The Regard Partnership Limited

The Regard Group - Domiciliary Care Cornwall

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Regard Group – Domiciliary Care Cornwall, is registered both as a domiciliary care agency and a supported living service. It provides personal care to people living in their own houses and flats, and to people living in a 'supported living' setting, so they can live as independently as possible.

People's care and housing are provided under separate contractual arrangements. The CQC does not regulate premises used for supported living; this inspection looked at people's care and support.

People using the service lived in five Supported Living settings in Cornwall. Houses in West Cornwall included Govis House, Fox House, Meadow View and Connexion Street and one supported living setting in East Cornwall called Buttermill. Not everyone using the service received a regulated activity; CQC only inspects the service being received by people who are provided with the regulated activity of 'personal care', for example which includes help with tasks such as personal hygiene and eating. Where they do, we also take into account any wider social care provided.

Since the last inspection the provider decided to close two of its Supported Living settings, Meadow View and Connexion Street.

The service was able to support a maximum of 44 people but only 16 people received personal care. This included one person at Govis House, four people at Fox House, five people at Meadow View and five people at Buttermill.

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

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

Right support:
The model of care and setting did not always maximise people's choice, control and independence and measures had not been taken by the provider to mitigate this. We visited three supported living settings. One setting we visited was in a rural location and there was an absence of local amenities and public transport options. The other two settings were near to the centre of towns and had access to the local community and amenities.

One supported living setting gave the appearance of being a registered care home due to the way it was structured and managed. This was not in line with the principles of Supported Living.

People were not always supported by enough staff on duty who had been trained to do their jobs properly. People did not always receive their medicines in a safe way. People were not always protected from abuse and neglect. People's support plans and risk assessments were not always clear and up to date.

Right care:
There was a lack of person-centred care, and the support people received did not promote dignity, privacy and human rights. People's needs and preferences were not always known or respected. Staff did not always have, or display, the skills and knowledge to meet people's needs. People did not have a choice in which agency provided their care.

Right culture:
The ethos, values, attitudes and behaviours of some leaders and care staff did not ensure people using the service led confident, inclusive and empowered lives. People were not empowered and lacked choice and control over their lives through their limited knowledge of opportunity and limited staffing levels in the service. People did not always receive person- centred support to live meaningful and active lives. People did not have opportunities to form community connections and make choices about who they lived with and the support they received.

The provider had not taken the opportunity, since the last inspection, to implement effective change to ensure the service met the regulations, reflected best practice expected by Right Support, Right Care, Right Culture, and offered improved outcomes to people. As a result, the culture in the service, staff ability to implement best practice and the opportunities offered to people remained poor.

People's experience of using this service and what we found
Relatives, staff and some health and social care professionals expressed concern about how peoples care needs were being met and felt the service at some supported living settings was not safe.

People, relatives, health and social care professionals and staff were concerned about the lack of consistent leadership in the services, and high staff turnover. Some of the staff in two of the five settings commented they felt morale was low and that communication could be better.

People, relatives and staff lacked confidence that any concerns they had would be listened to or acted upon.

People were not always supported by consistently caring and suitably trained staff. Staffing levels were not sufficient to meet people's care needs in a person-centred way. This was confirmed by feedback received from people living at the service, relatives and staff. Health and social care professionals also raised concern about the lack of consistent staffing and leadership which impacted on the care provided to people the provider supported.

The delivery and planning of care were not consistently person-centred and did not always promote good outcomes for people. Support plans did not contain detailed and person-centred information and therefore they did not always accurately reflect the needs of those who used the service.

Support plans were not always updated as people's care needs changed. People's care needs were not monitored or reviewed to learn how to improve the quality of life for the person.

Health and social care professionals raised concerns that people's health care needs were not met in a timely manner.

The service did not always follow the legal framework for making particular decisions in the person's best interests.

Information about how some people communicated was limited, which meant their needs were not fully understood. Information provided to people was not always provided in a format that was tailored to their needs.

People spent most of their days in the service doing repetitive activities, which although meaningful to the person in the context of the limited opportunities available to them, did not assure us each person was living a full and meaningful life.

The provider had submitted monthly reports to us to demonstrate how they were addressing the concerns raised at the previous inspection. However, the provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. Regional managers had completed audits which had identified significant issues with the service's performance prior to this inspection. However, action was not effective to address and resolve these quality issues.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update)
The last rating for this service was Inadequate (published 3 March 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvements had been made and the provider was still in breach of regulations.

At a comprehensive inspection in July 2018 the service was rated Good (published 28 August 2018) it was rated 'Good' in the domains of effective, caring, responsive and well led. It was rated 'Requires Improvement' in safe domain due to the numbers of safeguarding incidents recorded and staffing issues.

In July 2020 we undertook a focused inspection (published 24 August 2020) We received concerns in relation to management of the service and the quality of care and support that was being provided. There had been a number of safeguarding concerns raised by other professionals. At this inspection we only looked at the safe and well-led domain. We found that there were two breaches of regulation, safeguarding service users from abuse and improper treatment and good governance. We requested an action plan from the provider to understand what they would do to improve the standards of quality and safety.

In November 2020 we undertook a further focused inspection (published 12 January 2021 and supplementary report on the 3 March 2021)) The inspection was prompted in part due to concerns received about people's safety, staffing and leadership. A person using the service sustained a serious injury. The information CQC received about the incident indicated concerns about the leadership of the service, the safety of people using the service and the quality of care and support that was being provided. At this inspection we only looked at the safe, effective and well-led domains. We found that there were six breaches of regulation: person- centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance.

We imposed conditions on the providers registration following the inspection in November 2020. We have received monthly reports addressing the areas of safeguarding service users from abuse and improper treatment, staffing and good governance.

We requested an action plan from the provider to understand what they will do to improve the standards of

quality and safety in the breaches of regulation of person-centred care, need for consent and safe care and treatment. We met with the provider on a regular basis.
The service remains rated Inadequate. This service has been rated Inadequate for the last two consecutive inspections.

Why we inspected
This focused inspection was carried out to follow up on action we told the provider to take at the last inspection.

We reviewed the information we held about the service. No areas of concern were identified in the other key question of Caring. We therefore did not inspect this. Ratings from previous comprehensive inspections for this key question were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

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

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

We have identified six continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding service users from abuse and improper treatment, person-centred care, safe care and treatment, staffing, need for consent and good governance.

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.

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

Follow up
We will request an updated action plan for the provider to understand what they will do to improve the standards of quality and safety. The provider will continue to submit monthly reports as outlined in the imposed conditions on the providers registration. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following the inspection, the provider decided to cancel their registration for The Regard Group Domiciliary Care Cornwall. People who use the service, relatives, staff and health and social care professionals have been told of their decision. The provider is working with the local authorities to identify alternative care provision for the people they support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service effective?

Inadequate

The service was not effective.

Details are in our safe findings below

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below

The Regard Group - Domiciliary Care Cornwall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Following the previous inspection in November 2020 we informed the provider that we would be proposing to impose conditions on the providers registration in December 2020. The Notice of Decision to impose conditions on the providers registration was implemented in February 2021. The provider sent us monthly reports to evidence how they were addressing the concerns identified. We also met with the provider, initially fortnightly and then on a monthly basis.

This was a focused inspection to check whether the provider had met the requirements of the imposed conditions on the providers registration. This was in relation to Regulation 13 (Safe guarding), Regulation 18 (Staffing) and Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider also submitted an action plan in how they would meet the statutory requirements identified at the previous inspection. Therefore, we reviewed the requirements of Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment) and Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by a lead inspector. Two inspectors visited two supportive living settings, Fox house and Buttermill Cottages. One inspector visited Govis house. One inspector phoned staff and relatives to gain their views on the service.

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

The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection
This inspection was announced. We announced the inspection a day in advance to ensure that people would give us permission to visit them in their home. Before we visited the supported living settings, we discussed infection control processes for people, staff and inspectors, with reference to COVID-19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and the information we had requested when the inspection was announced. We sought feedback from the local authority and professionals who work with the service.

We had not requested the provider send us a provider information return as this inspection was completed in response to information of concern that the commission had received. We used all this information to plan our inspection.

During the inspection-
We spoke with five people who used the service and eight relatives about their experience of the care provided. We spoke with 13 members of support staff, three service managers, deputy manager, team leaders and area operations manager. We had telephone conversations with eight staff and received nine emails from staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with eight health and social care professionals who regularly visit the service. We received a group email from health and social care professionals plus four individual e mails from professionals who shared their experience in working with the services.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to robustly assess the risks relating to safeguarding service users from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the third time.

● At the previous two inspections people had not always been kept safe as the service had experienced a high number of safeguarding concerns. There remained a high number of safeguarding concerns. Some were raised by the provider and others by people, relatives, staff and health and social care professionals. These were then considered in the safeguarding arena.
● Relatives told us they did not feel that their family members were safe. Seven out of eight relatives spoken with raised concerns about their family member as they did not feel people were cared for safely.
● Feedback from health and social care professionals, about the safety of the service were negative in respect of three of the supported living settings. Stating 'Given the number of safeguarding alerts that keep needing to be raised this is not a safe service.'
● Protection plans which were in place to ensure people were cared for safely were not being followed consistently which placed people at risk.
● Where incidents had occurred that put people at risk of harm, professionals investigating these incidents were concerned that people were not being provided with the care or safety that they needed. For example, people were assessed by Commissioners as needing support from staff on a continuous basis. However, at one supported living setting there were occasions when staff were not always present. This placed people at risk of harm, and at times people were harmed as a result of being left with no staff support.
● Staff had contacted the CQC or Commissioners as they said they did not always feel able to speak to managers about their concerns or feel their concerns would be acted upon. Since our inspection visit Commissioners had been contacted by whistle blowers, to raise further safeguarding concerns which were currently being investigated.

The provider had failed to robustly assess the risks relating to safeguarding service users from abuse and improper treatment. This was a repeated breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had safeguarding systems in place. These had been shared in team and house meetings at all settings.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed in that risks were either not assessed or ways to mitigate these risks were not in place. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the third time.

● Some people could find it difficult to express themselves or manage their emotions. This could lead to distressed behaviour which could put them, or others at risk. As identified at the previous inspection, people's support plans remained out of date, and contained inaccurate information. They did not always inform, direct or guide staff in the actions to take when people were becoming distressed and how to support them. This meant staff did not have the relevant information to enable them to support people when they were distressed.
● We found, and staff confirmed, that behavioural support plans remained inaccurate. Staff said due to this they did not always read them. They instead asked other staff for advice on how to support people. This meant that there was no consistent understanding or approach in how to support people.
● Positive behavioural support (PBS) plans had not been reviewed following admission to the service to ensure they remained accurate.
● Risk assessments varied in their quality and detail. For example, one person needed support with their continence and to monitor the frequency and level of assistance with this issue. Records were inconsistently completed. This meant that people's care needs were not monitored or reviewed to learn how to improve the quality of life for the person.
● Staff did not advise visitors to the service how to approach people when they met them to ensure this was done safely both for the person and the visitor.

The provider had failed in that risks were either not assessed or ways to mitigate them were not in place. This placed people at risk of harm. This was a repeated breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection security arrangements to enter people's homes had been made robust. This meant people were no longer at risk of harm from unannounced visitors coming to their home.

Using medicines safely
At the previous inspection the provider did not have systems either in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

●People's medicine support plans were not always easily accessible to staff. In one supported living setting staff had not noticed that the medicine Support plans were missing from people's records. This meant staff and in particular, the high reliance on agency staff, would not have had access to medical information. This placed people at risk of harm.
● The service had reviewed their medicine systems but they had not had time to embed and therefore whilst medicine errors had reduced, they were still occurring. The latest being the day after we visited the service.
● Staff at three supported living settings told us they lacked confidence following their medicines training to administer medicines. Staff comments include "I am confident to give medicines but only to the service

users I work at. I have said I don't feel comfortable doing them at a different service" and "I was trained to give medication within a day I didn't feel it was enough at all".
● Staff felt there were not enough staff trained in the administration of medicines on each shift. This placed additional pressure on the whole staff team. Comments included: "Having enough staff that are meds (medicines) trained have been ridiculously low and means the staff that are meds trained are running around to the residents doing meds instead of who they are meant to be supporting." We observed this during our inspection at one supported living setting. This impacted on the people they supported as their staff team was consistently changing.
●Where people were prescribed 'as required' (PRN) medicines for pain relief or to help them to manage anxiety protocols outlining when and how to administer their medicines varied in their quality. Some did not identify when PRN medicine should be considered and how to administer it. At the last inspection we identified there was no monitoring of the impact of the medicine when given to the person, so that they could review its effectiveness. This remained the case.
● Following the last two inspections the provider had undertaken medicine audits in all the five supported living settings. It identified areas where action needed to be taken to ensure that medicine procedures were more robust. However, these systems were not embedded and there remained shortfalls with safe medicines management.

The provider did not have systems either in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the previous inspection medicine systems had been reviewed. The systems were different in each setting to reflect the needs of the service.

Staffing and recruitment
At the last two inspections the provider had failed to ensure staffing levels, identified as necessary to ensure people's safety, were consistently achieved. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

● At the previous two inspections there were concerns about the recruitment of staff, and staff retention. Managers at two supported living settings had identified that there were insufficient numbers of permanent staff to cover all shifts and had sourced agency staff to ensure the service was staffed safely. At one supported living house they had 13 full time equivalent vacancies that they were attempting to recruit to. Rotas showed that at two supported living houses they were reliant on agency staff to fill 40% to 50% of the staffing time.
● Relatives, people, health and social care professionals and staff reported that due to the changes within the staff team, and with managers there had been a lack of consistency within the service.
● People were concerned about the amount of changes within their staff teams. They were not involved in the recruitment of the staff and so had no say in who would provide them with their support. Comments from people included "It is a little bit better than it was but we do need our own staff rather than agency all the time" and " Some of the agency staff don't know what to do as they are new or strangers."
● Relatives were concerned about staffing levels, skills and the lack of consistent staff to provide support to people and the impact on them. A relative told us that their family member was "supposed to have a core team but often has agency at night so [person] won't interact with them as [person] doesn't know them." Another relative told us that at a weekend the service was short staffed, so their family member was not able to go out. The person had been distressed. The relative tried to contact the service and there was no reply.

The relative asked the person to get staff to phone them. This evidenced that due to a lack of staff this could place people at risk of harm.

● Health and social care professionals continued to express "concern" about the speed of staff turnover. This meant that staff knowledge of how to support people effectively was not consistent as the person's core staff team and managers were constantly changing.

● Staff told us that in two of the supported living settings they were short staffed. Comments included "Often short staffed. Can be only four of us should be five. Not safe", "Staffing levels are rarely appropriate we are nearly always short staffed" and "Staff levels have always been a problem and personally I don't feel safe or looked after".

● Staff told us that due to the staff shortages they were working long hours to cover some staff shortages and said they were tired which impacted on how they provided care to people. Staff told us of occasions when staffing was below their minimum staffing levels which impacted on people's care, and their one to one support. Comments included "Get a bit fed up when we are working with multiple residents instead of just one. Or working alone with someone who should be two-to-one" and "Staff levels are a joke we have had days where we are three staff down meaning residents that are meant to be two to one are one to one This also means that residents aren't able to go out. At times we have had only one female staff on site with two female residents each needing one to one."

● Staff told us that staffing levels impacted on people and their own safety. Safeguarding alerts had been made regarding people not receiving their assessed level of staff support which placed people at risk of harm. Staff also told us this placed them at harm. An example provided was that of a person who was at risk of physical harm to others and was commissioned to have two members of staff to support them at all times. There were occasions when only one staff member had been available to support this person. Staff commented "We have walkie talkies but if you were lone working with [person] and [person] attacked you and you couldn't get to the walkie talkie no-one would know until morning". This meant staffing levels were impacting on people's and staff members safety.

● The combined impact of the remote location of the setting and the complexity of people's needs meant the staffing levels in place were not sufficient to support people to live as independent a life as possible with opportunities for social inclusion and taking part in new and meaningful activities. This was not in line with the principles of Right Support, Right Care, Right Culture.

The provider had failed to ensure staffing levels identified as necessary to ensure people's safety were consistently achieved This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff had access to Personal Protective Equipment (PPE) and were aware of what PPE should be worn when providing personal care. Staff told us that with one person no PPE was worn because the person was unable to 'tolerate' it. The person's risk assessment for COVID-19 discussed what would happen if the person became symptomatic only. There was no reference to preventing the risk of infection. The manager confirmed that no desensitisation process had occurred with this individual. Following the inspection, the manager sent us a social story used to explain to the person why PPE was needed, however it stated that this was to be used only if the person was unwell and not for the prevention of the spread of infection. This meant that all necessary steps to prevent the spread of infection had not been considered.

The provider had failed in that, risks were either not assessed or ways to mitigate them were not in place. This placed people at risk of harm. This forms part of a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In contrast at another supported living setting a person would not accept staff wearing masks, so staff wore face visors. The manager had also completed a risk assessment regarding this.

Learning lessons when things go wrong
At the previous two inspections the provider had failed to have good governance processes and procedures in place. Audits and quality checks were not identifying risks and areas of poor practice. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the third time.

● Due to the findings of our last inspections, the senior managers conducted an audit of all their services and developed a comprehensive action plan. However, the areas that they said they had addressed, such as support plans and medicines had not been embedded as there remained significant shortfalls as outlined in this report. This had placed people and staff at risk.

The provider failed to have good governance processes and procedures in place. Audits and quality checks were not always identifying risks and areas of poor practice. This contributed to a repeated breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Service managers stated, at the previous inspection, that staff team meetings would be reinstated to look at issues such as closed cultures in care settings, medicines, and safeguarding. Staff meeting minutes evidenced that these were occurring in all supported living settings.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now changed to Inadequate.

Inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At our last inspection the provider had not ensured sufficient suitable qualified staff were available to provide a person-centred service for people. This was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

● Staff induction and shadowing undertaken by new staff was inconsistent. Some staff said they had received a "good induction". Others said they received no induction only "One or two shadowing or supernumerary shifts before being included on the service's rota". Staff commented "When I started, I had one shadow shift, so when I went in to start my next shadow, they were short staffed, so I was left alone with a client I didn't even know." Staff did not feel this gave them enough time to build and develop a rapport with people, before providing them with care and support.
● Staff provided a mixed view on how often staff received supervision. At two supported living settings supervision was implemented from January 2021. At the third setting staff varied in their view regarding how frequently they had supervision, with some commenting that they had received none, and others not for 'some months'.
● Staff new to the service were required to support some people without appropriate training. Staff, as at the previous inspection, said the quality of training was not detailed enough and they did not always feel confident to support people with the level of training they had received. Comments included; "I still think the training needs some work; I am against e-learning as it does not go into enough depth. We do not do specific training on people's mental health needs, I don't think it quite provides the training that you need" and "Most staff have had the 'pro act scip' training, but I think it could be more in depth, used to be a three day course now it is a couple of hours over video conference." Staff did not feel confident that they were provided with the training needed to equip them to support people in their care effectively.
● Some staff said that training was reactive rather than proactive, For example a staff member told us "I have had very quick restraint training which was given on the day we had to use it after a resident ran away."
● Health and social care professionals continued to express concern about the quality of training. Staff were not following the recommendations they provided to support people. This meant staff were not equipped to meet people's individual's needs.

The provider had not ensured sufficient suitable qualified staff were available to provide a person-centred

service for people. This is a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Managers were monitoring, which staff had attended training, and where there were gaps in staff members training. More training had been provided since our last inspection, such as safeguarding, medicines and 'pro act scip'.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection the provider had failed to ensure support plans were fully understood by staff and guidance available to staff in relation to people's communication needs was being consistently followed. This is breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

● Two of the supported living settings are being closed by the provider. Relatives told us that communication about the closure and the support in transition to new placements for their relatives was poor. Comments included; "The Regard have been no help with the transition. They haven't been in touch since they e-mailed me to say the home was closing" and "Since they informed us about the closure of [service name] they have not been in contact at all. All contact has been through a social worker, I feel that this is disgraceful."
● A person told us they were involved in the development and review of their support plans. However, relatives told us that they have not been involved in the development or review of peoples support plans.
● The manager at one supported living setting was actively asking support staff to input into people's support plans as they knew the people and could identify if there were gaps in the support plan. However, this work has been on-going for some time and there continues to be a delay in achieving this work for the people they support.
● Relatives did not feel confident that information provided to the service about how to support the person had been adopted. A relative stated "Because of [staff and management] changes we have had to represent information on occasions, things getting lost between changes". This meant that information was not effectively communicated so that the service could meet the person's needs and expectations.

This was a repeated breach of Regulation 9 (Person centred care) Health and Social care Act Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
At the last inspection the provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the third time.

● Some relatives raised repeated concerns about how people were being supported with their dietary needs. Four relatives raised concerns as to people's weight gain and queried their diet. Concerns in respect of provision of food had also been discussed by commissioners within the safeguarding arena. Comments from relatives included; "[person's name] is just getting ready meals/fast foods. I will take him home cooked meals with directions on how to prepare it. [Staff] are young support workers who don't know how to cook, haven't got the skills. It's not their fault they don't have the right training."

● Staff were not following the dietary guidance as outlined in peoples support plans. A person's support plan stated '[person name] to be encouraged to be involved with the preparation of his food and staff provide his drinks.' In the persons activity plan, it stated that each day the person was to 'help make lunch'. This was not recorded in the persons daily logs. Staff told us that the person had undertaken some baking but was not involved in the preparation of or made meals. In monitoring records of meaningful activities making cookies was recorded once in a two-week period, and there was no record of helping to prepare lunch or drinks. Dietary records were inconsistently completed. This meant that the actions identified in the support plan and recommendations from multi-disciplinary professionals were not being followed consistently, monitored, learnt from or reviewed.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This contributed to a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In one setting a person had successfully been supported to lose weight.

Ensuring consent to care and treatment in line with law and guidance
At the previous inspection peoples consent to care, and treatment was not always gained. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.
● Some people who lacked capacity were the subjects of continuous monitoring and control. At one supported living setting the manager stated all five people they supported were subject to a community DoLS, however they had no documentation to evidence this. The manager stated they had requested it, but it was still absent. There was no supporting documentation to identify what the restrictions were, how staff should support the person taking into account the restrictions in place, and how to monitor or review them.

● The service did not follow the legal framework for making particular decisions in the person's best interests. For example, a parent authorised for their relative to have a vaccination. This was not discussed through the best interest process. The manager acknowledged this process should have been followed and was not.

Peoples consent to care, and treatment was not always gained. This was a repeated breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● This contrasts with another supported living setting where an application for a court of protection order had been made. This demonstrated that there were inconsistent approaches across the settings.

Supporting people to live healthier lives, access healthcare services and support
At the previous inspection systems were either not, in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a repeated breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation for the second time.

● Health and social care professionals raised concerns that people's health care needs were not met in a timely manner. For example, five health appointments had been arranged to review a person's health and they had not been supported to attend any of these appointments. Staff were aware that the person needed support to open their mail. A hospital letter arrived and remained unopened. The person therefore missed their hospital appointment. A relative also told us that their family member was not supported to attend their flu vaccination. This meant people were not supported to access healthcare services when required.
● The provider had not supported a person or worked with the person to help prepare them to attend a blood test appointment. This had been requested as part of a protection plan since December 2020 and remains uncompleted.
● A relative informed us that she noticed whilst on a video call to her family member that their extremities were swollen and purple. The relative then asked staff to seek health advice, which they did. Prior to the relative's intervention staff had not noticed the change in the person's appearance or become aware of the need to seek medical advice.
● Some people's health reviews, which should be annually reviewed with a health professional, were out of date. It is acknowledged that Covid 19 has had an impact on being able to arrange annual health reviews. Systems were either not, in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a repeated breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement

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 varied in their quality of detail. We were assured on the 28 April 2021 by the service managers, the providers and their action plans that all support plans had been reviewed and were up to date. We noted that some work to the support plans had occurred since our previous inspection in that staff were asked for their input into people's care needs. However, we found that in two out of three supported living settings people's support plans remained out of date. For example, there was a wealth of information in a person's care records about the support they needed. The files were disorganised and spread between many different documents and in different locations meaning staff could not realistically know what they should be providing and how. The detail provided by the large range of documents was not all presented in the persons support plan.

● Peoples care needs were not consistently recorded accurately. A person's support plan stated the person had no visual or tactile needs. However, in other documentation it stated that the person was 'blind in one eye' and has 'at times numbness in his leg'. There was no support plan that directed, guided or informed staff to be aware of these care needs, or how staff needed to support the person with them.

● Support plans were not always updated as people's care needs changed. For example, when a person had a medical condition, the support plan did not provide any information or guidance on how this health condition should be approached by staff to meet the person's health needs. A person's epilepsy plan had not been updated and referred to resources in another county for support. We found that care files were not organised and some information, such as guidance from healthcare professionals, was difficult to find and therefore staff might not be aware of its existence. We concluded that people's support plans did not provide staff with sufficient accurate information to enable them to meet people's current care needs.

● Staff gave mixed responses about how they used peoples support plans. Some said they read them, others said they did not as they were not accurate. Comments included; "The Support plans are getting better, there are still the odd things that need updating. A lot of work has been done on them. When I started a lot of the paperwork was from 2017 but it is getting better. But there is still a long way to go with making them person centred.' And "I don't read them; I ask other staff what to do."

● Relatives stated they were not always consulted in respect of support plans. Comments included; "I have in the past consulted one staff member to help make suggestions for my brother's care plan which were added but then she left. I am not confident that the suggestions would then have been followed or implemented and I have had no further input into his care plan", "We suggested they use social stories but I don't believe they are being used" and "We have never been asked for our views."

● The level of choice and control people had over their lives was limited because records lacked detail to

guide staff how to support them. Some support plans described aspects of people's routines, for example getting up or going to bed, but others lacked specific detail about individual's preferences and the support they required. One person's support plan gave very little information about their preferred personal care routine, what they could do for themselves or what products they preferred to use. People's support plans did not detail how staff could support them to develop skills to increase the control they had over their lives.

● Support plans were not always reviewed regularly. For example, one person's support plan said it should be reviewed at least six monthly. it was last reviewed in February 2020. There was little evidence of meaningful consultation with people about their support plans to ensure staff understood their preferred lifestyle, wishes, aspirations or goals. Support plans did not reflect the hopes and dreams of other citizens but reflected short term goals which were limited by people's experiences. For example, for the whole week of one person's activity plan it stated to do the same thing each day every week. A list of activities had been recommended by the Occupational Therapist but there was little evidence that this was actively being tried. Monitoring records were inconsistently completed. Daily logs rarely recorded when the person had engaged with any activities during the day.
● Health and social care professionals felt that staff were not always responsive to their recommendations about how to support people. Comments included; "There seems a difficulty with putting ideas/recommendations into a plan that all staff follow and implementing the plan with clients. This could be due to confidence levels in the core staff team because more guidance and supervision is needed." And 'Information/recommendations have been shared verbally, in writing and through visits. If this information is sent to one person, it is often not shared or looked at. There has been more success when we have arranged to meet the core staff team together to talk through a plan/recommendation and then written up the plan and send it to them.' And 'There does not seem to be effective communication channels between staff members to identify issues, risks, concerns, successes, and achievements to facilitate development of robust support plans. This results in inconsistencies and a lack of planning to go forward with clients.' The provider was not comprehensively implementing, trialling and recording and reviewing outcomes of recommendations made by professionals. There was no real system or process for learning and improving people's care.
● People did not always have choice and control over changes to the service. A core team of staff had been introduced but people had not been involved in the design of the role and they were not always supported by their core team. For example, one person was saying something repeatedly that staff could not understand. Their keyworker was not supporting the person and approached us to explain what the person was saying. People's support plans state the importance of being supported by a consistent staff team to help develop meaningful and trusting relationships. However due to staffing levels this was not always taking place and was what we observed on the day of our inspection.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff appeared to lack skill in how to engage with people. In one supported living setting staff told us they were 'sitting around a lot' and waiting for the people who were on two to one support to call for them when they needed support. Care staff were located in a separate building to the people they supported. Therefore, people on two to one support did not have staff present to provide support at all times. Staff waited for the person to either ring their bell, or a buzzer was triggered, staff then responded in twos to see the person. On one occasion staff responded when the bell rang and returned within five minutes. Staff said the person wanted a cup of tea and then they left. There was no attempt at trying to engage with this person further.

● Staff did not appear to be able to communicate with people in a meaningful way. For example, a person was seen to be lying on the floor in their lounge. When we asked staff what the person was doing, they said he was lying on the floor, he wanted to play football with a named staff member who was busy. No other staff attempted to engage with the person. In contrast a visiting health and social care professional was able to engage meaningfully when they visited the service.
● Records about people and information in the service were not routinely produced in formats that would be easy for people to understand across the supported living settings. There was limited evidence staff had developed accessible records, for example 'easy read', to help people understand the records about them.
● Some information was recorded about how staff should communicate with people to aid their understanding. However, it lacked the specific details and techniques used by staff. A staff member told us staff used facial expressions, eye contact, touch and pointing to objects, to communicate with people but information about how to use these methods successfully with each individual were not recorded. This increased the risk of communication with people being inconsistent.

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
● The provider was not following guidance in relation to 'Right support, right care, right culture' which highlighted the importance of services being located so people can participate in their own local community and not in secluded grounds, or geographically isolated. One supported living setting was in secluded grounds and was geographically isolated, and no action had been taken to minimise the impact of this on people or to support people to develop links with the local community.
● Some people were able to engage with the local community without staff support and went to the local shop most days. Others relied on staff support to access the local community. We saw during the inspection visits that people went to the supermarket and in another supported living setting a person went to the zoo for the day. Some people were particularly isolated and had little, to no contact with the community and limited engagement in any activity or pastime. Records of people's activities in the two weeks prior to the inspection, showed most people who needed staff support to access the community spent most days in the service and that people rarely went out.
●Staff told us that staffing levels did at times limit people's options and wished people could access the community more. Relatives also stated this.

The provider had not supported people to have choice and control of their lives and had failed to implement appropriate systems to enable and support people to make decisions in relation to how their care was provided. The provider had also not supported people to ensure people were given information in a way they could understand. This forms part of a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At one supported living setting they held 'house meetings' and had attempted to introduce more activities in the setting. People at this location were pleased with the changes made. We were told that house meetings occurred at a second supportive living setting.

Improving care quality in response to complaints or concerns
●Relatives stated that they had 'no' or 'little' confidence that their concerns would be listened to, be taken seriously or acted upon. One commented; "I wrote to them with my views and I never got a response. My daughter also wrote, she then phoned and was told she would get a response. We never did."
●Staff also echoed this view. Staff said that senior managers were not listening to their concerns.
● The Commission has received a number of concerns since the previous inspection raised by people who use the service, relatives, staff and health and social care professionals. Some of the issues raised have been

discussed within the safeguarding arena. It is of concern that those who had concerns felt that the providers complaint procedure would not work effectively for them and felt they needed to use other avenues to raise concerns.

The provider had failed to follow or encourage people and staff to utilise their concerns or complaint systems. This forms part of a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● There was a complaints policy in place which outlined how complaints would be responded to and the time scale.
● The provider informed us that complaints were formally logged on a centrally managed spreadsheet, held by the Head of Quality and the Quality Lead from January 2021, which aided oversight of the complaint received and how it was followed up. Prior to this, complaints were recorded on a separate system which meant there was not a clear overview of all settings as a whole service. The provider advised us that in the four-month period between when the recording process was implemented and when we inspected, four complaints had been received from people or relatives of people who received a regulated activity. Since March 2021 the provider has sent a full list of any complaints received and the action taken to CQC and the local authority commissioners and safeguarding teams.

End of life care and support
● Some people had end of life Support plans in place. Where people were able to express a preference, these had been recorded; however, for those unable to clearly share their views, no further action had been taken to help ensure personalised plans were in place.
● At one supported living setting the staff supported someone at their end of life. Health and social care professionals were complimentary about how the staff team supported this person in their final days.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same.

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.

At our last two inspections the provider had failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and areas of poor practice. The care provider did not have good leadership and management in place. The care provider did not ensure people's care records contained the required level of detail relating to risk and care needs. Accurate and contemporaneous records were not always maintained regarding people's care. This was a breach of Regulation 17 Health and Social Care Act Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 for the third time.

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

- There had been a lack of stability in the management structure at the supported living settings. Since November 2020 there had been one change of manager at Govis and Connexion Street, three at both Fox house and Meadow View and four at Buttermill. This has resulted in inconsistent leadership at the supported living settings.
- Relatives were concerned about the level of management changes and how this had impacted on the care their family member received, and on the staff team. Comments included; "I have had several concerns around the management turnover and how this has affected the service. This has affected the consistency with leadership and feel it has a huge effect on how the service is led and clearly this filters through the staffing team. This has at times had an effect on care delivery which I have no doubt affects moral of both staff and service users". Another stated "When [person's name] first moved to [setting name] six years ago it was fabulous. It's just gone downhill, there is no leadership."
- Health and social care professionals also shared this view. Comments included; 'There has been a lack of management support and structures in place to guide, manage risks, nurture and develop staff teams.' And 'There needs to be an on-going investment to develop systems within the organisation to provide more support to staff in their work to improve quality. This is likely to have a positive impact on staff retention.'
- At the previous inspection in November 2020 we concluded in the report; 'There were significant failings in the management of people's records which could place people at risk of harm. For example, support plans were out of date, had not always been reviewed and did not inform, direct or guide staff in how a person's care needs should be met, risk assessment records did not always evidence how the risk was assessed and the findings were not consistently transferred to the care records.' This continued to be evident at this

inspection.

● At the previous inspection in November 2020 we concluded in the report; 'Due to the management changes there had been limited support or guidance for staff to help ensure they were aware of their roles, the expectations placed on them and an understanding of the needs of the people they support. Staff recognised that the lack of consistent leadership had impacted on the service's performance.' Whilst some staff were positive about the appointment of the manager at Fox House and Govis, there remained concerns about the management support at Buttermill and Meadow View. This continued to be evident at this inspection with limited progress made.

●There remained concerns about staffing levels in the services as described in the safe section of this report. Relatives and health and social care professionals all raised concerns about the impact of staff changes on the staff and on the people they supported.

● Staff felt there was a lack of management oversight and accessibility, especially for handovers and night support. Comments included; "There's no management structure within the night staff team. There is no one responsible for running the shift" and "Staff are leaving because of lack of management support. There is low morale in both day and night staff."

●The service provides care and support to people living in five 'supported living' settings, so that they can live as independently as possible. Two of these settings are closing. In the other three settings people had their own private accommodation. However, in two of these settings they had a dedicated managers office, a dedicated staff room and the organisation subsidiary company owned the building. This led to the settings appearing to be operated in the model of a care home, rather than the Supported Living Scheme model. The provider agreed that the present model was not in line with the principles of supported living.

●The Provider is required to ensure there is a manager registered with the Care Quality Commission (CQC) who is in day to day control of the service. The provider had recruited to this post in January 2021. To date an application to register with the CQC has not been submitted.

● Since January 2021 the provider appointed two service managers and a quality manager. All stated they had a positive induction to the post and acknowledged that there was a lot of work to do to improve the service. Comments from a service manager stated; "We only started addressing this in February/March" and "There has been good support from senior management, the CEO has been in touch, I have been very honest about my concerns and they have listened and have been responsive. I do feel I have been well supported. I have a long way to go still as it take time to embed things and develop good practice." It is of concern that the service has been in breach of regulations since July 2020 and little improvement has been made.

●There has been a consistent manager that oversees Govis and Connexion Street. Feedback from staff and health and social care professionals were positive about how the manager had worked with them and staff to ensure people's care needs were identified and met. This demonstrated the importance of having a strong consistent manager who develops a greater oversight of their service which then has a positive impact on care delivery.

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

● Some people told us staff had little experience and were not sensitive in their approach to them. As reported in our previous inspection report some staff referred to people as 'mate' which was not their preference and discussing in front of them their personal life and how they were looking forward to going home. This made the person feel undervalued and indicated to them that staff would rather not be there. Some people also told us that staff did not respect their confidentiality and therefore would not disclose information as they were concerned it would be discussed with other people. From talking with people who use the service they stated this remained the case.

● Staff told us that at times when they supported people who were anxious it could have an emotional or

physical impact on them. Some staff said debriefings following incidents to provide staff support or reflective practice were occurring. Other staff said there was no debriefing, though all felt there were no opportunities to learn from these experiences.

● As identified in the previous report people told us, confirmed by staff and care records, that they had not had their monthly reviews to set their goals and aspirations. Likewise support plans were not always person-centred. Support records did not describe how to support people's individual needs.

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

● As highlighted in the previous report, after speaking to people, staff and relatives we were not assured that staff were consistently respectful of people or each other. We were concerned that there was a closed culture within the staff team, which could discourage people and staff from raising concerns or acknowledging when something went wrong, in line with their duty of candour.

● As reported in the last inspection report; 'Where incidents had occurred, there had been ineffective governance to review the incident and learn lessons. Support plans had not been reviewed, following incidents, to provide up to date guidance. The poor review of incidents limited the provider's ability to effectively and robustly monitor the service provided.' We found this remained the case.

● The failure to ensure that the service met regulatory requirements, was due to inadequate governance. The provider has submitted monthly action plans as agreed, in line with the conditions imposed on their registration since February 2021. They attended monthly meetings with us and the Local Authority. It is of concern that little progress to improve the service has been made. It is to be noted that some of the breaches of regulation date back to July 2020 and have been repeated three times. The lack of progress in the time provided leaves little confidence that things could improve in a timeframe to ensure safe care and treatment for the people they support.

● The providers senior management team, manager and staff team cooperated with the inspection process. They recognised that the service was not always meeting people's individual needs and recognised that there was still more work needed to embed positive change into daily practice.

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

● The provider acknowledged that people were not involved in the recruitment of staff, their core staff team or their own regular support plan reviews. This meant people's views and experiences were not actively sought and considered.

● The provider undertook a survey of people's views of the service. People said they were unhappy with some aspects of their care. In one survey response it was stated the person said they did not feel safe, or liked the staff supporting them, and that staff were not always respectful commenting, they felt staff approached them 'sometimes like a baby'. In response to the survey question, how happy with your support are you, they had marked 'not happy'. An action plan was drawn up on the 18 March 2021 to discuss with the person, 'identify who the person likes be supported by and in what style'. However, to date this had not occurred. There was a delay in responding to the person's feedback and a lack of action about how to address the issues raised.

● Relatives felt they were not being listened to. Comments included; "It's not the way to run what is meant to be a caring business" and 'The communication has overall been extremely poor. There is very little feedback from [the provider] unless I have sought it and then it can be hard as information is not always passed on within the staff team' and "I feel that [the provider} have failed the people they set out to support and appear to be less than transparent and honest about it all".

Continuous learning and improving care

● In the November 2020 inspection report we wrote the following statement: 'Shortfalls had been highlighted to the provider from the Local Authority Quality Assurance audit in 2019 and our previous inspection in July 2020. Appropriate action had not been taken to address all the issues and therefore opportunities to improve the service had been missed. The provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. Regional managers had completed audits which had identified significant issues with the service's performance prior to this inspection.' We found that action was not always effective to address and resolve these quality issues and little progress had been made.
● The provider meets with their service managers and quality team weekly. The purpose of the meetings was to ensure senior oversight in updates of what had happened during the week, providing guidance and support to help address any challenges. In addition, the service managers met individually with a Quality Manager each week to follow up on progress against whole service action plans. It is of concern that little progress towards improvement had been made in ensuring peoples care and safety, staff support, or to have effective systems in place to monitor practice.

Working in partnership with others
● Feedback from professionals raised concerns about the provider and the way the service was run on a day to day basis. We were given examples of poor staff skills where professional's guidance was not being implemented and leading to safeguarding concerns.
● There was a shared concern about the management's communication and leadership and how this impacted on the care that people received. Comments included; 'There do not seem to be effective handovers or effective or efficient passing on of information either verbally or in writing. Record sheets and the communication book are not always filled in with appropriate detail and do not seem to be read by most staff. This means that there is little or no consistency amongst the staff regarding approaches that are being used to support residents. This results in inconsistencies and a lack of planning to go forward with clients.'
●The provider had shared some records with commissioners by agreement as they monitored the welfare of particular people. However not all professionals felt that documents were being shared openly. Professionals also reported that for people who moved on to new placements, not all their records or information was sent to the new care provider. This meant information in respect of people's care and support needs had not been shared to assist in their settling in at their new homes.

The provider had failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and areas of poor practice. The care provider did not have good leadership and management in place. The care provider did not ensure people's care records contained the required level of detail relating to risk and care needs. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 Health and Social Care Act Regulations 2014 for the third time.

● The service worked in partnership with healthcare professionals and services from a variety of disciplines and commissioning authorities. During the national COVID-19 pandemic there had been a reduction in professionals visiting the service. Provision was in place to enable video meetings and telephone consultations to take place instead of face to face meetings. Where practically possible, and where there was a need, healthcare professionals had visited the service over the last few months.
● The providers management team met with CQC on a regular basis and provided us with reports on the progress they felt they had made.
● The management team had notified us of incidents and safeguarding when they had been raised to them.