Life Path Trust Limited

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Inspection report

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Date of inspection visit:
15 March 2022

Date of publication:
31 May 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Life Path Trust is a supported living service providing personal care. The service provides support to people with learning disabilities and autistic spectrum disorders. At the time of our inspection there were 117 people using the service. 45 people using the service were receiving personal care.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of underpinning principles of "Right Support, Right Care, Right Culture.

Right support:
People were not supported to have maximum choice and control of their lives, the policies and systems in the service did not support this practice. Staff did not have a thorough understanding of the Mental Capacity Act 2005 and how to support people who did not have capacity to make decisions. People and relatives told us they thought permanent staff had good skills and knowledge. However, staff did not always feel they had the appropriate training to complete their roles effectively.

Pre-employment checks were completed to ensure staff were of suitable character. People who were prescribed medicines were administered these safely by staff who had received training.
People were supported to maintain contact with people important to them and to follow their interests.

Right Care:
People did not receive safe care. Allegations of abuse were not always referred to the appropriate organisations to be investigated and actions were not taken to protect people from further harm. Risks to people's health and wellbeing were not always assessed and information was not available to staff about how to support people safely.

The provider was undertaking work to improve care records however, we found these were not always

personalised and did not always contain accurate information.

Staff had guidance about people's communication styles but did not always consider how they would support people who did not communicate verbally to be involved in reviewing their care. Staff had received training in how to protect people from harm and knew how to report any concerns for people's safety.

Right Culture:
People, relatives and staff did not know who the manager of the service was or who to contact if they had concerns. There was not a culture within the service to empower people, relatives and staff to be involved in making improvements. Audits and quality assurance checks within the service did not drive improvements. The provider had arranged for comment cards to be available in each person's home to promote more feedback from people.

Language used to describe people and their behaviours was not always respectful and did not always reflect a positive ethos. Audits used to monitor the quality of care people received were not always effective in identifying and driving the required improvements.

People and relatives spoke positively of permanent staff who knew them well and treated them with respect. However, people and relatives stated the care provided by agency staff was not of the same standard and agency staff did not always know them well.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Last rating and update
The last rating for this service was Inadequate (published 26 October 2021).

At our last inspection we found breaches of the regulations in relation to safe care and treatment, protecting people from the risk of abuse, need for consent, treating people with dignity and respect and good governance of the service.

The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations.

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

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

We have found breaches in relation to safe care and treatment, protecting people from the risk of abuse, good governance and failure to notify of other incidents at this inspection.

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
The overall rating for this service is inadequate and the service remains in in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

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 safe Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective Details are in our effective findings below	**Inadequate**
Is the service caring? The service was not always caring Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below	**Inadequate**

Life Path Trust Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by four inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Two inspectors visited the office to review information relating to people's care and all four inspectors made phone calls to staff to gain their experiences of working for the service. Telephone calls were made to people and relatives by the Experts by Experience to gain their feedback of the service.

Service and service type
This service provides care and support to people living in their own homes. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 15 March 2022 and ended on 06 April 2022. We visited the location's office on 15 March 2022.

We spoke with five people who used the service and seven relatives about their experience of the care provided.

We spoke with 14 members of staff including the provider, care co-ordinators and care staff.

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

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk from abuse
At our last inspection we found the provider had not taken appropriate action to protect people using the service from the risk of abuse. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

- People were not safeguarded from the risk of abuse as systems and processes to keep people safe were not always followed.
- Most people and relatives told us they felt safe with staff but were not always sure how to raise concerns and did not always feel confident these would be acted on.
- One relative explained to us they were concerned the level of support had been reduced for their family member. This meant the relative was concerned for their safety as involved in this decision or any plans to mitigate the risk to their family member. The relative had raised their concerns with the provider and their family member's social worker but their concerns were not resolved.
- Staff told us they had received updates to their safeguarding training but did not always know who to raise concerns to. Staff told us they did not always feel confident concerns raised would be acted upon. A member of staff explained they had regularly raised concerns about the safety of a person, although referrals had been made to other organisations actions were not taken to safeguard the person in the interim period before the other organisations could provide support.
- Since the last inspection we had been notified of incidents where a person had reported violence and felt scared. We reviewed the care records for this person and found they did not contain information for how staff were to support this person to remain safe if they disclosed further incidents of violence. We asked a member of staff who stated there had been conversations with staff on how to report any concerns but there was no written guidance. The member of staff went on to state the guidance would be in the new care records which they were writing.
- Safeguarding referrals were not always made to the local authority for investigation. This meant we could not be assured all risks were managed appropriately and people were safe from the risk of abuse. Reviewing records, we identified there were times when people sustained unexplained injuries and these were not recognised as a safeguarding matter and were not referred to the local authority. This was a continuing failure to recognise safeguarding concerns which left people at continuing risk.

Systems were either not in place, or were not effective, to protect people from the risk of abuse and improper treatment. This placed people at the risk of harm. This was a continued breach of Regulation 13(1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At our last inspection people had reported allegations of abuse from members of staff. The provider had taken action to remove the members of staff from the service whilst the allegations were investigated. The staff members were dismissed from their roles and referred to the Disclosure and Barring Service which would alert future potential employers of the results of the investigations.

Assessing risk, safety monitoring and management: Using medicines safely
At our last inspection we found the provider had not taken appropriate action to protect people from 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. At this inspection, we found the provider remained in breach of regulations.

● Risks to people's health and wellbeing were not always assessed and information available to staff was not always accurate which meant staff did not have the information available to support people safely.
● Since our last inspection the provider had created new styles of care records. However, we found these did not always contain accurate information. One person who was diagnosed with epilepsy had inaccurate information as to how staff should respond if they had a seizure. We brought this to the provider's attention who updated the record.
● Another person's care records stated they had diabetes but there was conflicting information about the type of diabetes the person had. The care records did not include information about how staff were to recognise signs the person's blood sugar was too high or too low and how to respond.
● Staff told us they received training about diabetes and epilepsy, however staff did not always have accurate information on how to mitigate risk. We asked a staff member how they would recognise signs a person with diabetes had low blood sugar and how they would manage the risk. The staff member told us they would contact the 'diabetes nurse' who visited twice a day and the nurse was responsible for their diabetes care. Whilst the nurse had oversight of the person's diabetes care this action would not mitigate the immediate risk to a person. We spoke to another member of staff who supported a person with epilepsy. The member of staff was not aware the person's guidance if they had a seizure had changed after we had identified inaccuracies in the care plan. The care plan had been updated with new guidance three weeks prior to the conversation.
● Care records did not always contain sufficient information for staff to support people with their medicines safely. One person did not like things being locked away and did not understand the risks of taking their medicines contrary to the prescriber's instructions. A staff member agreed to update the care records as these risks were not clearly identified.
● Care records relating to medicines did not always contain detailed information. One medicine chart stated the person was not to have cranberry juice because it could impact on the effectiveness of one of the medicines they were taking. This was not documented in their care records.
● Medicine administration records (MAR) were not completed in line with national guidance. Handwritten MAR were signed by just one member of staff when guidance states this requires the signature of two members of staff.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they had received training before being able to administer medicines and they had their competencies checked regularly.

Staffing and recruitment

● People and relatives told us there were enough staff available to support them however they went on to explain the use of agency staff was high and they preferred being supported by people they knew .
● People and relatives told us they thought permanent staff knew them well but did not think agency staff had the same level of knowledge. One relative told us, "Sometimes they have agency staff and they don't know her so well." Another relative told us their family member liked their regular care staff, but would become upset if they were supported by a member of staff they did not know .
● Staff told us they knew the people they supported well, however went on to say there was high use of agency staff who did not know people and the risks associated with their care.
● Safe recruitment checks were in place to ensure people were supported by staff who were suitable to work in care services. Records showed pre-employment checks were carried out as required. The pre-employment checks included requesting references from previous employers and completing 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.

Learning lessons when things go wrong
● Accidents and incidents were recorded and investigated to identify if any further action was required to prevent future incidents however, we found recommended actions were not always taken. A member of staff had made a medicine error in September 2021, it was advised they would need to have their competencies checked before administering medicines again. At our inspection there was no record of the staff member having their competencies checked. A manager confirmed there was no record of the competency check being completed and could not state this had been done.
Following our inspection the provider informed us the risks of not completing the competency check had been reduced because the member of staff was no longer administering medicines.

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At our last inspection we found the provider had not assessed people's ability to make decisions for themselves. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

- The service was not working within the principles of the MCA.
- At our last inspection we identified people's decision-making abilities were not clearly recorded in care records. This meant staff did not have clear information on what decisions a person could make.
- At our inspection in July 2021 we identified a person did not have a mental capacity assessment in place to help staff understand what decisions they could make. We asked the provider to complete a mental capacity assessment for this person, however at this inspection we found this had not been done.
- A member of staff told us another person did not have capacity to make decisions about their finances. The person did not have a mental capacity assessment in their care records or guidance for how staff were to support them with these decisions. A member of staff told us an assessment had been completed by a social worker, but it was stored on the computer and staff did not have access to it because they did not know the password.

● Staff did not have a thorough understanding of their responsibilities under the Mental Capacity Act 2005. Staff told us they had received training about it but were not able to explain how they supported people in their best interests. One member of staff told us, "If they lack capacity, I'd make the decision for them." The member of staff was not able to explain how they would know if the decision was in the person's best interest. When asked about their understanding of the Mental Capacity Act a team co-ordinator told us, "I think it's still a work in progress as we need to know more really about the concept." They went on to explain they did not understand Deprivation of Liberty Safeguards and told us, "Not sure what it's for. I can't think, I couldn't tell you."

Systems were not in place to ensure that care and treatment must only be provided with the consent of the relevant person. This placed people at risk of harm. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support, training, skills and experience

● Staff received training when they started working for the organisation as well as time working with a more experienced member of staff. One member of staff told us, "Yes, I had training and shadowing, they give a lot of information and a lot of training."

● We received mixed feedback from staff about training they had received. Some staff told us they received regular training which they found useful. However, we found training was not always effective because staff were not always able to recall the information they had been provided, for example about Deprivation of Liberty Safeguards and the Mental Capacity Act.

● Other staff told us they had not received training they needed to complete their roles and responsibilities. A team co-ordinator told us, "I am writing the new outcome support plans. I haven't had any training though and they are hard to write as they are important." Another member of staff told us they supported a person who could become physically aggressive. They stated, "I can't remember having any behaviour training though I have kind of found my own way of working with them which works."

● People and relatives told us they thought permanent staff were well trained. One person told us, "Yes I think so but not agency staff they go from job to job, they can't be as well trained." A relative told us, "Main staff yes, agency staff no."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

● People and relatives told us they were able to access health and social care services when required and staff would support them to make appointments when necessary.

● Since our last inspection the provider had worked with other agencies to review people's care needs to help identify if additional support was required.

● People were supported to eat a diet which was in line with their preferences and dietary requirements.

Requires Improvement

Is the service caring?

Our findings

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

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

At our last inspection we found the provider had not supported people in a way which promoted their dignity and did not support people to be involved in making decisions in their care. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was now meeting this regulation.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were supported in a way which promoted their dignity, however we found some care records continued to use language which was not always person centred or respectful.
- We received mixed feedback from relatives and people about whether they were involved in making decisions about their care. Some people and relatives told us they had been asked for their views whilst others had not.
- Consideration was not always given to how people, who did not communicate verbally, would be included in reviewing their care. A staff member told us, "I don't know yet how I will do the plans for the people who don't talk, that is going to be a big challenge, I'll need to give that some thought."
- The provider was working with a local organisation to gain independent advocates for people who could not express views themselves
- We received mixed feedback from staff about how independence was promoted. One member of staff told us they supported a person to make a meal they enjoyed. They told us, "I help them to prepare the salad, but they do most of it. I help them set the timer for the chicken to make sure its cooked. We are only to prompt as we need to promote independence." Another member of staff said, "I'm not sure, they need a lot of support and can't do much for themselves, I do most things for them. They can get frustrated if I ask them to do things."

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

- People spoke positively about permanent staff that supported them. One person said the staff were, "Brilliant." A relative told us, "Generally they are kind to [name] and caring. Staff are always friendly."
- A member of staff told us there had been improvements since our last inspection in how they supported people. They said, "I think we have got better at being client orientated, there is more focus on the opinion of [people] mattering."
- Care records included information about people's equality and diversity needs and how staff were to support them with these, for example how to support a person to follow their chosen faith.

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 requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care

● At the time of our inspection the provider was creating new care records for people supported by the service. The provider aimed for all care records to be reviewed by the end of 2022. The new care records included information about people's physical, emotional and mental health needs as well as people's views and preferences. However, we found some of the information contained in the care records had been copied from other people's care records which meant it had not been personalised to the individual and did not contain accurate information. We brought this to the provider's attention who corrected it immediately.

● People told us they were involved in planning and reviewing care. One person said, "I look at it (care records) with staff." However, relatives told us they had not been meaningfully involved in reviews. One relative said, "Sometimes, well two or three times a year they send us a letter with information on telling us how [name] is doing." Another relative told us, "No not really, I think they are waiting for a new house, I'm not sure."

Improving care quality in response to complaints or concerns

● People and relatives were not always sure who to contact if they had concerns or wanted to raise a complaint. People and relatives told us there had been a number of changes to the management of the service and this had led to confusion. One relative told us, "I have no idea who the manager is and wouldn't know who to contact specifically if I had a concern."

● The provider told us they had arranged for comment cards to be created and made available in people's homes so they had an accessible means of raising any concerns if they wanted to.

● A staff member told us how a person had become upset when the staff supporting them had changed. They went on to explain how they supported the person to make a complaint and the original staff were moved back to support the person again.

● When complaints were received the provider arranged meetings with the person or relative to discuss the issue to find solutions.

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.

● Care records included details of how a person preferred to communicate and to recognise how a person how a person was feeling.

● The provider had created individual communication passports to support staff to understand how people

communicated if they did not communicate verbally or had limited verbal communication.
● The provider had created information for people using different communication styles, for example in Easy Read. Easy Read is a style of communication which uses a mixture of images and short sentences.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant
● We received mixed feedback from people and relatives about the support they received to maintain relationships. One person told us they did not have contact with their family and did not have friends. Another person told us they were supported to see their relatives each week. One relative told us they had not seen their family member since before the COVID-19 pandemic but had regular phone calls to them. Another relative told us their family member was supported to see them regularly.
● People told us they were able to follow their interests and do activities they enjoyed. One person told us, "I like going to town, bingo and going out for meals." Another person told us, "I like going for walks."

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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 inspection we found the provider did not have effective processes in place to maintain oversight of the care provided and to drive improvements. This was a breach of Regulation 17 (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- There was not a registered manager in post at the time of our inspection. The previous registered manager left the organisation in August 2021. A new manager was recruited in November 2021 but resigned in February 2022 before they had registered with us. During our inspection, we were introduced to a new manager who was due to start with the organisation.
- The provider had not taken sufficient action to make improvements based on the findings of our last inspection. At our last inspection we found audits and quality checks were not robust, did not drive improvement and did not ensure the provider was meeting their regulatory requirements. At this inspection we found audits and quality assurance checks continued to be ineffective. A medicine administration record we reviewed was noted to have been audited and no areas for improvement were identified. The audit had not identified the date of birth for the person was incorrect. Audits had not identified incorrect information about people's health needs. Audits and quality checks had not always ensured information was shared with us and other organisations as required, for example after people sustained injuries. The provider shared this information following our inspection.
- Quality assurance systems had not been effective to make sure staff had information about people's capacity to make decisions and how to support them in their best interest if they lacked capacity.
- Where areas for improvement were identified with staff practice, recommended actions were not always completed which meant we could not be assured improvements had been made.
- Staff told us they were not always able to contact a manager when they required support or advice. A member of staff explained that although there was always a manager scheduled to be on call outside of office hours, the on-call phone was often not answered which meant they were unable to gain support if

needed. One member of staff said, "Trying to contact managers is a massive problem when on shift. Like the on-call manager, if there is a problem, you can't get them at all."

●Staff told us they did not always feel supported by managers or the provider. One member of staff told us, "I do not know anything about the management, there is no handbook, I don't know who is who really. We don't get regular visits from the managers, they used to visit the homes, but managers never visit the homes anymore, ever."

● People and relatives told us they were not regularly contacted by the provider to give their views of the service. A person told us they were not asked for feedback from the provider and did not feel confident the provider would respond to feedback. A relative told us, "I don't get to hear a lot from the managers. They need to be more in touch with families. I don't get any communication."

● At our last inspection we found an open and honest culture was not promoted within the service and concerns raised by people were not acted on appropriately. At this inspection we found the provider had given staff additional training about upholding the values of the organisation, but this had not been embedded with staff. Staff we spoke with were not aware of the findings of the previous inspection or were dismissive of the concerns raised, stating the concerns had not been about their 'area.' The attitude that the concerns were not relevant to them meant staff were not acting in an open way and did not feel responsible about improving the culture of the organisation .

● People and relatives were not aware of the outcome of our previous inspection or the work being undertaken by the provider to make improvements.

● Staff were not always aware of how to whistleblow. Whistleblowing is when a person raises concerns of poor practice or concerns within their organisation. A member of staff told us, "I have no idea what that is. I've never been trained on whistleblowing."

Systems were either not in place, or robust enough, to demonstrate that there was adequate oversight of the service. This placed people at risk of harm. This was a continued breach of Regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider told us they had issued staff with information of how they could raise concerns which included a dedicated phone number and email address.

Working in partnership with others

● Since our last inspection the provider had worked closely with the local authority safeguarding teams and external consultants to make improvements within the service. Actions had been identified, for example creating new care plans and new quality assurance systems. However, these were not complete or had not been in place for long enough at the time of this inspection to see the impact the changes had made.

● At our last inspection we had identified concerns about how people's finances were managed by the provider. The provider had worked with the local authority to identify alternative arrangements for people and a number of people had new appointees in place or were in the process of arranging this.

●The provider was in the process of arranging independent advocates for people supported by the service who were not able to share their views of the care they received.