Miss Sunita Larka

Miss Sunita Larka t/a Direct Care and Support Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Miss Sunita Larka t/a Direct Care and Support Services is a 'supported living' service providing personal care to people living with a learning disability or autism in the community. The service has five houses located in residential streets. Three to six people live in each house. There is also an annexe flat which one person can live in alone. The service can support up to 20 people. At the time of our inspection there were 19 people being supported by the service. People have their own bedrooms and share the rest of the house with each other. Each home has staff on duty during the day and a sleep-in member of staff on duty at night.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where people do receive personal care, we also consider any wider social care provided.

People's experience of using this service and what we found
People did not always experience a service that was safe. People did not always have detailed and robust individual risk management plans that gave staff all the information needed to protect people from harm.

Medicines were not always managed safely. The expiry date of medicines was not always checked, meaning there was a risk of medicines not working. Giving 'when required' medicines did not follow best practice, which meant people could potentially be given these medicines incorrectly or more frequently than necessary. 'When required' medicines are medicines which are only needed in specific situations, such as when a person may be experiencing pain.

People were not always protected from the risk of COVID-19 infection. The provider was not always following national guidance for COVID-19 infection prevention and control. Although the provider had clear reasons for this, they were unable to provide us with evidence of an ongoing risk assessment process that considered individual risks to people and staff.

There was not always evidence the provider had learned from incidents. This meant people's risk assessments had not always been updated to show how staff could prevent or manage similar incidents in the future. The provider's quality checks were not always appropriately followed up with action to improve the safety and quality of the service. Checks had failed to identify the issues with medicines.

Other aspects of the service were safe. There were enough staff to support people safely. The provider had procedures to make sure they recruited people who were safe to work with people.

The service had an open, person-centred culture and people appeared relaxed and happy. People and staff had regular opportunities to feed back. Staff were clear about their roles. The provider shared information with people in a way they could understand.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. People led varied lives and engaged with a variety of community activities. Some people attended college and some people had jobs.

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.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

People lived in small households in residential homes in the community. They could come and go as they pleased, have visitors whenever they liked and engaged in a variety of community activities. People had their own bedrooms and the support people received was individual to their needs and preferences. The staff knew people well and supported them to express their views and to attend college or have jobs. People lived their own individual lifestyles.

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

Rating at last inspection
The last rating for this service was Good (published 05 December 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident. At the time the incident was subject to a police investigation. As a result, this inspection did not examine the circumstances of the incident. The police investigation concluded there was no case to answer and the police closed their investigation.

The information CQC received about the incident indicated concerns about the management of safeguarding people. We undertook a focused inspection of the Key Questions Safe and Well-led to examine those risks.

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

This report only covers our findings in relation to the Key Questions Safe and Well-led.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Miss Sunita Larka t/a Direct Care and Support Services on our website at www.cqc.org.uk

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

We have identified breaches in relation to safe care and treatment, good governance, not notifying CQC of incidents and the provider's lack of knowledge and understanding.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Miss Sunita Larka t/a Direct Care and Support 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak.

Inspection team
This inspection was carried out by two inspectors.

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.

Notice of inspection
We gave a short notice period of the inspection to make sure it was safe for us to conduct the inspection due to COVID-19 risks.

What we did before the inspection
Before the inspection we looked at previous inspection reports and notifications the provider is required to send to us about significant events at the service. We reviewed information and concerns we had received

from local authorities and we discussed the service with the local safeguarding team. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service and observed some interactions between people and staff. We spoke with four members of care staff, including two senior carers, the training manager and the responsible individual. The responsible individual is the owner and person responsible for supervising the management of the service. We looked at people's needs and risk assessments, support and care plans and medicines records. We also looked at staff recruitment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further risk assessments, staff training data, the provider's policies and procedures and quality assurance records. We also looked at feedback from people, relatives and staff.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; systems and processes to safeguard people from the risk of abuse

• People's risk assessments and risk management plans were not detailed enough. They did not always contain the necessary information for staff to recognise warning signs and manage risk safely. For example, people did not always have specific plans to help them manage their diabetes or personal relationships with others. This meant staff may not have had adequate knowledge of how to safeguard individual people from foreseeable neglect and abuse, including from other people who used the service.

• Where action was taken to address risks, plans were not always clear or coordinated. For example, some information was recorded in people's files and some was kept in their rooms. This meant staff may not have always been aware of all the information needed to manage people's needs and risks.

• When people's behaviour challenged the service, care records were not always reviewed and updated with enough detail for staff to manage the risk as safely as possible.

• The service had a safeguarding policy and clear safeguarding procedures and staff understood how to recognise and report abuse. Staff knew people's needs and preferences well and people appeared happy and comfortable with staff.

Using medicines safely

• The service did not have a policy or procedure in place for giving 'when required' medicines. This meant staff may not have had all the information they needed to give 'when required' medicine safely and in line with best practice.

• The Medicines Administration Record (MAR) charts we looked at during our inspection did not have photographs of people attached to them and did not have a space to record 'when required' medicines. Staff recorded when these medicines were administered on the back of people's individual MAR charts. This again was not in line with best practice. It increased the risk of people receiving somebody else's medicine and not receiving 'when required' medicine as needed or being given it too often.

• Staff did not always check the expiry dates of medicines. We didn't find any medicines past their expiry dates. However, the lack of adequate checks meant people could potentially experience pain or harm if their medicine was not effective due to being past its expiry date.

Preventing and controlling infection

• Staff did not always follow national guidance to protect people from the spread of the COVID-19 virus. The provider had not done all they could reasonably do to ensure people were protected from this risk. For example, we observed staff did not wear masks in one of the homes. The provider said they had assessed the situation and decided not to use masks because two people living there had said staff wearing masks

made them feel anxious. However, individual risks to people and staff from COVID-19 had not been fully considered and the provider had not regularly reviewed the decision not to use masks. Staff did wear masks in the other homes.
• The provider took staff temperatures daily and people's temperatures twice a day to check for symptoms of COVID-19.
• The homes were visibly clean, tidy and free from unpleasant odours and people helped staff to keep their home clean. There were handwashing facilities and hand sanitiser available in the homes and the office.

People were at increased risk of harm due to the lack of robust risk management plans, inadequate infection prevention and control in one of the homes and poor adherence to best practice in the administration of medicines. This meant the provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection the provider updated some people's risk assessments and sent us specific risk management plans to help some people manage their diabetes and personal relationships. The provider also informed us they had reviewed their infection prevention and control practice. The provider confirmed all staff were now wearing face masks in all the homes, in line with national guidance. The provider also reassured us that people's medicines folders contained people's photographs. Although the provider made these improvements, they had failed to identify the issues and made the improvements after our inspection as a result of the CQC inspectors' findings. Therefore, the provider was still in breach of the regulation for safe care and treatment.

Learning lessons when things go wrong
• Incidents and the immediate actions of staff and the manager were clearly reported. However, it was not clear from the records what lessons the provider had learned from incidents. For example, people's risk assessments had not always been updated to include how the provider intended to manage and reduce the risk of similar incidents occurring again.

Staffing and recruitment
• Staff completed regular training and there were enough staff on duty to provide people with the care they needed.
• The provider had a recruitment policy and procedures to ensure staff they recruited were safe to work with people. This included criminal record checks and references from previous employers.

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

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

• Systems were not robust enough to demonstrate safety was effectively managed. The provider had failed to properly assess, identify and reduce risks to people.
• The provider's audits were not always effective and did not always lead to learning and improvement. For example, medicines audits showed staff had not checked the expiry date of medicines during a period of three months. This meant the provider had not used the audits to identify patterns and trends in order to improve staff practice.
• Incident reports did not make it clear that people's families had always been notified of an incident.

The provider's failure to properly assess, identify and reduce risk to people meant the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider lacked knowledge and understanding about the regulated activity of personal care. This meant the provider had not properly assessed and understood which people were receiving a service regulated by CQC. The provider had informed CQC that fewer people were receiving personal care than were receiving personal care. This had limited CQC's oversight of the service because CQC only inspects where people receive personal care.
• The provider lacked knowledge and understanding of the Mental Capacity Act 2005. This meant the provider had not assessed people's ability to make decisions for themselves. The provider told us everyone had full capacity to make their own decisions. However, people's care records showed some people did not always have the mental capacity to make all decisions themselves. This placed people at an increased risk of abuse or harm.

The provider's lack of understanding and failure to meet some legal requirements meant the provider was unable to demonstrate the competency required to carry on the regulated activity and to manage it. This meant the provider was in breach of Regulation 4 (Requirements where the service provider is an individual or partnership) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection the provider has appointed a person to manage the service. The person has applied to CQC to become the registered manager. A registered manager is a person who has registered with CQC to manage the service. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

• The provider had not always notified the CQC of incidents. For example, the provider had not notified us of three incidents to which the police had been called. It is the provider's legal responsibility to notify the CQC of incidents involving the police.

The provider's failure to notify the Care Quality Commission of incidents meant the provider was in breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider held regular residents' and staff meetings and sent feedback surveys to people and staff twice a year. This was to give people and staff the opportunity to share their views and contribute to making decisions about the service. The provider also used social media groups for staff communication and video calls to keep people in touch with their families.
• People's families had expressed concern about people's mental health during the COVID-19 national lockdown. The provider employed a qualified mental health nurse to work in the homes every day and to do activities with people. People's families had said they were happy with the provider's response and that people seemed happier within themselves as a result.
• Individual people had an allocated member of staff called a keyworker and could use their support sessions with their keyworker to discuss any issues they wanted to talk about.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service had an open and inclusive culture. Managers and staff had an open-door policy, which meant people could talk to them about anything at any time without having to arrange it in advance. Information was given to people in a way they could understand.
• People's care plans were person-centred, and staff knew people well. This meant people were treated as individuals and the care and support people received was specific to their needs and preferences.
• One member of staff told us it was a good company to work for and they had learned a lot about working with people with learning disabilities. Another staff member said they liked working for the company because people were much more independent and active. For example, people participated in a variety of community activities every day. Some people attended college and some people had jobs.

Working in partnership with others
• The provider worked closely with local authorities, mental health services, Clinical Commissioning Groups, pharmacies and the National Health Service, including GP surgeries, to support people and to access staff training.
• The provider also liaised with people's colleges and employers.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of police incidents.

The enforcement action we took:

We imposed the following condition:

The Registered Provider must ensure that the regulated activity Personal Care is managed by an individual who is registered as a manager in respect of that activity at or from all locations.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessing risk and safety monitoring and management was not always robust enough. Medicines management did not always follow best practice. Infection prevention and control did not always follow national guidance for Covid-19.

The enforcement action we took:

We imposed the following condition:

The Registered Provider must ensure that the regulated activity Personal Care is managed by an individual who is registered as a manager in respect of that activity at or from all locations.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not understand quality performance, risks and regulatory requirements. Systems were not robust enough to demonstrate safety was effectively managed. Learning from incidents and audits was not clear.

The enforcement action we took:

We imposed the following conditions:

The Registered Provider must ensure that the regulated activity Personal Care is managed by an individual

who is registered as a manager in respect of that activity at or from all locations.

Regulated activity	Regulation
Personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider was unable to demonstrate the knowledge and competence required to carry on the regulated activity and to manage it where there is no registered manager.

The enforcement action we took:

We imposed the following condition:

The Registered Provider must ensure that the regulated activity Personal Care is managed by an individual who is registered as a manager in respect of that activity at or from all locations.