Precious Homes Limited

Elderberry Mews and Mulberry Court

Inspection report

80 Kings Road
Sutton Coldfield
West Midlands
B73 5AE

Tel: 01213926935

Date of inspection visit:
08 August 2019
09 August 2019

Date of publication:
15 January 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Precious Homes Limited provides personal care to people in their own homes within a supported living setting in18 self-contained flats. The flats are split into two units known as Elderberry Mews and Mulberry Court. Each flat consists of a bedroom, lounge, kitchen and bathroom. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service provides personal care to younger adults who have learning disabilities, autistic spectrum disorders or mental health needs. At the time of the inspection there were five people receiving personal care at the service.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support. People did not consistently receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

At this inspection in August 2019 we found serious concerns about the management of people's medicines. Medicine errors were not identified, or action taken to mitigate risks. This exposed people to actual harm. People had been subjected to unsafe staffing levels and inadequate care and support. Incidents were not consistently recorded, monitored or reviewed to improve people's safety. Actions to support people with their behaviour had not been identified to reduce risks to their safety. Allegations of harm or abuse were not always recognised, investigated or referred to external agencies, to promote people's safety at the time they occurred.

Staff had not received training and support and their competencies were not checked to ensure they worked to the required standards and were able to meet people's needs. People had access to a variety of healthcare support. However, this was not coordinated in a timely way to ensure people new to the service had access to a GP. People were supported to have maximum choice and control of their lives. Staff knew how to support people in the least restrictive way possible and in their best interests.

People were relatively new to the service and their support plans were still at the development stage as staff began to understand people's needs and preferences . People and their relatives were being involved in this process. People had not always received care from staff they were familiar with, this had affected the consistency of care they received. Relatives said people had not always been well supported, with a lack of consideration for peoples' diverse needs.

The provider had made some recent changes to how the service was managed and led this meant that people's needs had started to be responded to with more consistency. Relatives stated they were happy with the improvements that were being made to staffing levels, and skills mix. Relatives described individual staff as caring and could see that positive relations with people were developed with the regular staff.

Relatives had felt their concerns and complaints were not always listened to or acted upon. However, they were confident with the new management team in place and the level of consultation they were currently having.

The provider's quality assurance system failed to identify that care and treatment was not provided in a safe way or that this newly registered service was adequately resourced to meet people's needs. Audits did not identify serious concerns with medicine management, staffing levels and skills and the management of incidents and risks.

The provider had undertaken an analysis of incidents and a lessons learnt report. A review of incidents to identify safeguarding concerns had taken place, with retrospective safeguarding referrals made. The provider had acted on their duty of candour and shared information about the current issues within the service with people who used the service.

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

This service was registered with us on 28/03/2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about unsafe medicines management, staffing levels, and concerns shared with us about people's care. A decision was made for us to inspect and examine those risks.

Due to unforeseen circumstances there was a delay in the report being completed and published following inspection and a further inspection visit has taken place. For more details, please see the most recent report which is on the CQC website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to medicine management, staffing levels, training and staff supervision, and good governance arrangements for monitoring the care provided at this inspection.

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

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always effective.
Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.
Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.
Details are in our well-led findings below.

Inadequate

Elderberry Mews and Mulberry Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and one assistant inspector on both days of the inspection.

Service and service type
This service provides care and support to people living in 18 supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

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

the Local Authority and professionals who work with the service. We had received concerns prior to the inspection about unsafe medicines management, staffing levels and skills, and people's care. We took this information into account when planning the inspection.

During the inspection
We met three of the five people who lived at the service and we spoke with two relatives, eight staff, and three members of the operational team. We reviewed a range of records across the two services provided. This included five people's care records, medication records, incident reports, two staff files, and staff training records. A variety of records relating to the management of the service including policies and procedures were reviewed.

After the inspection
Following our inspection, we received several updates from the provider and copies of their own investigation reports. We continued to receive feedback from commissioners of the service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed or administered appropriately to make sure people were safe. People did not have their medicines as prescribed which had placed them at risk.
- Relatives and external professionals expressed concerns about the safety of people's medicines. They told us of occasions where medicine was not given or too much was given.
- Medicine administration records from May 2019 to August 2019 showed there had been several errors where people either did not have their medicine or had too much. For example, there were three occasions where people were administered too much medication over a twenty-four-hour period. The registered manager had not identified these errors for themselves and had not taken any action at the time of inspection. In one incident, the person's daily records indicated the person had experienced adverse symptoms from this medication error and the person's relative expressed concern about the affect this had had on the person.
- Staff did not follow the prescriber's instructions for 'as required' [PRN] medicines. PRN protocols were in place with guidance for staff regarding when and how to use such medicine, which reflected the doctor's instructions. However , these instructions had not been followed which had resulted in a person having too much medicine. The registered manager had not identified this error and had not taken any action at the time of inspection.
- There were three occasions where people did not receive their regular daily medicines to manage symptoms of their medical conditions. This could potentially put people at risk of experiencing unnecessary symptoms due to not taking their medicine as prescribed.
- We found examples where prescribed creams had not been applied within the prescribed instructions.
- As a new service there was little or no evidence that medicine errors had been picked up or acted upon which increases the risk to people using the service. Staff responsible for administering medicines had received medicine training in their initial induction, and a competency check had been carried out before they administered people's medicines. The provider was not aware of medicine errors at that time, they were not identifying which staff were making errors to ensure that action could be taken to ensure they administered people's medicines safely.
- Discussion with the management team identified that they recognised medicines had not been managed safely and they had begun to improve their checks and increase competency assessments on staff administering medicines. Whilst their checks identified two further errors in the days before the inspection, this also showed mistakes were still being made. Without staff being skilled enough to administer medicines safely, people were at increased risk of unsafe medicine practices.

The provider had failed to ensure people received their medicines safely which left people at risk of harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

● We received concerns prior to our inspection that people were not always safe at the service because of insufficient numbers of staff with the right skills being available. There was a high use of agency staff which caused a lack of consistency for people. People within the service had a learning disability and autism. Providing staff who have the knowledge and skills to understand and support people's complex needs is really important so that people are supported by staff who they are familiar with , and who understand their unique needs to provide continuity of care and minimises people's distress.

● We found the service did not always provide enough staff that have the right mix of skills, competence or experience to support people to stay safe.

● People had been at increased risk of harm from ineffective deployment of staff. Prior to inspection, there had been a serious incident where a person had been left alone in their flat, when they should always have the support of two staff members. This had exposed them to a significant risk of harm. This incident was discussed with the management team who told us the incident was under investigation by both the provider and local authority safeguarding team. The provider had taken steps to reduce the risk of this happening again.

● Relatives told us they had raised several concerns about the inconsistency and impact on people from staff who did not understand people's complex needs and behaviour. Relatives said, "There was no organisation, staff are not allocated properly, staff don't know how to care for people". Another relative said, "We didn't always have the right number of staff or staff who had experience". Commissioners who purchase the service also informed us of an occasion when people had not received the 2:1 support they needed.

● Staff told us they had struggled to manage people's needs. A staff member said, "Prior to now, (the last few weeks), it has been a nightmare, agency just not turning up, not enough staff with the right training". This had impacted on people not having consistent support and an increase in behavioural incidents. Rotas showed a high proportion of agency staff had worked between April and July 2019 when the service first opened. There was no system in place to show that the skill mix and experience of staff was kept under regular review to make sure that people received consistently safe support.

● There had been a significant number of incidents during the previous few months. A relative described the impact of different staff on their family member. They said, "Staff didn't understand how to communicate or support [person] with their behaviour which made them more upset and caused more behaviours". During this inspection, we saw the provider had reviewed these incidents and concluded the service was not adequately recruiting staff with the right skills. Their analysis of incidents concluded that not all staff had been trained in the management of actual or potential aggression, (MAPA). This is a range of techniques used where people may display behaviour that could be described as challenging. It is designed to help staff keep people safe. Where people who have a need for staff to have this training were supported by agency staff, situations may not always have been managed safely.

● At the time of this inspection, we saw the provider had started to improve staffing levels and the skills mix of staff. Experienced staff from the providers other service had been deployed to work at the service. Staff told us this provided them with support and guidance.

● We saw rotas had been reviewed and planned to meet the dependency needs of people. As a result of the re-deployment of staff to the service, the use of agency staff had significantly decreased. Relatives told us they had noticed improvements in how people were being supported.

● We saw that these recent changes meant that staff were available in the right numbers to support people in line with their assessed needs. A person told us, "I'm much happier now; I've got my own staff; I didn't like agency staff".

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● The provider's systems and processes were not fully embedded to protect people from potential harm or abuse. A serious notifiable incident of failing to provide staff to support a person (neglect), had occurred within the service. The provider had failed to escalate this to the local safeguarding authority as soon as they were alerted to the incident.
● There was evidence that prior to the inspection. people had been exposed to harm from unsafe medicine practices. This included failure to provide people with their prescribed medicines and causing potential harm by administering too much medicine.
● During the inspection the management team showed us that they had recently identified incidents of a safeguarding nature from their incident analysis report. These included incidents of self-harm and unsafe medicine practice which had not been reported and escalated in line with local safeguarding procedures. We were told that these had now been shared with the local authority safeguarding team retrospectively for investigation.
● We also saw systems had been put recently put in place to review key areas of potential risks to people's safety. These will need embedding to ensure that people receive safe care, and that these will enable the early detection by the provider when things have not gone well,to ensure that changes are made quickly to reduce the risk of a reoccurrence We will assess the effectiveness of these systems at the next inspection.
● The staff we spoke with had training in safeguarding people from abuse and understood the different types of abuse people may be subject to. However, they told us that staff concerns about people's safety had not always been listened to.
● When things went wrong with people's care, the approach to reviewing and investigating the causes had not been robust. During the inspection, we saw the management team had conducted a lessons learned exercise and acknowledged there had been missed opportunities to review concerns shared by staff some months previously with the on-site manager. These concerns had not been escalated to the provider to identify issues affecting people's safety.

Failure to operate systems effectively to protect people from abuse or improper treatment is 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.

● There was some evidence of recent learning from events. During the inspection we saw the management team were trying to develop a consistent approach to safeguarding. For example, systems were in place to review incidents as they occurred, so that any actions needed to improve people's safety could be put in place. Management staff were reviewing incident reports, medicine practices and information coming into the service that might affect people's safety and identifying where these needed to be escalated to the local authority safeguarding team.

Assessing risk, safety monitoring and management
● We found risk management plans were not always clear. Prior to the inspection, actions to support people with their distressed behaviour had not been identified or recorded so that staff had the information they needed to reduce risks to people and their own their safety.
● During the inspection we saw the provider had carried out an analysis of incidents which had been reviewed by their multi-disciplinary team, (MDT). We saw actions to support each person with their behaviour had now been identified and added to people's support plans. For example, strategies were in place for reducing people's anxieties, managing physical harm towards others and risks associated with people undertaking activities. When staff have imbedded these strategies, this will help to promote people's independence to do the things they enjoyed whilst remaining safe and minimising any distress to them .
● The provider had arranged for the (MDT) lead to be based at the service in response to the concerns they

had recently become aware of. This was to support staff in using the right techniques and approaches when working with people. This meant people were receiving a more consistent approach to their needs. Relatives said staff were now working more consistently with people which had reduced the number of incidents occurring.

● We saw that strategies for managing a person's choke risk due to eating too quickly were in their care plan and staff were able to describe how they supported the person with this risk in accordance with the risk management strategy.

● We found that some risk assessments did not have enough information to guide to support people safely. For example, a care plan identified a person was at risk of dehydration. There was no subsequent risk assessment in place to guide staff how to manage this risk to ensure the person remained hydrated .

● Prior to our inspection, concerns had been shared with the provider about out of date food supplies being available in a persons' flat. The person's care plan identified they needed assistance to shop for food but there was no control measures in place to guide staff about the level of assistance needed to ensure they had enough food and that the food available was safe to eat We were able to corroborate that the person had food supplies.

● Emergency evacuation plans were in place to support people in the event of a fire. These were being updated with information relevant to the individual and their environment. The provider had acted to ensure agency staff, who had previously not had a security fob, were issued with a security fob to enable them to access and exit the building in an emergency.

Preventing and controlling infection

● We saw that staff wore personal protective equipment when supporting people with aspects of their care. People had been supported with keeping their flat clean and hygienic.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were assessed prior to admission to the service. This had involved the individual and or relatives and appropriate healthcare professionals. The assessments had not been effective in ensuring that systems were in place to meet people's needs upon admission to the service. For example, a relative told us whilst their family members' diverse needs were assessed, the service was 'not prepared' in terms of delivering effective care. For example, providing staff with the right communication skills to support the person.

Staff support: induction, training, skills and experience

- Staff did not all have experience, training or skills to support people who had complex needs including a learning disability and autism. The provider was not monitoring the skills of care staff in these areas to ensure that staff were competent to deliver effective support and that they had appropriate training and supervision.
- Relatives and staff told us that people were not always supported effectively with their behaviour and at times the staff approach had caused an escalation of a person's behaviour. A relative said, "At times it made the behaviour worse because staff didn't know how to manage the behaviour". Feedback from an external professional identified that staff were not always applying their MAPA training effectively in terms of supporting a person, and in protecting themselves. Staff required refresher training in terms of (MAPA) because they were not consistently applying the training.
- During the inspection we saw a MAPA trainer had recently been placed on site to support staff to use the right MAPA techniques. Staff told us this was improving their confidence in using their training.
- Competency checks on staff use of MAPA were not in place to ensure staff applied their training effectively.
- There had been several medicine errors within the service. There were ineffective systems to ensure that all staff who administered medication were competent to do so, and no checks were in place to ensure staff were given additional support when they had made medication errors. The management team told us they aspired to establish regular competency assessments to ensure staff applied their training to the required standards.
- Staff spoke positively about some of the training that they had completed, which had included autism and some training on communication skills such as Makaton; a form of signing. However staff had not undertaken specific training related to peoples assessed sensory processing difficulties, including sensory

awareness and positive behaviour support. This is training that was relevant to the people using the service to ensure staff could support people in the way that they needed. This meant staff were not equipped to provide effective support to people. For example, they did not understand when to provide people with personal space which had led people demonstrating further distressed behaviours that challenged staff.
● We were told the provider was reviewing additional training and intended to provide other workshops to support staff in meeting people's assessed needs.
● Several staff told us, and records confirmed, that they had not received regular supervision in which to reflect on their practice. One staff member said, "The support has been poor". Staff told us that recent management changes in the service had been positive; they felt they could now seek and receive support and guidance. A staff member said, "The last couple of weeks you can see the improvements". We found staff supervision was not fully established to review staff practice and promote a good quality of life for people.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's care and treatment needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● People had not been consistently supported with planning their meals around their food preferences. A relative told us when their family member first moved into the service, this support was inconsistent. They said, "Staff chose the food and planned the meals, [name] was not actively involved in choices".
● Another relative expressed concern that staff lacked knowledge about nutrition. They explained certain high calorie foods had caused a person side effect. The persons' care plan lacked information related to their dietary needs and the importance of menu planning. In both instances the menus were planned by the relatives, to ensure their family member had a suitable diet. Families had provided laminated menus and communication systems to support people to make meal choices.
● We asked staff how they promoted people's eating and drinking. Staff were able to identify people's support needs whilst eating, their preferences of what to eat and how they liked their meals to be presented. We saw that staff supported people with food shopping so that they had regular supplies of the foods and drinks they liked. A person told us, "I plan my shopping list every week with staff and plan my meals, I like my food".
● Some people required encouragement to eat and drink. Staff were able to describe how they promoted this. For example, by maintaining routines that were important to people when eating and drinking and understanding the importance of not disturbing people whilst they ate.
● We found there was a lack of consistency in the effectiveness of the support that people received in relation to their choices and nutritional needs. The management team told us they had recently become aware that some people had not been fully involved in menu planning and they were reviewing this to improve consistency and ensure everyone had the support needed to be involved in menu planning and choices.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Concerns were shared with us by an external professional about delays in registering a person with a GP. We saw the management team was working with the other agencies to ensure the persons' care was coordinated.
● Relatives told us healthcare was sought. We saw people were supported to access services; a person was being supported to attend hospital on the day of the inspection. Staff we spoke with were able to demonstrate that they had worked with the person and the health professionals over a period of time to

support the person to receive planned treatment. A person who used the service told us they had been supported to access health services; they were visiting the optician that day.

● Records showed people had access to other specialist healthcare professionals including mental health teams, occupational health and psychiatrists.

● People had health action plans identifying their health needs. These provided information about how a person should be supported when receiving health treatment. For example, if they need additional support when having tests at the hospital, or how they communicate pain.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We saw that staff sought people's consent and accepted their refusals. For example, when knocking on people's doors, we heard staff ask people if they wanted to meet the inspector and their refusals were respected.

● We saw people were assisted to make their own decisions using their communication systems. For example, whether they wished to follow their planned activity for the day.

● Best interests' meetings had taken place where circumstances indicated a specific decision needed to be made on behalf of a person. We saw records to verify this.

●Staff we spoke with were aware of which people were subject to an authorised DoLS and people's care plans identified what restrictions on people's liberty were in place.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- We saw that whilst individual staff were kind and caring towards people, the systems and processes implemented by the provider had not always supported staff to display their caring values. For example, people had not always received care from staff they were familiar with. This had affected the consistency of care they received. Relatives said people had not always been well supported, with a lack of consideration for peoples' diverse needs. There had been a lack of support for some people, as reflected in the feedback we saw from external professionals.
- During the inspection we saw people interacted with staff and appeared comfortable in their presence. Relatives told us that positive relationships were forming now that there was more continuity of staff. One person told us, "I like my staff, they treat me well; when I need help, or I am upset they help me".
- Two relatives told us their family members were happy living at the service. A relative said, "I know [person] is happy because when we are out they sign, 'home' to go back". Another relative told us that they were happy with the improvements they were seeing, and the attitude of staff, they said, "The keyworker is great; she knows [person] well. She has been thoughtful; she bought a big cork board for messages and is making a book about [persons'] routine to help other staff".

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

- People were supported to express their views. One person told us how they met with staff on a weekly basis to plan their personal timetable to include the activities they wished to pursue and their everyday living tasks. They told us how they had recently completed a course at college and wanted to put it in the newsletter to mark their achievement. They said, "I'm writing an article and staff are supporting me".
- We saw staff using Makaton to support a person to make decisions. The persons' relative told us, "Staff are much better at supporting [person] to make their own decisions, such as which clothes to buy or what meals to plan".
- There was evidence of developing and using people's communication aids such as social stories, pictures and symbols. These, and the use of 'Now and Next' boards helped staff to engage with people and support them to make decisions. Relatives told us they were being consulted and involved in care plans so that people's preferences and routines could be reflected.

Respecting and promoting people's privacy, dignity and independence

- Relatives told us people were being supported with their personal appearance and that personal care routines were established and followed. People had plans in place to support their dignity when out in the community.

● People's privacy was respected. Care plans identified when people might be expressing their wish to be alone and how staff should support this.
● People's independence was promoted; people were supported to varying degrees to shop and cook, manage their laundry and domestic tasks. A relative told us of progress they had noted in a person developing self-help skills. Feedback from an external professional reflected that a person was being encouraged to be much more independent than where they lived before, and becoming more involved in most daily domestic tasks within their flat.
● We observed staff promoting people's social skills. for example, supporting them to interact with the inspector.
● People were supported to maintain relationships with people who were important to them. Care plans provided guidance to staff about individual people's arrangements such as how they contacted family members and their preferred contact times.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
This is the first inspection for this newly registered service. This key question has been rated requires Improvement. This meant people's needs were not always met.

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

● People had not always been supported by staff who knew them and understood their needs and routines and therefore people did not always receive personalised care. For example, a recent incident days before the inspection showed agency staff were allocated to support a person who they did not know. The persons' care plan stated they should always be supported by staff familiar to them to reduce any anxiety this may cause.
● People had not always had the staffing levels they needed, or support from staff who had the skills needed to respond to their needs. This meant people did not always receive continuity of care. The provider had recently acted to improve the staffing levels and skill mix to meet people's needs. They had assessed people's needs and developed strategies to support people with their behaviour. Staff told us they had a better understanding of responding to people's anxieties and how to support their behaviour.
● People had only been living at the service for a short while. It is disappointing the provider did not have sufficient resources available to meet people's assessed need at the time they came to live at the service, this has resulted in people not consistently receiving the care and support that they needed. The steps the provider had started to now put in place needed to be embedded but relatives and staff had noted some improvements in the quality of the service provided to people.
● People and relatives were being involved in developing care plans. We saw these included information as to how people wished to receive their support and in identifying people's preferences and goals and the support they needed to achieve these. For example, promoting personal care and the routines and support needed to achieve this. Relatives told us staff were more familiar with people's routines and the response to people's needs was improving. Feedback from an external professional identified improvement in relation to a persons' personal care needs and in achieving their goals in self-help skills.
● A relative shared with us that there were limited choices for their family member to pursue their interests. The lack of staff who were car drivers had impacted on the person's anxieties, now making it difficult for them to leave their flat. They had shared this with the provider. At the time of inspection this had not changed, and the family were continuing to provide this support themselves.
● Our observations showed that staff could be responsive to people's needs. For example, we saw staff support a person who requested to go on a walk. We saw the strategies they used matched those in the care plan. Another person had been supported to follow their planned activities for the day, which included accessing the community. They told us staff responded to their needs by for example, meeting their requests to go out. We saw people were supported to follow their own routines for the day, which included support to cook, clean and engage in activities.
● People were supported to pursue their hobbies and interests and had weekly meetings to discuss/identify their plans. A person told us of all the places they enjoyed visiting, and the support they had to pursue their

goals with education.

Meeting people's communication needs
●The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard which requires providers to meet people's communication needs. People's communication needs were identified, recorded and highlighted in care plans. Staff supported people with their individual communication systems to share information. Easy read and pictorial documentation to help people understand written information was available.

Improving care quality in response to complaints or concerns:
● The provider had a complaints policy and procedure in place. A complaints record was also available to record complaints. Two relatives told us they had raised concerns with the on-site manager, but these were not resolved. Further analysis showed that these concerns had not been recorded or shared with the management team for action in a timely way in accordance with the providers complaints policy . The management team had identified from people, that their concerns had not been escalated and in response to this they had issued families with additional contact numbers to escalate concerns directly to the provider and management team which had meant that for these two relatives that they now felt listened to, and their concerns were being addressed. These related to the staffing situation. Relatives said they were confident that the changes in the management team in place meant that they would respond to their concerns.

End of life care and support:
● People using this service are younger adults. Care records showed that people and their relatives had not yet been asked about their wishes at the end of their life to ensure the provider is aware off people's wishes.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership.
Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There registered manager was not initially based on-site when the service was registered. The daily management of the service was provided by an on-site manager who had left the service prior to this inspection. The registered manager being based off site had contributed to the shortfalls in the service not being identified sooner. At the time of inspection, alternative management arrangements were in place with the registered manager and management team based on-site which was contributing to improvements needed being identified and addressed .
- We found that roles, responsibilities and accountability arrangements were not clear. For example, there had been a serious incident where a person had been left unsupervised, significantly compromising their safety. This incident had involved the decision making of the on-site manager and failure to ensure adequate staff were deployed to support people.
- The provider's governance and quality assurance systems were not used effectively to assess risks and monitor and improve the quality and safety of the service provided. It is disappointing that the providers systems had not been used effectively to ensure the quality and safety of this newly registered service at the time the service started to operate . This has meant that people experienced a significant period of time where they received sub optimal care.
- We found that the systems in place for monitoring people's medicines were inadequate and did not identify the concerns we found. This meant people experienced and were exposed to on-going risk of harm from not having their medicines as prescribed. The systems had failed to ensure the provider could identify where quality or safety of the support people received was being compromised.
- The monitoring of incidents that affected the safety of people was inadequate. There had been a significant level of incidents that had exposed people to the risk of harm which the management team were not aware of. We found during the inspection that the provider had carried out a recent full review and analysis of incidents and acted to support each person with their behaviour. However, incidents were not reviewed at the time they had occurred, or patterns or trends identified, and action taken to mitigate risks.
- Systems in place to record, monitor and analyse staff levels, skill mix and deployment of staff were ineffective and had not ensured that people were supported by the right number of staff with the right skills from the time they came to live at the service. Whilst some action had been taken at the time of inspection, this had left people at times exposed to the risk of harm.
- Audits had failed to identify that staff supervision and competency checks were not regularly carried out. This meant staff performance was not regularly assessed to help identify where improvement was needed.
- Safeguarding systems were not embedded and safeguarding information was not escalated to the local

safeguarding authorities at the time of incidents. As a result, people experienced and were exposed to on-going risk of harm.
● Audits had failed to identify that records related to people's needs did not always have important information. For example, strategies for managing a person's choke risk due to eating too quickly were in their care plan. The same risk was not recorded in their hospital passport which could mean they might not have the support they needed when away from the service.

The provider had not ensured that their quality assurance systems were used effectively to provide people with safe and good quality care and to drive improvement. The lack of oversight of the service had left people at risk of harm. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● During the inspection we saw the new management team had started to make some improvements. They had arranged meetings with staff, additional training, and competency assessments were being put into place, so that platforms were in place to support staff in their role. The responsibilities to monitor staff performance had been clarified across the management team. These changes need to be embedded so that people using the service benefit from being supported by staff who are skilled and supported to meet their needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not ensured a positive culture within the service that achieved good outcomes for people. Relatives told us the issues they raised did not lead to improvements. A relative said, "I raised concerns with [on-site manager], but I didn't feel they were addressed, but more recently I've been working with the registered manager and he gives me feedback".
● Staff did not feel they were listened to and that their views were dismissed. A staff member told us, "I told [on-site manager], what I thought; went in one ear and out the other". Another staff member said, "It was difficult because it was just, [on-site manager], no team, so nothing got done". For example, about unsafe medicine practices and staffing levels.
● We saw that management changes had occurred because the registered person had identified that the on-site manager arrangements had not been effective in identifying shortfalls within the service.
● Staff told us that in recent weeks since the management structure had changed, the atmosphere was more positive and inclusive and outcomes for people were more positive.
● Relatives told us they were now being involved with care planning of their family member to ensure that staff were aware of their needs and preferences.
● The relatives of two people who used the service told us their family members were happy and settled at the service and consistency of care had improved. A relative said, "We can see improvements and it looks like management are listening".

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
● Relatives told us they were not given a full explanation when things went wrong. For example, a relative told us they were informed of medicine errors, but not why they kept occurring.
● The provider did understand the duty of candour. They had written to people and their families expressing their wish to be open and honest and to apologise for the current failings in the service. We saw a copy of the draft letter to verify this.

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

characteristics; Continuous learning and improving care

● Relatives told us they had raised several concerns since the service opened but they did not believe these were escalated to the provider because they had no feedback and saw no improvements. One relative told us, "At times it was chaotic, the manager made promises that weren't kept". Another relative said, "I did share concerns with the previous manager, it didn't change things". There was no record of how people's feedback was captured or used to improve the service.

● Relatives told us they were now, [over the last few weeks], more involved and consulted which meant people's needs were being identified and plans to meet them, put into place. Relatives said they wanted the service to 'grow and succeed'. A relative said, "There were so many issues, but now they are improving, they, [the provider], is listening and has shown me what is being done".

● Staff we spoke with were positive about the management changes in the service. A staff member said, "Previously we were not listened to but there has been a massive improvement; managers are supportive and give guidance, we can discuss issues with them and they are listening".

● Whistle blower procedures were known to staff. We saw that the new management team had taken immediate action when they received this second alert. They also acknowledged that an earlier whistle blower alert had not been managed appropriately. Information provided to us post inspection from the management team, identified the need to provide staff with contact details of the provider and external managers so that information could be shared with the right people. The provider had addressed this.

● For a new service, there had been limited opportunities to share information with and obtain the views of staff because staff meetings had not been consistent.

●People had been involved in regular meetings with staff in which they could discuss their weekly plans and activities. A person told us, "I have my meetings and go through my weekly activity plan and discuss my menus".

Working in partnership with others

● Prior to the inspection the provider undertook a comprehensive investigation report into what went wrong, and lessons learnt, and this was shared with CQC and other relevant parties.

● An incident analysis was also undertaken, and the report shared with CQC. We saw evidence of learning taken forward from these during the inspection.

● The provider acknowledged there had been serious shortfalls across the service and missed opportunities to recognise and manage emerging risks. They had already undertaken a lot of work to improve 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people received their medicines safely which left people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to operate systems effectively to protect people from abuse or improper treatment is 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.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent skilled and experienced persons to meet people's care and treatment needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that their quality assurance systems were used effectively to provide people with safe and good quality care and to drive improvement. The lack of oversight of the service had left people at risk of harm. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The enforcement action we took:

We have issued a warning notice.