Optima Care Limited

Shine Supported Living - South East

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Shine Supported Living - South East is a supported living service registered to provide personal care. The service provided care and support to seven people with a learning disability or other complex needs living in supported living' settings, so that they can live in their own home as independently as possible. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. Two people were in receipt of personal care when we visited.

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

People were not being protected against abuse. There were instances of harm taking place at the service where appropriate action had not been taken by the provider to mitigate the risk of harm occurring again. The local authority were not always being informed when safeguarding incidents occurred.

The behaviour that challenged people was not being managed in a safe way. Behaviour charts were not being completed for people where required to do so. Staff had not always received appropriate training to ensure they could meet people's needs. There were not always sufficient staff to safely support people.

The leadership at the service was not robust and there was not sufficient auditing by the provider to review the quality of care provided. Notifications were not always being sent to the CQC when it was appropriate to do so.

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

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People were not always supported with their independence. Staff did not always have an understanding of the support and care people needed to enable them to have a fulfilled life.

Right support:
• Model of care and setting did not maximise people's choice, control and Independence

Right care:
• Care was not person-centred and did not promotes people's dignity, privacy and human rights

Right culture:

• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives

Following this inspection, we worked closely with local authorities to ensure people were safeguarded from ongoing harm. Two people were supported to move out of the service.

Rating at last inspection (and update)

The last rating for this service was Requires Improvement (published 10 January 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found sufficient improvements had not been made and the provider remained in breach of regulations.

The service is rated as inadequate in the key questions Safe and Well Led.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We received concerns in relation to people being safeguarding from the risk of abuse. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.
We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shine Supported Living - South East on our website at www.cqc.org.uk.

Enforcement

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

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people not being protected from the risk of neglect and abuse, risks related to the care being provided to people, the lack of suitably qualified staff and the lack of robust provider and management oversight at this inspection.

We took action against the provider and cancelled their registration at Shine Supported Living. Everyone who received a regulated activity has moved out of the service, and we have de-registered Shine Supported

Living with the Care Quality Commission.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Shine Supported Living - South East

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Our inspection was completed by two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a new manager working at the service who supported us on the inspection.

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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
Due to the complex needs of people using the service we were unable to speak with them or observe care. We did not want to cause anxiety to people with our presence. We spoke with four members of staff including the manager and care staff.

We reviewed a range of records. This included two people's care records and their medication records. We reviewed a variety of records relating to the management of the service, agency staff profiles and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one relative of a person using 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.

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

At our last inspection of the service, we found the provider had continued to ensure risks to people were appropriately managed, and we found people were still at risk of unsafe care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider still in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

- We found that care plans did not always contain up to date and relevant information concerning the risks associated with people's needs. At the previous inspection we identified that one person, who was at high risk of constipation, did not have the appropriate monitoring in place in relation to their bowel movements. At this inspection we found the recording was taking place however there was no risk assessment or guidance in place in relation to their constipation.
- The manager told us that both people using the service were at risk of choking. They told us one person had a recent incident where they had choked on an apple. Despite this neither of the care plans contained a choking risk assessment in place.
- One person had behaviours that were challenging which put themselves and other people at risk. The manager told us on the morning of the inspection that the person had, "No real challenging behaviour." However, the manager told us the person could pinch the other person they lived with. One member of staff told us, "She does pinch but she thinks it's a game." There were no strategies in place for staff on how best to support the person with this. We saw there had been several incidents where the person had pinched and bitten another person.
- Another person had a condition with significant associated health risks for them. There were no assessments in place related to the specific risks associated with this. The manager told us they had typed them up but not printed them off yet. One member of staff we spoke with was not aware of the person having this condition.
- Accidents and incidents were not always recorded and analysed to look for trends which meant there was little opportunity for lessons to be learned when things went wrong. Staff told us of multiple incidents where one person frequently pinched another person. We looked at the accidents and incidents audit that had been recently completed by the provider. We noted that the only two incidents had been recorded relating to this behaviour in October 2020.
- The manager told us that incidents relating to this behaviour were recorded on an ABC chart. An ABC chart is a direct observation tool used to collect information about events that are occurring within a person's environment which affects their behaviour. However, when we asked to see the ABC chart for the person, they told us staff were not completing them.

Using medicines safely

● The management of medicines was not always undertaken in a safe way. According to their Medicine Administration Record (MAR) one person was required to have their medicine for epilepsy, "With or just after food." However, according to the person's daily notes on 3 March 2021 they were given their medicine at 08.10 before they had their breakfast at 08.35.

● On the day of the inspection we identified a gap on one person's MAR on the 21 February 2021. Staff had either forgotten to sign that they had administered the medicine, or the medicine had not been given. We spoke with manager about this who said they would investigate this. However, we were sent the MAR chart after the inspection and it had been signed retrospectively and there was no record of an investigation. We noted on the MAR sent to us there were another four gaps for the 7 March 2021. This omission was not identified by the member of staff administering the person's medicine in the evening and was not picked up until the day after. There was a risk people were not receiving their prescribed medicine.

● Although medicine training was provided to staff each year assessments of their competencies to administer medicines was not always taking place. There were signatures on people's MAR charts for staff that had not had their competency assessed based on the information from the manager. The medicine policy stated, "Risks will be managed, monitored and mitigated by the following mechanisms: Training and competency checks for all relevant staff." The policy on this was not being followed.

● Although weekly medicine audits were taking place these were not effective in identifying errors. For example, an audit undertaken on the 23 February 2021 had not picked up on the gap on the person's MAR.

The failure to always manage risks associated with people's care in a safe way was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● A relative we spoke with had concerns about their family members care. They told us often when their family member went home to visit, they would, "Come home with scratches around her neck, bruises on her arms and a bite make on her shoulder." They told us on one occasion recently their family member had a bruise that was going yellow. They said, "I think she gets bruises because there isn't enough staff."

● People were not being protected from abuse and harm. Staff told us that one person would frequently, "Pinch" the person they were living with in a forceful way. One told us, "(Person A) might grab (person B). They said person B would often have marks on their body, "I don't know where it's come from." The manager told us, "She (person A) can pinch (person B) quite hard or pull her top." Despite knowing this, sufficient steps had not been taken to reduce the risks to (person B).

● Although staff were knowledgeable on what constituted abuse and that they would report instances of abuse they were not putting this into practice. There was no formal recording of when the person A had harmed person B. This was despite staff being reminded to do so as stated in the minutes of a staff meeting in November 2020. The minutes stated that all staff were to record these incidents on a behaviour chart. The local safeguarding authority had not always been notified of these incidents of abuse.

Failure to ensure people were protected from the risk of abuse was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● There were insufficient staff deployed to keep people safe from harm: staff did not have the right skills, training or competencies to support people safely or to meet their needs. This had a major impact on people's safety. Both people at the service had behaviours that could be challenging. However, staff that were allocated to support both people had not had training in positive behaviour support (PBS). We asked

the manager whether agency staff had received PBS training. They told us, "The agency, they've told me it's part of their induction. I am pretty confident in the ones who come to me are okay." However, when we checked the agency profiles, they had not had PBS training.

● One person had epilepsy and their care plan stated that staff supporting them would need to have training around this. Although substantive staff had received this the agency staff that were supporting the person on a regular basis had not.

● When agency staff worked at the service, they were not always given an appropriate induction into the care that people needed. One member of agency staff told us that on their first day at the service they were given a short handover from the member of staff going off duty. They told us, "It was stressful. It wasn't easy. I was on my own on the first day." We asked them if they had read any summary care plans for people when they first started and they said, "No, as I was busy and on my own." They told us they had never worked with people that had a learning disability before they started at the service.

● In addition to staff not having the right training or skills, there were insufficient staff deployed to ensure people's needs were met in a safe way. This had a major impact on individual people's safety. The manager told us that each person was required to have a one to one with a member of staff during the day. The need for this was also confirmed in one person's care plan that they required a one to one from a member of staff. However, a staff member confirmed that two staff had only been allocated for the week prior to the inspection. They told us, "Until recently, there was one staff member from 07:00 – 12:00. Until this week there was regular lone working." This was also confirmed by the manager later in the day. A relative told us, "I was told there would be staff for each of them last week, but this should have been in place already." Another member of staff said they worked on their own with both people on their first shift at the service. After the inspection we were notified that the staff levels had reduced again to one member of staff for the morning shift.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Preventing and controlling infection

● 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 using PPE effectively and safely.
● 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 well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the previous inspection we found that there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 17.

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

- At the previous inspection we identified that the leadership, auditing and governance was not robust which meant that the quality of care was poor. At this inspection we found this had not improved. There was a lack of management and provider oversight and we continued to find shortfalls that had not been picked as sufficient audits were not taking place.
- There were ineffective systems in place to robustly check the quality of care. We asked the manager to send us the audits that the provider had undertaken. The last audits took place in April and August 2020 and actions raised from that had not always been addressed. For example, it stated that resident meetings needed to take place and that incidents and accidents need to be analysed monthly. Neither of these had been actioned. The lack of auditing had been raised as a concern at the previous inspection, yet steps had not been taken to address this.
- Daily notes were task-focused rather than person-centred. Staff were recording that personal care and meals had been given. These lacked person-centred information such as how the person felt throughout the day and what conversation topics were spoken about. Despite there being prompts on the notes to do this. This information can help provide responsive and personalised care to a person. One person's summary care plan had important information at the front of the file relating to the risk management for one person. However, the page was torn and could not be read which meant new staff may not be aware of this particular risk.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- There were agency staff that had been working at the service for a long period of time. They told us they had not been invited to attend any staff meetings or received any formal supervision. The manager told us, "I would like to make them feel part of the team. If we are having a team meeting and they happen to be here, then I would invite them." However, the agency staff we spoke with confirmed they had never been

asked to attend. This was despite this being raised as a concern at the last inspection.
● A relative fed back that they struggled to get hold of staff at the service. They told us, "There is no phone there. She (their family member) has come home before with the wrong medicines. We had to drive all the way back to sort it as there's no one to phone."
● Staff fed back they did feel supported by the manager. Comments included, "There have been lot of positive changes. I feel listened to. She's approachable. Hands on as well" and "She is very supportive." However, staff were working a 12-hour shift and were not allocated a break despite staff telling us they would like one. Employment law states, "An employee has the right to an uninterrupted break of at least 20 minutes if they work more than 6 hours in a day." We spoke to the manager about this, they told us, "I will pop over and ask them if they want to step out." They acknowledged this was not a formal break.
● People's needs at the service were not always considered. Both people had been moved from one bungalow to next the bungalow next door. One person preferred to have a bath and were able to do this in the previous bungalow. However, there was only a shower in the bungalow they now lived in. This meant they were having to go next door each time they wanted a bath.
● There was no system in place to gain people's views or to hear their feedback about the service. No meetings for people had taken place despite the audit in April 2020 stating that these needed to take place. There had also been no surveys with people, staff or families since 2019. Again, this was mentioned as an action on the April 2020 audit. One member of staff said of the survey they completed in 2019, "Surveys were done but we don't receive any feedback."
● The manager and staff worked with other external organisations in relation to people's care. For example, we were present whilst the manager spoke with a speech and language therapist in relation to the management of one person's eating and drinking. However, there were instances where health care professionals needed to be contacted in relation to concerns about people's care. For example, it was noted in a staff meeting in January 2021 that staff were concerned about one person's compulsive behaviour. The note stated the manager was going to refer the person to a psychologist. However, there was no evidence this had taken place and no record in the person's care plan around this behaviour.

As quality checks and leadership was not robust this is a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. However, this was not always taking place.
● After the inspection we identified instances of safeguarding that should have been notified to the CQC, but no steps had been taken to do this by the provider in a reasonable time. For example, in January 2021 one person was physically abused by another person. However the CQC were not made aware of this until March 2021.

As notifiable incidents were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent CQC notifications where required to do so.

The enforcement action we took:

We have cancelled the registration for this location.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people received safe care and treatment.

The enforcement action we took:

We have cancelled the registration for this location.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from abuse.

The enforcement action we took:

We have cancelled the registration for this location.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established to operate the service effectively.

The enforcement action we took:

We have cancelled the registration for this location.

Regulated activity	Regulation

Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient suitably qualified staff deployed at the service.

The enforcement action we took:

We have cancelled the registration for this location.