Pathway For Care Limited

Pathway for Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Pathway for Care is a supported living service providing personal care to people with a learning disability and/or autism. Support was provided across four different supported living settings where people had their own flats or rooms. As part of our inspection we visited people in all four supported living settings. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection there were 12 people receiving a regulated activity.

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

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The Mental Capacity Act 2005 was not consistently followed to ensure people's capacity was assessed and that decisions were made in people's best interests and in the least restrictive way possible. However, we found staff frequently consulted people about day to day choices regarding their care. These included areas such as how and where people spent their time at home, what they chose to wear and food choices.

Some people's health care needs were not always monitored to ensure they received the support they required, and referrals were not made in a timely manner. Medicines management systems were not always robust in one setting which meant there was a risk of people not receiving their medicines in line with prescription guidelines. In some instances, we found people were supported well with both their healthcare and medicines. Staff worked alongside other professionals in order to provide holistic care which for some people had resulted in a reduction of their prescribed medicines.

Due to the availability of resources people were not always able to pursue their interests and preferred routines. In other instances, we found people received support to access local facilities and public transport in line with their interests.

Right Care:
Systems in place to monitor and review risks to people's safety and well-being were not always robust. Where incidents were reported, lessons learnt and systems for reflective practice were not consistently followed.

Staff were aware of people's support needs in relation to their sensory and emotional support. They were aware of triggers to people's anxiety and how to support them during times of distress. Where appropriate, a multi-disciplinary approach was taken to manage risks to people's well-being. Staff were aware of their responsibility to protect people from potential abuse and concerns were reported and investigated in line with requirements.

Staff supported people with care and kindness. Choices were provided to people in relation to their day to day support and how people wished to spend their time. People's dignity and privacy were respected, and staff communicated with people in the way they preferred.

Right Culture:
Systems were not always implemented to ensure a positive ethos of the service was fully embedded into practice and to monitor outcomes through quality assurance processes. This had led to a lack of consistency across the different settings and meant people did not always receive support in a responsive way. This was of particular concern in one of the four supported living settings.

The culture of the service was positive and staff understood the aims of the service in providing people with a personalised service which focussed on their quality of life. Staff knew people well and understood what was important to them.

The provider and management team responded positively to address concerns identified during our inspection. Investment was taking place in electronic systems designed specifically for the service. The aim of this development was to provide more robust information and enable the staff team to respond to people's changing needs in a timely way.

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 requires improvement (published 24 October 2018). During the inspection we identified a breach of regulation in relation to the governance of the service. 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 the provider remained in breach of regulations.

At our last inspection we recommended the provider continually review people's risk assessments to ensure they remained current. At this inspection we found improvements were still required in this area.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the governance of the service, the way in which risks to people's safety are reviewed, their health monitored and person-centred care. The service was not always adhering to the Mental Capacity Act 2005 to ensure people's legal rights were protected.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Pathway for Care

Detailed findings

Background to this inspection

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

Inspection team
The inspection team was made up of three inspectors and an Expert by Experience who made phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The manager had submitted an application to register.

Notice of inspection

We gave a short period notice of the inspection to ensure staff had the opportunity to discuss our visit with people and to gain their consent where required.

Inspection activity started on 21 June 2022 and ended on 8 July 2022. We visited the settings where people receiving support lived on 21, 22, 23, 27 and 29 June 2022.

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

We used all this information to plan our inspection.

During the inspection
We spoke with eight people and three relatives about their experience and observed people support. We received feedback from three health and social care professionals. We spoke with 13 members of staff including the manager, regional manager, the Director of New Services and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained 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; Learning lessons when things go wrong

At our last inspection in November 2020 we made a recommendation in relation to risk assessments being updated promptly when required. At this inspection we identified concerns regarding the consistency of how risks were managed. These concerns related to one of the four settings we visited.

● Accidents and incidents were not always robustly managed to minimise risks to people's safety. Staff reported incidents of concern in a variety of ways dependant on the situation. These included completing incident forms, behaviour monitoring forms and events logs. However, there was no co-ordinated approach regarding how this information was collated in all settings. Behaviour monitoring forms and events logs were not consistently reviewed and monitored alongside more significant incidents. The service manager assured us reflective practice was discussed with staff although no record of this was maintained. This meant there was a risk that any learning required may not be recognised and acted upon.
● Accident and incident forms were reviewed and signed off as part of a multi-disciplinary team process. This involved senior management and specialists discussing incidents and agreeing any further actions or monitoring required. The management team were unable to demonstrate how these discussions had been fed back to staff for their learning and people's risk management plans amended as required. The provider assured us this concern would be addressed immediately.
● Risk assessments did not always contain sufficient detail to guide staff in how to support people safely. For example, one setting was in an isolated area on a road with no pavement. Risk assessments were in place for one person in relation to them leaving their home without support. This did not consider these environmental factors or give staff any indication where the person may go based on previous experiences.

The failure to ensure risks to people's safety were robustly assessed and accidents and incidents effectively monitored was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other areas we found risks to people's safety were managed well. People were involved in identifying risks to their safety and the support they required to mitigate these. For example, one person was able to describe to staff the action they wanted them to take during times of anxiety. This included how they would communicate and how staff should respond. Risk assessments were personalised covering areas including safety when out doing different things, on-line safety and risks when at home.
● Staff could recognise signs when people experienced emotional distress and knew how to support them in a safe way. Where required people had positive behaviour support plans (PBS) in place which guided staff on potential triggers and the action they should take to support the person to remain calm. Plans considered people's sensory needs and how they responded to communication during times of anxiety and

distress.
● Staff we spoke with showed a good understanding of people's needs and things which were important in supporting them to manage their emotions. These included the importance of people's routines, where specific items of importance to the person should be placed, how their meals/drinks should be arranged and how to respond to people's sensory needs.

Using medicines safely
● People's medicines were not managed safely in one setting. Where people had been prescribed medicines to be taken as and when required (PRN), guidance was not always available to staff on when and how these should be administered. During our inspection we observed a senior staff member advise a staff member to administer PRN to one person each time they went out. Staff confirmed to us this was not always required as if the persons routine was followed, they did not show signs of anxiety. We advised the provider of our concerns during the inspection. They took action to ensure an investigation was completed, guidelines were implemented, and staff received additional training.
● Robust systems were not always followed to ensure people's medicines were accurately monitored and recorded. Staff had not always accurately transcribed medicines administration records (MAR) with the correct prescription and administration details. Staff had continued to sign MAR charts despite the information being incorrect. This meant there was a risk people may receive the wrong medicines at the wrong time. The provider took action to address these concerns during our inspection.
● We identified gaps in administration records of three people. As regular stock checks were not completed this meant the provider was unable to assure themselves people had received their medicines in line with their prescription. In addition, where additional monitoring records were required, we found these had not been completed following each administration.

The failure to ensure robust medicines management was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other instances we found people's medicines were managed safely. People could take their medicines in private and staff explained what they were taking in a way people understood. PRN protocols were in place and medicines were stored, administered and recorded safely.
● There were examples of people being supported to reduce their medicines in line with STOMP guidance (stopping over-medication of people with a learning disability, autism or both). For example, staff were supporting one person to reduce their medicines using a staged approach and with input from healthcare professionals.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe with the staff supporting them. One person told us, "I feel safe because staff are nice here and I like them." One relative told us they knew from their loved one's responses when speaking with them they felt safe. People appeared relaxed in the company of staff. We observed people sharing their thoughts with staff with confidence and authority.
● Staff had completed safeguarding training and were able to describe their responsibilities in keeping people safe from the risk of abuse. One staff member told us, "I have no concerns here but if I did, I would go to management. If nothing was done, I would then ring the social worker or safeguarding. The contact numbers are in the office. I wouldn't hesitate to whistle blow to keep them safe."
● Safeguarding concerns were reported in line with requirements and where additional information was requested this was provided. Where one local authority had raised concerns regarding reporting procedures, the provider had worked alongside them to ensure reporting expectations and guidance was followed.

Staffing and recruitment

● People told us there were sufficient staff available to meet their needs although some people and relatives felt high use of agency staff in some settings impacted on the support people received. One person told us, "There is a lot of agency, there isn't a lot of permanent staff and I find that difficult. Some days I am with staff I don't know." One relative told us, "There's enough staff to the best of my knowledge and they know my relative's risks."

● The manager told us the provider had recently run a successful recruitment campaign which had resulted in the majority of vacancies being filled. We observed that group inductions were taking place during our inspection with staff receiving training and shadowing permanent staff members. They informed us that recruitment had been completed in a personalised way with the aim of each person having their own support team. Whilst the majority of people were unable to take a full part in the interview process, the management team had looked to match people and staff with similar interests and the skills individuals required.

● Staff recruitment and induction systems promoted safety, including those for agency staff. Prior to being employed, a range of checks were completed to help ensure staff were suitable for their roles. These included an interview, a review of previous employment and references, health screening and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● People told us that staff wore masks when supporting them. We observed appropriate systems were in place to prevent and control infection.

● People were supported by staff who had received training in infection prevention and control (IPC). This helped them to follow good hygiene practices when providing people with care and support.

● Staff assured us they had access to sufficient levels of personal protective equipment to minimise the risk of infections spreading.

● People were able to receive visitors in their home and were supported to go out and meet others in line with government guidance.

Requires Improvement

Is the service effective?

Our findings

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

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

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

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

We checked whether the service was working within the principles of the MCA
● The majority of people we spoke with confirmed staff listened to their views and provided support in the way they wanted. One person told us, "Staff always ask before they do something, and especially before they come into my room. They always knock." A second person said, "They do allow me to make decisions about care."
● People supported at one setting told us they found the restrictions around locked internal doors in corridors difficult. Staff had passes to enable them to move around freely. However, people's capacity to hold a pass and any risks involved with this had not been assessed. When speaking about this system two people said this reminded them of a prison or hospital setting and restricted them from accessing the main lounge and office area freely. The provider told us they were in the process of addressing this issue with the housing provider and would review people's capacity and risk assessments.
● People's capacity to make specific decisions was not always assessed where restrictions were in place. Best interest decisions were not always completed to demonstrate the least restrictive options were being followed. For example, decisions such as people receiving constant supervision, locked doors or where they were unable to leave their home without staff support had not consistently been assessed. This meant people's legal rights may not always be protected.
● Staff were able to explain the main principle of the MCA and were aware of the restrictions in place such as people not being able to leave their home without support. However. they were not able to tell us how and when the MCA should be put into practice to ensure restrictions to people's freedom were monitored. One staff member told us, "That's something the managers do. We don't get involved." A second staff member said, "To be honest I find it confusing. I'm not really sure when we should be doing capacity assessments

and when it's the job of the social worker."
● The manager told us they were aware these processes needed to be implemented more robustly. During our inspection they forwarded information which demonstrated they had begun to address this issue.

The failure to ensure the principles of the Mental Capacity Act 2005 were consistently followed was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other instances, we found the service worked alongside relevant local authorities to discuss applications to the Court of Protection to deprive someone of their liberties. These applications were reviewed to ensure that should conditions be imposed, theses would be monitored.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always have health action plans in place in order to ensure their health care needs were fully addressed and monitored. One person required annual treatment due to a health care condition. Records showed, and staff confirmed, the person had not been supported to make the relevant appointments for almost two years. This put them at risk of further deterioration to their health. Following our inspection the service manager confirmed they had begun the process for the required referrals to be made.
● Where people attended appointments or received healthcare treatment this was not always fully recorded to ensure this could be monitored. The manager told us they had implemented a system to record outcomes of appointments. However, we found this system was not always being consistently used and was not designed to link up with health action plans once implemented. This meant staff were unable to fully monitor people's health care needs and follow-up on referrals and appointments.
● One person had been waiting for six months for the outcome of a referral for dental treatment. They had originally been told this should take up to three months. Staff had not ensured this was followed up. Another person received frequent support from a visiting healthcare professional. Their visits were not recorded and there were no notes of how the person was progressing. This meant there was a risk of staff not being fully aware of the person's healthcare needs or any advice provided.
● Plans were not always in place to support people who found health appointments difficult. For example, one person's records highlighted they were anxious about medical appointments and had previously refused to attend. There was no plan in place of how to support the person to reduce their anxiety and no specific communication plans around this concern. This meant there was a risk the person may not receive the health care support they required promptly. The person had on-going health concerns which meant they were likely to need to attend medical appointment regularly.
● People were not always routinely supported to register with a dentist or to discuss the benefits of this. Staff in one setting told us this had not been a priority. The manager agreed to address this with individuals following our inspection.

The failure to ensure people's health care needs were effectively monitored was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In some instances, we found people's health was monitored well and a range of professionals were involved in people's care. This resulted in a holistic response to people's needs and helped the staff team gain confidence working with individuals, knowing they had the resources to support them. One person told us how much happier they were since moving to their current home. The staff team were able to explain the support they had received from a range of professionals. They told us this consistent approach had led to a

reduction in the person's anxieties.
● Staff were responsive when people's healthcare needs changed. One person's support needs changed significantly following a period of ill health. Additional staffing was provided, and staff adapted their approach with the support of health care professionals. This meant the person was able to return to their home and continue to be supported by the staff team they knew well.
● Following our feedback during the inspection the manager ensured where annual health and medication reviews had not taken place, appointments were made with the GP.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's support plans were not always comprehensively completed and accessible to staff. Two staff members told us they felt staff had lost confidence in supporting one person and did not feel they had sufficient guidance to follow. The person's care file contained a number of different documents relating to their support in different living environments and reports from other services. This presented contradictory information regarding the person's needs and how they preferred their support. The manager addressed this concern immediately and confirmed they would discuss the persons needs with staff.
● In other instances, we found support plans were detailed and reflected people's preferences and chosen lifestyles. Staff were observed to engage with people in line with the guidance available to them.
● A comprehensive assessment of people's needs was completed prior to their support starting. The assessment process involved the person, relatives and other professionals involved in their care as appropriate. This helped to ensure a holistic approach to gathering information and to establish relationships going forward.
● People's transition plans were focussed around their particular needs and designed to minimise people's anxiety. For some people this meant a long transition where people could get to know staff alongside their existing support team or families. One healthcare professional described how the staff team had ensured the person was ready to move on with their transition plan at each stage. This supported the person to remain in control of the situation and reduced their anxiety.

Staff support: induction, training, skills and experience
● People told us they felt staff supporting them had the skills they needed. One person said, "Staff know what they are doing, they know I need help and they know how to do this."
● Staff told us they felt their training and induction into the service was good and gave them the skills they needed. One staff member told us, "I had a very good induction, the other staff were very helpful as there was a lot to learn." A second staff member told us, "The training has worked well for me and we get reminders. It's important to do the training as things change and we need to stay up to date."
● Where staff required specific training to meet people's needs this was provided. One person's mental health support needs meant staff needed to be aware of additional risks and how to mitigate these. Staff received training around this to ensure the person was kept safe. The provider told us their aim was to ensure person-centred training was provided to a person's designated staff team prior to staff supporting them. Records showed this process had started and staff confirmed this had given them confidence in supporting the person.
● Staff received on-going supervision in their roles. This gave them the opportunity to discuss any concerns or additional training needs. Staff in one setting told us they felt supervisions would benefit from being more structured. We spoke with the manager who informed us that this process was now being monitored more closely and records confirmed this was the case.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff encouraged people to maintain a healthy diet whilst respecting people's choices. One person told us, "Staff help me cook simple meals and not from a packet. I am learning these skills, and staff try their best to

advise me on healthy eating."

● People's care plans contained information in relation to their food preferences and these were known to staff. One person showed us their kitchen which they said was stocked with all the things they needed to cook meals of their choice. We heard the person speaking with staff about what they would have for lunch. Staff made suggestions of healthy foods and they prepared this together.

● People chose when they wanted to eat. Staff supported people to cook when they chose to eat and to fit around their schedules. One staff member told us, "Everything's flexible, people choose what they eat and eat when they are hungry. We make suggestions but it's up to them at the end of the day."

Good

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were supported by staff who were kind and caring towards them. One person told us, "All the staff are kind pretty much all the time." One relative told us, "My relative gets the care they deserve. I know this because I am very close to my relative and know how to interpret what they are saying." People told us they enjoyed the company of the staff supporting them.
- Staff showed a genuine interest in people's comfort and well-being whilst supporting them. We observed staff regularly checking how people were and asking if they needed anything. Staff had developed a good rapport with people and were heard sharing jokes and speaking about common interests and their families. One person regularly chose to sit on the floor and staff sat beside them as they preferred, rather than standing over them.
- People's religious and cultural needs were respected. Arrangements were in place for people to practice their faith how they wished. One person's records showed they were supported by staff to attend church services whilst other people preferred to go with family members. Information relating to people's cultural needs were included in people's support plans and staff demonstrated an awareness of these.

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

- People and their loved ones were involved in making decisions regarding their care. One person told us, "I know my care plan. I sat with staff and we worked it out together." A second person had written their own care plan which clearly outlined what was important to them and how they wished to be approached dependant on how they were feeling. Their wishes had been considered when designing guidelines for staff. On occasions, resources such as transport and drivers were not always available to people in line with their choices. We have reported on this in the Responsive area of this report.
- People appeared comfortable and at ease with the staff supporting them. One person told us, "Staff are very nice in the way help me. They are patient with me. I feel like this is my home." Where some areas of people's home were shared, people were supported in a way which also respected the wishes of others. Staff were heard initiating conversations between people and supporting people to build relationships.
- People were fully involved in day to day decision making and staff respected people's choices. This included when people chose to get up, how they wanted to be supported with their personal care, where they wished to spend time and food choices. Staff demonstrated an understanding of people's body language when offering options and offered gentle encouragement to people.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff supported them to develop their independence. One person told

us, "I am happy here and I want to learn to be independent. I have staff who support me with this. The staff here help me learn how to do things rather than doing everything for me."

● Staff supported people with their daily living skills and encouraged people to take an active role where possible. We observed people planning shopping lists, preparing food, doing laundry and completing cleaning tasks. Staff told us they enjoyed this aspect of their role, "I normally work with the same person so it's good to see them develop their independence. This can be a difficult job at times but it's always rewarding."

● People's privacy and dignity were respected. We observed staff knocked on people's doors prior to entering their homes/rooms. Staff recognised some people preferred to spend time alone. We observed staff gave people space or sat outside people's flats so they were on hand to provide support should the person require this.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

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

- People and their relatives gave mixed responses in relation to how people were supported to do things they enjoyed, when they wished to do them. One person told us, "Sometimes I go out and sometimes I don't, this is what I choose, and staff know this is how I am." One relative said, "My (relative's) life has gone haywire since they moved in (to the service). They need structure and routine, and this just isn't there. I keep asking for a plan, but nothing is in place."
- Some people had their own vehicles and in one setting the provider had a car and driver available to support people to go out, as detailed within the support plans. However, staff were not always able to respond to people's changing needs or wishes promptly, due to the range of demands on the vehicle and availability of drivers. This meant people were not always able to do things they enjoyed or follow routines which were important to them.
- People were not always able to spend their leisure time as they wished. Staff told us it was important for one person to go out for a drive in their car each day but due to a lack of drivers this was not always possible. The staff member told us, "Going for a drive is (person's) favourite things to do. Every day they will go and get their shoes to show they want to go. You feel really bad saying no to something they love." Records showed the person had been out on three occasions in the previous 10 days.
- The provider told us they were looking at alternative options for people on an individual basis such as using volunteer drivers, people purchasing their own vehicles and recruiting more drivers. However, these were long term options which did not address people's immediate needs.
- People were not always supported to look at options for things they enjoyed doing and to plan for things they would like to do. Staff did not always evidence how people spent their time, and for some people, there was a lack of structure to their day. Daily records for some people reflected they spent much of their time in bed or watching television. There was no reference to how staff were supporting people to plan and structure their time or strategies they had tried, to encourage people to do things they enjoyed. The manager told us they were beginning to address this and develop activity plans with people. We observed an initial training session for people and staff was taking place to explore different leisure options.
- People's support, aspirations and achievements were not always monitored and reviewed to aid their personal development and opportunities. Systems to review people's support and progress each month were not consistently completed. This meant there was a lack of future planning in order to ensure any difficulties experienced could be discussed and any achievements built upon.

The failure to ensure people received the support which was consistently responsive to their needs and wishes was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

● With exception of the one setting highlighted above, all others were in central areas with good access to facilities and transport links. People told us they liked where they lived and were able to make use of the resources and leisure facilities in their local area. One person told us, "I walk with staff to the shops and we can go out for lunch." We observed one person discussing which plants they were going to buy for the garden when they went shopping the following day. They clearly knew which shops they were going to visit to buy certain items.
● We observed some people led active lives and took part in a range of things they enjoyed, and which supported their independence. Staff were focussed on people's quality of life outcomes. People in some settings spent the time going out to do their shopping, going out for meals and to the cinema etc. When at home we saw people spent their time doing things of their choosing. One person told staff they would like to do some baking. Staff responded immediately to support the person with this. They later played board games together which was an animated and fun competition.
● Staff were able to describe how they had encouraged some people to take part in things where they were anxious about. For example, staff showed us photos of one person who had enjoyed going to the local park. Other staff spoke about a person recently being able to attend a family wedding for a short time. Staff demonstrated pride and enthusiasm for people having achieved these things.
● Where monthly reviews of people's support and experiences were completed, this had led to people experiencing new things and their quality of life being enhanced. For one person this had led to them exploring new things within the local area, building positive relationships, growing in confidence and to a reduction in their prescribed medicines.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People had individualised communication plans in place. These included the use of visual aids such as photographs and pictorial prompts. Guidance was available to staff regarding how and when to use the aids to support people in decisions making.
● Where required, positive behaviour plans highlighted how communication should be adjusted to support people when they were anxious. Guidance described how people's ability to respond changed and how staff should support this by changes in their approach.
● Staff demonstrated an understanding of people's communication needs and how they responded. We observed staff using different approaches and showing understanding of where people benefitted from a tactile approach to gain reassurance.

Improving care quality in response to complaints or concerns
● Information on how to make a complaint was available to people and their relatives in an easy to read format. Staff were aware they should report any concerns and record complaints to ensure they were responded to.
● Where complaints had been raised, records showed these had been responded to in line with the provider's policy. Where relevant, the service had liaised with the local authority and other professionals involved in people's care.
● In some settings, people were encouraged to provide feedback regarding any concerns during monthly update meetings with their keyworkers. Staff ensured these concerns were taken seriously such as

supporting people to work through any concerns regarding other tenants.

End of life care and support

● At the time of our inspection no one at the service was receiving end of life care. The manager assured us that should this be the case they would work alongside the person, their family and others involved in their support to ensure their wishes were met.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to consistently ensure effective communication and to assess, monitor and mitigate the risks relating to people's health, safety and welfare. This was a 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 regulation 17.

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

- We received mixed responses in relation to the culture and leadership of the service from people, relatives, staff and external professionals. Comments included, "I am not wholly impressed with the management; it's a pass the buck situation. They will say we will tell the team but when I ask the team they haven't been told", "I compliment the management regarding their structure and enabling" and, "I feel it is positive but with better leadership, staff would be more aware of their roles and who to go to."
- There was a positive and person-centred ethos within the management team and the staff we spoke to. However, systems were not always implemented to ensure this ethos was fully embedded into practice and to monitor outcomes through quality assurance processes. This had led to a lack of consistency across the different settings and meant people did not always receive support in a responsive way.
- There was a lack of consistent management oversight. One setting had experienced a number of different service managers in a short space of time. Staff told us this had led to changes in the organisation of systems and how people received their support. For example, medicines systems and recording had been changed which had led to recording errors during the time both systems were in place. As the system had not been regularly reviewed these concerns had not been identified. The provider had not ensured systems were in place to identify these shortfalls.
- Quality assurance systems did not always lead to improvements being made in a timely manner. A consultant had been employed to complete audits of all settings. This had identified a range of concerns in relation to people's care including shortfalls in the implementation of the Mental Capacity Act 2005. However, this had not been addressed within the action plan for the setting. We found continued concerns regarding the implementation of the MCA during our inspection.
- Actions plans were not always effective in ensuring continuous improvement and development. One service improvement plan highlighted people's health needs assessments needed to be more robust and

outcomes of appointments recorded. This was recorded as having been actioned in February 2022. However, we found there were on-going issues regarding the recording of health needs and appointments at a number of settings. In addition, the service improvement plan stated all support plans needed to be reviewed and to be consistent across the services. Although this was marked as completed in March 2022, no system had been implemented for continual update and review of people's needs and aspirations. During our inspection we found care records available to staff did not always reflect people's current needs.

● Records in relation to people's care were not always organised and did not always contain sufficient detail. Daily notes reviewed did not always give an in-depth understanding of people's routines, how they spent their day and what they had enjoyed. People's notes often concentrated on their personal care and mealtimes and did not consider how the remaining time was spent. This was especially relevant as the majority of people supported received a minimum of one to one support during the day. In one setting we found daily records were not stored in an organised manner which made it difficult to refer to specific days or incidents. This also prevented staff from reviewing how the person had spent their time in the days prior to them working together to ensure they were aware of any incidents or where things had worked well for the person.

The failure to ensure robust and effective quality assurance systems were in place was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and senior leadership team informed us they had recognised these concerns and new audit tools were in the process of being implemented. We saw that workbooks were in place for each setting which covered areas including reviews of support plans, medicines, health and safety and finances. The first cycle of the audits in this format were about to start at the time of inspection.

● In other instances, we found service managers and senior support staff had a good oversight of people's needs. There was a shared vision and understanding amongst the staff team of how they worked together to support people to achieve positive outcomes and to live a life of their choosing. We saw examples of people and staff planning and organising their time together in a way which put people at the centre of their own support.

● There was no registered manager in place. However, our records showed the manager had made an application to register with the Care Quality Commission. The manager had been in post for a number of years and knew the majority of people, staff and the individual settings well.

● The provider and manager were open and transparent during our inspection. They shared information in relation to improvements they planned to make and in providing previous audits, action plans and records. Where concerns were raised, either in individual settings or across the organisation, these were reviewed, and systems implemented to begin to address the concerns. The provider was aware of the impact of changes within the leadership team and were in the process of implementing management systems which would minimise the risk of this happening again.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

● The level of engagement in the running of the service varied between different settings. Some people told us they felt fully involved in the running of their home and the service whilst others told us improvements in communication were required. The provider described a number of projects linked with new IT systems which were designed to give people, relatives and staff increased involvement and opportunities to provide feedback. They informed us one person had been involved in the design of the electronic systems review process in order to gain their views on how the system worked.

● People told us they were able to feedback comments to staff regarding their support and their views were listened to. One person told us, "I got a bit upset this morning and after I calmed down, I had a chat with the member of staff who definitely listened to my point of view."
● Staff told us they enjoyed working with people and felt their immediate manager and senior colleagues listened to their views. One staff member told us, "They [managers] listen to us, you can ask them for something, and they sort it out immediately. The managers always answer their phone to us. I have confidence in them." However, some staff told us they did not always feel supported by the senior management team and felt senior managers were disconnected from the services.
● Staff reflected they did not always feel informed of changes within the organisation and felt their efforts were not always acknowledged when they went above and beyond in their roles. The provider told us they continued to develop ways in which staff could feedback to the senior leadership team. They told us they felt the changes within the leadership team meant there would be greater support, presence and accountability within the service going forward.
● The provider had a duty of candour policy in place which set out what would fall under the remit of a duty of candour incident and how this would be investigated and responded to. The manager was aware of this policy and their responsibilities. Records showed where duty of candour incidents had occurred, investigations were completed and people and/or their relatives were informed in writing with an apology given.

At our last inspection the provider had failed to submit statutory notifications. This was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

● The registered manager was aware of their responsibilities in ensuring that CQC were notified of significant events which had occurred within the service. Notifications were forwarded to CQC as required to ensure risks within the service could be monitored.

Working in partnership with others; Continuous learning and improving care
● The service worked alongside other professionals in order to support people's care and monitor the service provided. For example, the management team had been supported by the local authority in one setting to monitor the improvements required and how these were implemented. The process had resulted in positive changes in a number of areas.
● The provider demonstrated a commitment to on-going improvement and development of the service. They informed us of investments in technology to support people and staff in their roles. In addition, this would give greater flexibility in responding to people's needs, recording people's progress and monitoring outcomes. The system was bespoke and centred around the person-centred values of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's health care needs were monitored and addressed and that people received support which was consistently responsive to their needs and wishes.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's safety were robustly assessed, accidents and incidents effectively monitored and that robust mediciones management systems were in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust and effective quality assurance systems were in place.