also been discussed and updated in discussion with the person's GP.
● At the other settings people told us they had received their medicines as prescribed. This was further confirmed by their families. One relative said, "He is on some medication which the staff manage, they are very good, and he gets it on time." Similarly, another family member described, "Medication is given on time and goes very smoothly."
● We saw evidence that staff were following appropriate systems in place to ensure medicines were administered, stored and recorded. This included staff following clear guidelines in place for the use of PRN medicines.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Some settings had fostered a culture of reflective practice and shared learning which enabled staff teams to use incidents and accidents as a way of developing their own practices. For example, at one setting it was evident that all concerns were discussed individually and collectively as a strategy for driving improvement. One staff member who worked there told us, "We have staff meetings every month and we discuss any areas of concern ….what approach works well with people and how we can be more effective."
● At one setting in particular, the multiple management changes, alongside staffing shortages had meant that a culture of learning from events had not yet been established. People and their families shared frustration at repeated incidents and concerns. These were discussed at length with the management team who explained that a new incident reporting system had recently been introduced. It was evident that since the introduction of this new tool, senior management had a better oversight of incidents and were working hard to embed reflective culture across all settings.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection since the service was re-registered. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Prior to the new senior management team being in post, the assessment process had not been used effectively to ensure services were only offered where people's needs cold be fully met. Service managers described situations where they had been pressured to accept placements for people who they knew could not be appropriately supported within their service.
- The principles of Right Support, Right Care, Right Culture had not been consistently followed and despite people sharing flats or living spaces, compatibility with each other had not been always been considered. People and their families described situations in which they had been expected to accept a new person moving into their accommodation without due consideration being given to whether the new person's needs were compatible with their own.
- At one setting, the inappropriate placement of a person had disrupted the running of the service. Managers and staff expressed frustration as they had highlighted to a senior manager that they would not be able to safely support that person prior to their arrival.
- The concerns about the assessment process were discussed with the new registered manager and senior management team. They recognised that historically the assessment process had not been sufficiently robust and were working hard to resolve this. They were also in the process of undertaking a full re-assessment of people's needs to ensure proper plans and support systems were in place to deliver appropriate care.
- Prior to the conclusion of the inspection, some changes to people's accommodation had been made which had mitigated the negative impact of people with differing needs living together.

Staff support: induction, training, skills and experience

- People and their families provided mixed feedback about the skills and experience of staff. We received some positive examples of how staff had supported people well, especially where staff had worked with people for a while and had a good understanding of their needs. There was however a general consensus amongst people and their families that there weren't enough regular staff with the specialist skills and experience to support people effectively.
- One family member told us, "I think they need more training and educating around the different disabilities that residents have as they treat them as if they all have the same disability." Similarly, another relative commented, "At the start some of the staff didn't understand [Person's diagnosis] and just thought he was autistic, and they didn't know how to de-escalate a situation to avoid [distress]." These views were reflected in the narrative recorded in incident reports and daily records.
- Staff told us, and records confirmed that they had access to a wide range of relevant training courses. It

was evident however that at some settings staff turnover was so high, or the range of different complex needs that staff were expected to support meant that this learning had not always been successfully embedded.

The failure to ensure suitable and sufficient staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The improvement plans for each service highlighted that the inconsistency of staff skills had already been identified and specialist staff from other parts of the business had been arranged to come and deliver face to face learning with staff. Where these sessions had been held, the feedback was positive, and the registered manager confirmed that they were now including regular temporary staff in their training. The provider also confirmed that they had now properly established the range of needs the service was able to support and as such would no longer be offering support to people whose needs were outside their statement of purpose.
● New staff were required to complete an induction programme in line with the Certificate in addition to shadowing more experienced staff. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● In settings where staff teams were more established, the induction of new staff was effective. For example, one person told us, "I'm not thrown into having new staff. I will be introduced, and they will slowly start supporting me. If I [am unwell] new staff call other staff until they are used to me." Likewise, at another setting, a staff member told us, "I've been supported to do a National Vocational Qualification at Level 4 – you can request any training that you want to develop your skills."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain adequate hydration. Feedback across the settings was mixed in respect of the way people were supported with their meals. With the exception of one setting where people tended to eat together, people planned, prepared and ate meals individually which offered choice.
● Where staffing was an ongoing issue, people and their families raised concerns that this impacted on the support people received in respect of nutrition. At one setting, a relative told us, "She needs support to cook, this is rather patchy. I think if she doesn't have the energy to cook and no one to support her then she just snacks." Similarly, another family member commented, "My son orders his food online. I think he needs more support from staff on this as sometimes when I visit his fridge is bare."
● Regular staff were aware of people's dietary needs and preferences. For example, one staff member told us, "[Person's name] needs to eat soft food due to a choking risk." Likewise, at another setting we observed staff encouraging a person who had recently lost weight to eat. We overheard them saying to the person, "I made your favourite, grilled cheese."
● Care records outlined people's dietary needs, detailing any health risks and cultural preferences to ensure support was appropriately tailored to the individual.
● Where needed, pictorial aids were used to support people to make choices about their meals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Where settings had consistent management arrangements, they had forged good relationships with the other agencies and made appropriate referrals on behalf of people to request specialist support. At one setting, the relationship with external professionals had been more challenging due to the turnover of managers. The new management team were working hard to rebuild these relationships and more proactive engagement was evolving.

● People were supported to access health care services and we observed that staff were committed to advocating on behalf of people when they were physically or mentally unwell. For example, staff had noticed the decline in one person's mental health following a change in their medication and were actively seeking specialist support in respect of this.
● Families informed us that whilst people were supported to make and attend medical appointments, these were sometimes impacted by staffing shortages. For example, one relative told us, "She does sometimes have to cancel appointments because they are short staffed."
● Staff spoken with all recognised the importance of people attending health care appointments and said they made every effort to prioritise support for these. They did acknowledge that on some occasions this was not possible. One staff member told us, "If we are really short staffed then we prioritise staff to focus on the basics. After medication, personal care and meals, we prioritise getting people to their appointments."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Whilst staff knowledge of the MCA was variable, people told us, and we observed that staff understood the importance of gaining consent from people and supporting people to make their own decisions. For example, staff routinely sought consent prior to delivering care and administering medicines.
● The registered manager had now ensured that all relevant applications for a community DoLS had been completed.
● Staff had access to relevant MCA training, but the registered manager advised that they had recently secured the support of a mental health lawyer to do sessions around best interests. One staff member told us, "Yes, we were trained and I'm up to date with this training. I just think the main thing we have to remember is finding the least restrictive option for people."
● Staff knew when to raise concerns about MCA to their managers and talked about the challenges for them when people who had capacity made unwise decisions. One staff member described a situation in which a person with capacity had made a decision that staff felt was not positive for them. The staff member shared how they had talked with the person to help them understand the risks and said, "You have to respect their decision if they are able to make it. All you can do in those circumstances is just keep talking about it with them."
● Staff recognised the challenges where people living in the same setting had different levels of capacity and the risks associated with that. For example, one staff member told us, "Some people like to eat together, but we have to make sure each person understands the implications of this, cost of food, electricity etc so that one person isn't being financially disadvantaged without knowing that."
● Care records identified where people's capacity fluctuated and how best to manage this.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People and their families expressed that whilst they felt most staff were kind in their approach, there were a few exceptions to this. At one setting people repeatedly raised concerns about the way they were treated by night staff. For example, one person told us, "They (staff) are rude to me. It's the night staff. The day staff are perfect."
- At another setting, people highlighted that a staff member was often abrupt in the way they spoke with others. One person told us," It's ok here, but one staff member is rude and doesn't speak nicely to people." Similarly, another person commented, "One staff member is so rude to others; both residents and staff. There's always arguments when they are working."
- Other concerns impacting on how people felt they were treated was directly attributable to staff shortages. We found that staff often either did not have the time to deliver the most compassionate support or people were supported by temporary staff or staff who did not always know how they liked their care to be delivered. One person described, "There's a general lack of enthusiasm from staff – lack of positive vibe and that's because they are so busy." Similarly, the relative of another person said, "Some of the staff are kind and that's usually the permanent staff but not all the agency staff are, the good ones are like diamonds." Staff also spoke candidly about how the pressures on them made it difficult to deliver truly person-centred support and that they didn't always have time to spend with people in the way they would like.

The failure to consistently provide person-centred care was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider's own development plan for the service had already identified that some work was needed to improve the culture of settings as new staff were recruited and management changes embedded. We will continue to monitor this as part of the provider's ongoing action plan in respect of managing staff.
- Despite the issues raised above, people and their families were both also keen to praise those staff who supported them well. One person told us, "They [care staff] really care and will put the individuals needs at the top to support them in the best way possible." Likewise, another person said, "The staff and team leaders are fantastic, they do everything they can to ensure everything is perfect." They went on to highlight some staff saying, "They are the best staff. They are good people." A relative expressed, "Front line support workers are brilliant mostly."
- Staff teams across settings offered a diversity that benefitted people. We saw that there was willingness to explore and celebrate different cultures. A relative told us the most recent event had been a party for Diwali.

● Staff understood people's religious and cultural needs and funding requests were being made to support people to actively practice their religion where they wished to do so. For example, one staff member told us, "We managed to secure the additional 1-1 funding for [Person's name] so we could support him to church every Sunday."
● One family member told us, "It would be nice if they took her to the Temple for worship. Whilst this was not yet happening, we saw evidence that staff were seeking a review in order to discuss funding in respect of this.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care
● People and relatives shared how the impact of being short staffed affected people's encouragement to be independent. For example, some people, at one setting in particular expressed that they wished staff had more time to support them doing things like preparing meals, rather than just doing it for them quickly. Similarly, a family member told us, "I think they need to encourage independence a bit more, as whilst they are happy to do things, she will let them"
● It was also evident that some people had had the opportunity to develop new skills and increase their independence. One relative told us, "They were so good in encouraging my brother to walk independently." Equally another family member commented, "They have been very encouraging in helping my daughter to be more independent with travel training to walk into town and do her own medicines."
● Many staff spoken with were passionate and motivated by their involvement in people becoming more independent. For example, "We try to get them to do as much as they can by themselves." For example, one person had always wanted to make her own tea. We got them a special kettle and they made tea for everyone and we cried that day."
● With the exception of the comments above about a few individual staff, the majority feedback was that staff promoted people's privacy and dignity. One person told us, "They help me with showering and staff are very respectful of my privacy and dignity. Honestly, I have no problems with that at all."
● Care records included information about how people liked to dress, do their hair or make-up. One person said, "I go to the salon and when I go it makes me happy." Similarly, we noticed another person with brightly painted gel nails, and they told us, "Having nice nails is important to me and they do take me into town every 2 to 3 weeks so I can get them done."
● We observed that staff respected people's privacy and routinely knocked on people's doors before entering. Some people had instructions for visitors on their doors and we saw that staff checked these before disturbing them.
● Staff talked confidently about the things they did to help make people feel comfortable during personal care. For example, one staff member reflected, "I make sure I treat people exactly how I would treat my family with dignity and make sure I keep their privacy."
● Staff availability permitting, people generally felt included in discussions about their care and how they received support. One person told us, "I can make choices. I tell them when I want them to help me and they help me."
● Relatives shared examples of the way staff gave their family member choice. One relative told us, "[Person's name] is able to choose what he wants to do and what he doesn't. They give him options of what he wants to do."
● Staff used different communication systems to facilitate people making decisions about their care. One staff member shared, "We have a communication book for one resident to point to say what she wants."
● At one setting we saw staff spending time encouraging people to express their views and using pictorial aids to help them communicate their choices.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection since the service was re-registered. This key question has been rated requires improvement. This meant people's needs were not always met.

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 and their families consistently told us that insufficient staffing meant that they were often unable to spend time doing the things they enjoyed. This issue was especially acute at one setting, where the majority of people were unhappy about their lack of meaningful occupation. One family member said, "My son said to me recently, "This is not a life, I feel like a prisoner."
- People expressed understanding why outings during the pandemic were stopped but were deeply frustrated that this was still the case. One person told us, "People are always saying they need more to do and more variety; it all feels a bit dead at the moment. We have an activity timetable, but it doesn't really happen as not enough staff or positive energy to make it happen."
- One relative also told us, "Because of staff shortages, there is no spontaneity, and everything has to be done by arrangement."

The failure to consistently provide person-centred care was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager recognised the significant impact that social isolation was having on people's emotional wellbeing and shared the plans in plans in place to get people back into the community through either jobs or education. She also reflected that in addition to the issue with staffing shortages, many of the staff who had been recruited during the pandemic had never supported people outside the service. It was therefore taking time to train them to feel confident in that aspect of their role.
- At settings where management and teamwork were strong, staff had been creative in managing the impact of being short staffed. For example, one staff member told us, "Some activities have been postponed as a result of staffing, but we've tried to re-arrange the things that people like doing for different times rather than just cancelling them. We've also done things like a BBQ and themed events within the service, so people still get to engage with others."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The impact of staffing shortages and the high use of temporary staff meant that people did not always receive personalised support. The registered manager reflected, "If we were fully staffed in every setting then things would be much more person-centred."
- The provider's own improvement plan had already highlighted the actions needed to deliver care that consistently met people's needs and active steps were being taken to achieve this. In addition to ongoing recruitment, managers were liaising with people's funding authorities to arrange formal reviews to ensure

support plans were accurately reflective of people's current needs. Senior management were working hard to ensure staffing models followed the supported living model and not that of residential care. Until very recently shifts were being arranged to reflect the needs of the group, rather than the individual.
● The registered manager also confirmed that a new shift pattern for staff was being introduced on 1 February 2023 which would better facilitate people's support during the day and provide a dedicated handover period to ensure all staff could be properly updated at the start of their shift.

The failure to consistently provide person-centred care was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Our conversations with staff highlighted that whilst they were not always able to deliver personalised support, the majority of core staff across settings had a good understanding about what person centred care meant. One staff member told us, "It means whatever you are doing surrounds the person and has to do with them. The care is unique to each individual". Likewise, another staff member reflected, "It's making sure we adapt our approach depending on who we are looking after as they are all so different."
● In addition to the examples of things not going well, we also heard how people had received support people in a really positive way. For example, one person had not felt able to go to the hairdressers for many years. Staff explained how they had slowly worked with the person to achieve this goal. They told us, "We talked about it, planned it and then took them to visit the salon, firstly the outside and then going in and now they are ready to take the next step and attend an appointment."
● At another setting a person had previously required 2-1 support in the community and this had now reduced to 1-1. Staff reflected, "We've achieved this through active engagement with him and now we understand him, and he trusts us, the risk is much lower."
● Care records were in the process of being further reviewed, but they were mostly highly personalised documents with evidence that people had been involved in their creation.
● People and relatives expressed that whilst their latest review may be overdue, they had been involved in the development of care plans.
● Some settings had introduced summary care plans for temporary staff to enable easy access to the most important information about people and where in place, this was reported to be working well.

Improving care quality in response to complaints or concerns
● Complaints or concerns were not consistently listened to and used to improve the running of the service.
● At one setting in particular, people said they had given up raising complaints because nothing was ever done. When asked if they could raise their issues beyond the setting, they told us, "It's impossible to complain to head office as I don't know who anyone is."
● Relatives experience was variable, whilst some families said they either had no concerns or would be happy to raise them, others didn't feel their views mattered. One relative shared how they had had to complain repeatedly before there complaint was eventually listened to and resolved in an appropriate way.

The failure to act on feedback from people and other relevant persons was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The feedback we received was shared with the registered manager who demonstrated that she was now actively involved with addressing some of these concerns and prior to the conclusion of the inspection a number of the issues had been resolved and others were in the process of being investigated.

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.

● Most people used verbal and written information to communicate, but for those that had specialist needs efforts had been made to make information more accessible to them. For example, at one setting, two people had an easy read version of their care plan to aid their understanding of the information that was recorded about them.
● At another setting, pictorial aids and photographs were used to enable people to make active choices in respect to meals and activities.
● Where people used alternative communication systems such as Makaton, we saw that staff were able to use this effectively. Makaton is a language programme that uses signs together with speech and symbols, to enable people to communicate.
● The new senior management team had made annual Makaton training a mandatory requirement for staff. One staff member told us, "We do Makaton refreshers every year. A month or two before we get a prompt by e-mail. If you don't complete it, you can't work."

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- People, families & staff told us that they didn't feel connected with the wider organisation. Active Care Group have been through a significant period of change at a senior level. Where these provider changes were coupled with management change at a local level, there was a feeling of uncertainty within settings which impacted on the way care was delivered and received.
- At one setting, people had been significantly affected by the lack of consistent local management. One relative told us, "We have had 3 local managers in a year that's not really continuity." At another setting, relatives expressed concern about things going well when the service manager was on duty. They said, "I don't think it's that well managed if the manager is there it runs smoothly but not if they are not there."
- Staff shared their frustrations about having been previously unsupported by the previous senior management team. For example, one told us, "We told senior staff that we couldn't support one person and it was overruled. It felt like we'd been set up to fail."

The failure to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Whilst it was evident that the new governance framework provided a more robust overview of the service's compliance, the lack of follow-up for some settings meant that some issues which had been previously flagged as needing improvement were now having a huge impact on people's lives.
- One person told us, "We have tenants' meetings and people say a lot, but things changing is another thing! The same things get mentioned at every meeting." Likewise, another person described their attendance at tenants' meetings as "Groundhog Day."
- Staff raised concerns that big decisions that affected the running of the settings were being made at an organisational level without consultation with anyone. One staff member said, "We are just told to implement something that has changed; no discussion, no explanation and then we have to explain to the tenants when we don't even get it ourselves."
- The provider told us people's tenancies were dealt with by a different organisation and that their legal rights were protected. There was however no evidence that people had been given any information in relation to their legal and human rights as outlined in Right Support, Right Care, Right Culture.

The failure to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the frustrations above, service managers reflected positively on the support they now received from the registered manager and new senior management team. One service manager told us, "I get really good support from above. They visit and are not putting pressure on me to accept new referrals whilst so much is going on."
● At some settings, engagement with people was more effective and people had good relationships with staff and met regularly to discuss their support and goals.
● Where communication was effective, the impact of staffing shortages was less frustrating for people. For example, a person at one setting told us, "The staff shortages mean sometimes activities that can be moved are changed to when staffing is available. I'm ok about that as I know what's happening and if it's something important like an appointment then that will happen."
● At settings where established management teams were in place, staff felt supported in their roles. For example, a staff member at one setting told us, "We have a strong leadership culture within the service and lots of structure for support." Likewise, another staff member told us, "[Name of service manager] is an amazing manager. I wouldn't still be here if it wasn't for them."

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; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● People told us that staff apologised when things went wrong. One person said, "About 6 months ago staff gave me my morning medication at night. They came and told me the next day what had happened. I wasn't very happy about it, but I was grateful of their honesty." Relatives also expressed that they were kept informed when things went wrong. One relative said, "Yes, they do ring me if something has happened and let me know what's being done about it."
● Staff confirmed that they felt confident to speak up if they made a mistake. One staff member informed us, "Whatever has happened our boss would say you should always report more than report less."
●Throughout the inspection process there was evidence that the new senior management team were actively listening and implementing changes that demonstrate lessons have been learned and care will be improved. For example, we saw that recent comprehensive inspections had been completed on behalf of the provider for each setting and the reports of these had flagged many of the issues raised in this report.
● To address the concerns raised, specific teams and specialists were being deployed across the service to support individual settings. The registered manager and service managers confirmed that the dedicated support of a human resources manager was beginning to facilitate the robust management of staff, especially where concerns had been raised. One service manager reflected, "It finally feels like we are getting the support to deal with the issues. For example, when staff haven't completed their training, I get the support to be able to cancel their shifts until this has been completed."
● Managers demonstrated that they understood the importance of coaching and developing a culture of reflective practice. One service manager told us, "Staff are not good at sharing lessons learned and that's a leadership issue. It's going to take time, but by developing the senior staff and showing them how to challenge, they will in turn be able to coach their teams better. I'm currently taking the time to do their supervisions and appraisals so I can show them the standards that are expected."
● A new incident reporting system had recently been introduced and whilst it was still being embedded, it was evident that this tool was enabling better senior management oversight of what was going on in the service. The registered manager reflected, "The problem with the old system was that if someone recorded

something in the wrong place, then no one else would see it. The new system has a much better series of prompts for staff and then myself and other managers get email alerts of new entries." The recent increase of statutory notifications in a timelier way reflected the registered managers assertions.

● The new senior management team had recently implemented a more detailed quality assurance framework which required service managers to undertake a full audit across their setting each month. From this the service improvement plan was updated to allow better oversight of where the gaps were in each setting. We could see that some actions were taking time to have a positive impact on people, but they were happening.

● Since the initial feedback was shared with the provider and our partner agencies, the provider has engaged fully with the processes set up to ensure the quality of care is improved. Prior to the publication of this report, the provider had already arranged group and 1-1 engagement meetings with people and their families of the setting where most concerns were raised

● The provider has also set in motion a detailed plan to resolve long standing issues with regard to the operation of settings under supported living practice, including a lack of separation between people's tenancy and support in terms of the way services were being delivered.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The lack of personalised care was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that the systems were in place to ensure that medicines and risks were managed in a consistently safe and person centred way.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes consistently protected people from abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure suitable and sufficient staff were deployed in a way which ensured that people consistently received safe, effective and person-centred support.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care in accordance with regulations and best practice.

The enforcement action we took:

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