FitzRoy Support

Jellicoe Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Jellicoe Court is a supported living service providing personal care to both younger and older people who have a learning disability or autism. The service was supporting 15 people at the time of the inspection.

The service has not been fully developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This guidance 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. People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service had been commissioned by the local authority to support people with disabilities to achieve independent living. It accommodated up to 18 people in separate flats. This is larger than current best practice guidance. People had tenancy agreements with the housing association which managed the building and people were supported by the provider. One person retained input from their previous provider as per their choice.

People's experience of using this service and what we found
The service had been inadequately led. Commissioners had placed two people in the service, whose challenging and aggressive behaviours meant they were not suitable to be accommodated in this location. One person had since moved, but staff and people remained at risk of experiencing aggression from the remaining person and the safety of people and staff could not be assured, until this person moved to more suitable accommodation for their needs. Staff reported they did not feel fully safe working with this one person.

The provider although aware of issues within the service in relation to people's safety and in particular staff's safety, had failed to take robust action to protect them. There was a lack of robust systems to monitor and evaluate the quality of the service provided to people. There was a lack of evidence to demonstrate people's views on the service had been sought. Records were incomplete, inadequate and not always there, for us to review. There was a lack of analysis of incidents and complaints to identify and address any trends.

The previous registered manager had recently left the service and had not led it well. They had not ensured their legal responsibilities were always met. They had not promoted an open and transparent culture. This meant commissioners and CQC had not been fully informed of all safety events at the service they should have been made aware of, for people and staff's safety.

People's risk assessments did not contain sufficient guidance for staff. There was a lack of written evidence to demonstrate identified risks to people and staff were all managed safely. People did not always receive their medicines safely, as robust records were not maintained to guide staff and ensure a complete record of

people's medicines administration.

People's care records provided staff with insufficient information to provide truly person centred care. Although permanent staff had a good understanding of people's care needs. This information was required in writing to ensure consistency across the staff team and to inform new staff. People were not always provided with information about their care in a format they could understand.

The provider had not ensured all relevant pre-employment checks had been fully completed on applicants to ensure their suitability to work with vulnerable people.

People were not always supported to have maximum choice and control of their lives although staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The provider had not always sought people's consent for their package of care, although people were consulted by staff about decisions related to their day to day care. Where people lacked the capacity to consent to the provision of their care legal requirements had not been met.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. People could not be totally free to make choices at all times due to the behaviours of one person, which impacted upon the safety of others. People's records did not provide staff with sufficient information about people upon which to base the delivery of their care. Although people appeared to be involved by staff in a wide range of external activities. People's records were not sufficiently complete to demonstrate best practice guidelines had been met.

People were going to be provided with accessible information about how to make a complaint. The provider was aware processes to capture complaints had not been sufficiently robust and planned to address this.

There were sufficient staff rostered to provide people's care. Staff recruitment was on-going. Staff reported overall they felt supported in their role. Records did not demonstrate they had received the provider's required levels of supervision and this was being addressed.

The service development implementation manager had evaluated the full extent of the issues within the service since they took day to day control in November and has prepared an action plan, which they plan to implement with the new manager. They have been fully open and honest during the inspection process about their findings.

People were treated with compassion, kindness, dignity and respect by staff. The staff demonstrated an interest in the welfare of the people they cared for and were knowledgeable about them. Staff involved people in day to day decisions about their care, including what they wanted do with their time and what they wanted to eat. Staff respected people's dignity and privacy.

People were supported by staff to attend a diverse range of activities in the community and had opportunities for stimulation and development.

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 29/03/19 and this is the first inspection.

Why we inspected
This was a planned comprehensive inspection.

Enforcement
We have identified breaches in relation to safe care and treatment, governance, consent, person centred care, notifications and requirements relating to workers.

Conditions have been placed upon the providers registration at this location.

Follow up
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 6 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 caring. Details are in our caring findings below.	**Good**
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**

Jellicoe Court

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.

Inspection team
This inspection was completed by one inspector.

Service and service type
This service provides care and support to people living in one 'supported living' setting, which has 18 flats, 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 does not have 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. The last registered manager had left the service on 27 October 2019. The service had been managed since 4 November 2019 by the service development implementation manager. The new manager for the service had commenced their role on 18 November 2019.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 12 December and ended on 16 December 2019. We visited the office location on 12 and 16 December 2019.

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 also reviewed information we had received about the service since they registered.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. We also spoke with a visiting social worker. We spoke with members of staff including five support workers, both deputy managers, the new manager and the service development implementation manager.

We reviewed three people's care and medicine records and three staff records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the local authority who commission the service and a second social worker.

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.

Assessing risk, safety monitoring and management: Using medicines safely

- The provider had not taken sufficiently robust action to protect people and staff from one person's behaviours which placed them at ongoing risk of assault. One person told us how they locked themselves in their flat when this person was aggressive. Another person told us staff protected them if anyone showed behaviours.
- Staff told us they did not feel fully safe working with this person. A member of staff confirmed they had been recently physically assaulted and this incident had been reported to relevant authorities. Records documented numerous incidents of physical aggression or threats, since April 2019.
- One person who presented with particularly challenging behaviours, could not manage with more than one member of staff in their flat at a time. Staff wore an alarm pendant when they entered the person's flat and there was CCTV to enable them to assess the person's mood before they entered their flat. However, this person's care could not be provided without placing staff at risk of physical assault.
- The person who lived in closest proximity to this person's flat was at the most risk from them when they became aggressive. Although staff knew the action to take if the person exhibited behaviours. There was a lack of a written risk assessment to provide staff with written guidance about how to protect the person in closest proximity from aggression if an incident occurred near their flat.
- Staff told us and records confirmed they had completed training, for working with people whose behaviour challenged. This training teaches behavioural techniques, to break away if people's behaviour challenges. Although refresher training in this area and training specific to the needs of the people cared for has been booked for January 2020. Staff told us the training they had received to date was not sufficient to keep them safe from one person's behaviours.
- There was a lack of evidence to demonstrate all incidents which affected people's health, safety and welfare had been reported to external relevant agencies as required. Commissioners had not been made fully aware of the full number and type of incidents which had occurred, where they involved aggression to staff, property damage or threats. To enable them to determine if further action was required and to monitor the service effectively.
- People had risk assessments in place. However two of the three people's risk assessments we reviewed were not robust, they did not provide sufficient information about how the identified risk to the person was to be safely managed. For example, one person's epilepsy plan provided insufficient information about how the person might present or how staff should respond if they experienced a seizure.
- This person was also at risk from weight loss. However, there was no plan in place to monitor their weight and records of their meals did not demonstrate they had eaten sufficient to maintain their weight. The risks to another person from weight loss had also not been addressed. There was no evidence anyone's weight

had been taken regularly to monitor where there were potential risks to them from weight loss.

The provider's failure to provide safe care and treatment safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.

Using medicines safely

● People did not always receive their medicines safely. People's medicine administration records (MARs) were not always clear which month the record related to. As at the top of the MAR it stated one month but then the daily record of administration related to a different month. For example, one person's MAR said it was for November but then the days of the month showed the record was for August. People's MARs did not accurately document what day or month the medicine had been administered.

● There were gaps in people's MAR records, with no explanation as to why medicine had not been given. One person had four gaps on their MAR for November 2019. There was a lack of evidence to demonstrate if they had received these medicines.

● A person's medicine records lacked a protocol for one of their medicines, they took 'as required' to guide staff in its use.

● Two of the people's records we reviewed had a medication plan. However, a recent care plan audit showed not all people had the required medication plans in place, to instruct staff.

● Four staff had not yet completed a medicines competency of their practice as required. Therefore the provider could not be assured of their practical competency in medicines administration.

● The provider's incident record showed there had been five medicines errors which had occurred from July to December 2019. Where actions were planned following medicines errors to reduce the risk of repetition. There was a lack of evidence to demonstrate these had taken place.

The provider's failure to manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.

●Training records showed all staff except new starters had completed medication training. Staff had access to the provider's medicines guidance. Staff had received relevant medicines training.

Staffing and recruitment

● People were at risk of being supported by unsuitable staff. Staff's recruitment records did not contain all of the information required. Two staff files lacked the date they finished full-time education, so the provider could not assure themselves of the date from when staff commenced work. There were gaps in the employment histories for two staff. One staff's file did not contain their references, to demonstrate their character. The provider had not ensured all relevant pre-employment checks had been robustly completed for people's safety.

The failure to ensure all of the pre-employment information required was obtained was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.

● The provider had ensured other relevant pre-employment checks had been completed. Such as checking the applicants identity and ensuring a Disclosure and Barring Service (DBS) check was completed before they commenced their role. The DBS check enables employers to check if applicants are unsuitable to work with people.
● Staff recruitment to the service had been an issue and the service development implementation manager told us there were currently 200 hours a week vacant. They told us recruitment had taken place and the vacant night staff roles had recently been filled. In the interim the vacant hours were covered generally by one agency, to provide continuity for people.
● Although one person told us they did not like being supported by agency staff. Overall there appeared to be sufficient staff rostered to meet people's needs.
● There was a shift leader for each shift and a staff allocation sheet was now in place, to ensure staff knew whom they were to support.

Systems and processes to safeguard people from the risk of abuse
● Staff had completed safeguarding training or were scheduled to do so if they were new. Staff had access to relevant safeguarding guidance. Staff spoken with understood what safeguarding was and what could constitute abuse. We saw evidence of referrals to safeguarding authorities.

Preventing and controlling infection
● Fifteen staff had completed infection control training and four needed to complete it. The service development implementation manager was aware of staff's training requirements and was making the required arrangements. Staff had access to relevant infection control guidance and equipment such as gloves and aprons.

Learning lessons when things go wrong
● Staff told us they understood when to raise concerns and had done so. The provider's incident log demonstrated staff had raised incidents when they occurred. Although there was evidence incidents had been reviewed. This process was not completed effectively, to improve the service for people. There was a lack of written evidence to demonstrate incidents had been used effectively as an opportunity to learn and reduce the risk of repetition.

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.

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.

- Two care plans reviewed did not contain people's written consent to the care provided. Neither was there a completed MCA assessment to show they lacked capacity to consent to their care or that a best interests decision had been made with relevant people to determine if the support proposed was in their best interests.
- The recent audit of care records completed by the service development implementation manager showed only one person's capacity had been assessed and this assessment required updating. The audit did not include whether people had given their consent to their care.
- There was contradictory evidence regarding one person's capacity to make decisions about their care and treatment. A psychiatric report said the person lacked the capacity to consent to their medication or treatment plan. The person had then signed their consent to their care. There was a lack of evidence to demonstrate their capacity to consent to their care had actually changed since the psychiatric report.
- Records showed staff covered the training topics of MCA/DoLS in four of the provider's training courses, rather than in one designated course, which would have focussed only on MCA/DoLS . Staff spoken with appeared to understand the application of the MCA as it applied to their day to day work. However due to the lack of mental capacity act assessments where people lacked the capacity to consent to their care, we were not assured those planning people's care with them had fully understood legal requirements to gain

people's consent or ensure a MCA assessment and best interest decision was made.

The provider's failure to obtain people's consent for their care or ensure legal requirements were met where they lacked the capacity to consent to their care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.
● One person had restrictions on their care. The service had correctly identified this person was potentially deprived of their liberty and social services were in the process of making a referral to the court of protection for authorisation. However, there was a lack of evidence to show how it had been determined the person lacked capacity to consent to the restrictions in place and hence an application was required.
● Following the inspection this evidence was provided. However, the provider should have ensured this was available on the person's records at the time of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's records did not contain a copy of their initial assessment. Following the inspection we were provided with copies of two initial assessments we requested for people, which should have been available at the inspection. These demonstrated the provider had completed a holistic assessment of people's needs prior to agreeing to the provision of their care.
● The provider's polices and guidance for staff reflected current legal requirements. However, there was a lack of evidence to demonstrate regulations or good practice had been consistently followed.
● Technology was used to support people where required. This included the use of door and bed sensors so staff knew if people got up or gone out and falls detectors, people could wear on their wrists. This ensured staff could monitor and respond to people as required.

Staff support: induction, training, skills and experience
● There was evidence staff had completed the provider's induction to the company and staff who were new to care had completed the care certificate. This is the industry standard induction.
● Staff told us they had received good training. The service development implementation manager was aware not all staff were up to date with their training and was taking the required action to ensure this was completed.
● Although staff told us they had received regular supervisions and observations of their work. There was a lack of records to demonstrate when they had received supervision or if they had received the number of supervisions required by the provider. Records demonstrated staff supervisions had been booked to take place in the new year.
● Records did not consistently demonstrate all staff had completed their probation or been offered an appraisal. However, staff told us they felt well supported in their role.

Supporting people to eat and drink enough to maintain a balanced diet
● People were involved in decisions about what to eat and chose what they wanted. We saw staff assisted people with the preparation of meals or with their shopping where they required this level of support.

Staff working with other agencies to provide consistent, effective, timely care
● Records showed people had input from other teams such as social services and learning disability teams. However, as highlighted in safe, we were not assured all relevant information had been fully shared to inform other services. Therefore other services were not fully aware of information which might have influenced their interventions and decisions, such as whether to place further people in the service.

Supporting people to live healthier lives, access healthcare services and support

● Although people told us they received support with attending their health care appointments, there was a lack of written evidence to demonstrate the support they had received.

● Care plans reviewed showed people had not received their annual health check or medicines review as per good practice. Only one person had a health action plan to say what their health needs were and how they were to be met.

● One person's care plan said they went for regular eye and dental checks. However, the audit of care plans completed by the service development implementation manager, did not demonstrate they had actually received this care. Their audit showed only four people had seen a dentist and these visits were all in the past two months. No-one had seen an optician or podiatrist. The service development implementation manager had identified this as an action on their service improvement plan. During the inspection the new manager showed us the proforma they planned to introduce to document and monitor people's health care appointments.

Good

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service.

This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were treated with kindness and compassion by the staff who provided their care. We observed people enjoyed the company of staff and appeared relaxed and content in their presence. Staff smiled at people as they interacted with them and were warm and reassuring in their approach. A person said, "Staff are kind and caring." A relative confirmed, They [staff] have a good rapport."
- Staff were observed to have time for people. They did not rush them but spent time with them. They provided people with information clearly and simply, so they could understand. A relative confirmed, "Staff stop and listen to people. They explain things."
- Staff understood how people communicated. Staff told us how one person liked things written down. Another person used some Makaton symbols, which staff had learnt during the course of their work.
- Staff demonstrated a good understanding of the people they cared for. They knew people's routines and what they liked and did not like. A relative said, "They [staff] understand them all."

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

- Staff involved people in day to day decisions about their care. We heard staff asking people about how they wanted their support provided. For example, asking them what they wanted to do and what they wanted to eat.
- Staff gave examples of where people's relatives were involved in decisions about their care. For example, attending multi-disciplinary reviews. Where people lacked a person to represent their views or wanted an external representative, they had advocates in place.
- Staff now had a clear allocations list which showed which staff were allocated to support whom across each shift. This ensured staff knew who they were to spend time supporting, and when.

Respecting and promoting people's privacy, dignity and independence

- Staff were heard to speak to people in a respectful manner. People's records were respectful to them.
- People's personal support was provided in the privacy of their own flat. Staff understood people's right to choice and privacy and these were respected.
- The purpose of the service was to enable people to live more independently. We saw staff supporting a person with their breakfast in their flat. They confirmed staff helped them to manage their cooking. People were also supported to manage their tenancy, their money, their time and their flat.
- People's families were welcomed and felt free to visit. A relative told us, "We have gone in both announced and unannounced."

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

- The recent audit of care records completed by the service development implementation manager showed large amounts of the providers required information for people's care plans was either missing or required updating. This included; people's one-page profile to provide a summary of their care needs. This would have been particularly useful for agency or new staff when supporting the person. Also either missing or incomplete were people's support plans, activity plans, risks assessments, hospital passports, behaviours support plans, health action plans and risk assessments. All information required by staff to provide personalised care.
- One person's care plan was extremely basic and did not contain sufficient information about the person and their preferences and goals to enable staff to provide fully person-centred care. A second person's care plan also contained limited information. Neither fully addressed the person's needs in relation to their physical, mental, social and spiritual needs. Although staff spoken with had a good knowledge of people. There was insufficient written information to inform the provision of people's care and to ensure constituency of approach between staff, especially if agency staff were working with the person.
- The provider required staff complete a 'end of month report' with people, in order to check if their care and treatment met their needs. One person would not have been able to participate in this process, but this was not documented. Another person's records, showed staff had last completed this process with them in February 2019. The third person's records did not demonstrate the end of month report had been completed. Staff had not implemented the provider's process to seek regular feedback from people about their care, to enable any required amendments to their care plans to be made.

The failure to provide sufficient information to enable staff to provide fully person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service development implementation manager was now fully aware of the above issues and was starting to take action for people.
- There was evidence people had multi-disciplinary reviews of their care with their social workers. A relative said, "We have had reviews attended by the social worker and the advocate." However, there were not clear records to demonstrate if everyone's care had been formally reviewed and when.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Only one person's records we reviewed had fully assessed their communication needs. This person also had a communication passport to inform other services of how they communicated in the event they transferred between services.
● However, the other two people's records we reviewed contained limited information about their communication needs. Staff had not documented if people required information about their care to be available in a more accessible format for them.
● Although people's care records were kept in locked cupboards in their flats. They were not truly accessible to them. As they could not access them without staff support and there was a lack of evidence to demonstrate they had been provided in a format they could understand if they wished to review them. One person told us although staff helped them read information, they would like it provided in an easy read format.

The failure to demonstrate information about people's care had been provided in format suitable for them was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Staff were seen throughout the inspection to be supporting people to access their local community to participate in a range of activities. A relative confirmed their loved one attended a day service and staff had explored opportunities for work with them. A person told us staff took them out to attend activities and on day trips. Another person told us they attended social clubs.
● Staff told us people were provided with a range of opportunities for stimulation, education, exercise, work experience and social interaction. They were supported to stay in contact with people who were important to them.

Improving care quality in response to complaints or concerns
● Only one person's records out of the three reviewed demonstrated they had been provided with the provider's complaints process in an easy read format. We spoke to the service development manager who told us they were aware of this and in the process of making the required arrangements.
● The complaints file contained two complaints, one of which did not relate to the service. The second complaint demonstrated it had been investigated and a meeting was held with the complainant.
● We were not assured all complaints had been captured and responded to, due to the lack of complaints records. The service development implementation manager was aware the recording of complaints was an area which required improvement.

End of life care and support
● The provider had an end of life policy in place and people's care plans contained documentation to capture their end of life wishes. Staff had not yet explored with people their preferences and choices in case of an accident.

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

- The provider had completed a quality assurance report on the service in June and July 2019. This highlighted risks related to people and staff's safety, aggression, staff retention, incomplete records, people's support plans and staff burnout.
- The provider also completed an environmental report in June 2019. This highlighted the building was not designed for use as a secure setting and was close to the main road. It stated it was unsuitable for caring for people with aggressive behaviours. The service accommodated two people at the time who exhibited significantly challenging behaviours.
- Although the provider's own audits of the service demonstrated the risks to people and staff were known by them. They did not take effective action to address the risks they had identified. One person who exhibited aggressive behaviours has since left the location. However, people and staff remained at risk from the second person. There was a lack of robust action at the time in response to the issues highlighted in the two audits, to manage the identified risks and improve the service for people.
- Although work has continued with commissioners to find a more suitable placement for the second person, staff in particular remained at risk of physical assault when providing their care. Staff had experienced physical assaults since the provider's audits of June and July 2019.
- Risks to people and staff's health and safety had not been properly assessed, monitored or mitigated. The environmental audit of June 2019 noted not all incidents had been documented on the provider's central recording system to evidence the increased risks associated with the location or to justify additional resources to support staff.
- The provider was unable to demonstrate all incidents had been reviewed for any trends. For example, there was no evidence the information from the 171 recorded occurrences since 25 April 2019 had been used to identify trends.
- The provider has continued to agree to provide care to new people since their June 2019 audits highlighted the significant level of risk to people, staff and others. Records showed since the start of June 2019, a further four people had been placed, despite the ongoing risks to people and staff. The provider had not acted on the outcomes from their own audits to keep people and staff safe.
- Staff were not given time to assess new people and settle them before new people moved in and on one day two people moved in on the same day. People have been moved in to the service too quickly for staff to identify, flag and manage any potential risks to them.

The failure to operate effective systems to ensure compliance with Regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.
● The previous registered manager did not ensure all required notifications were submitted to CQC as legally required. There were three occasions when incidents were reported to the police but the required notification was not made to CQC. There were seven records on the provider's electronic occurrence records system where safeguarding incidents were reported to the local authority, but CQC were not notified as legally required.
● The provider's records showed two notifications were made to CQC which CQC did not receive. This meant CQC were unaware of the full number and type of incidents in the service to enable us to monitor it effectively and take the required action.

The failure to submit all statutory notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The previous registered manager had left their post on 27 October 2019. The service development implementation manager had then taken temporary charge of the service. A new manager who had experience as a registered manager started their role on 18 November 2019 and they were just coming to the end of their induction.
● The new manager was fully aware of the challenges of the service and the depth and complexity of the issues. They provided two examples of services, where they had previously driven improvements, which indicated they had the required skills to manage this service.

Continuous learning and improving care
● Processes were not in place to assess, monitor and improve the quality of the service provided. The service development implementation manager told us they had not been able to locate any audits when they took over day to day management of the service on 4 November 2019. They told us areas of the service which should have been audited by the previous registered manager and were not, included, medicines, housekeeping, health and safety, care plans and records. We also identified issues across these areas.
● The service development implementation manager had completed a care plan audit since they took charge of the day to day running of the service on 4 November 2019. This had identified numerous gaps in care records, including care planning, risk assessments, behavioural support plans, mental capacity assessments and medication plans. Records were insufficient to provide people with safe and effective care.
● Records were not accurate or complete. The service development implementation manager's audit of care records had found gaps across all aspects of people's care and medication records. Two of the three people's records we reviewed, contained minimal information, whilst the third person's records had been updated since the service development implementation manager's arrival and contained sufficient information to provide their care. There were gaps in the daily records and medicine administration records for the three people reviewed.
● Staff told us paper records were scanned, uploaded and then destroyed. The service development implementation manager, told us they were not totally confident this process had been followed and records may have been shredded without being uploaded.
● Staff told us they had regular supervision, but there were a lack of records to confirm this.
● One person told us they had not always received all of their one to one hours from staff. There was a lack of records to show whether people had received their commissioned one to one hours.

The failure to operate effective systems to ensure compliance with Regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service development implementation manager was now fully aware of the above issues and was starting to take action for people.
● The service development implementation manager had completed an action plan for the service based on their recent audit which identified all of the issues we found. The action plan identified 25 areas for action which had been rated depending upon their urgency. They aimed to complete this by February 2020 with input from the manager and the two deputy managers. Although the time frame was ambitious. It demonstrated they had scoped the extent and depth of the issues since their arrival and commenced work to address them for people.
● The service development implementation manager informed us since scoping the extent of the issues, the decision had now been made for them to remain at the service, to support the new manager in implementing the work required. They told us there would also be input from the quality team in the New Year and the provider's behaviour support specialist. Staff expressed their confidence to us in the new management team as did commissioners of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had not sought or acted upon information from relevant persons to continually evaluate and improve the service provided. There was a lack of evidence to demonstrate people's monthly meetings with their keyworkers had taken place, to provide them with the opportunity to provide their feedback on the service. There was no evidence people, staff or professionals views on the service had been formally sought and acted upon, through for example, surveys.

The failure to operate effective systems to ensure compliance with Regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not fully supported or valued the staff team. They had been left at risk of aggression during the course of their work with people, as insufficient action had been taken to support them or keep them safe. They remained at risk of aggression whilst one person remained in the service whose needs could not be safely met in supported living. There was a culture of accepting aggression as part of the job.
● There had not been a culture of openness and honesty. The service development implementation manager told us the last registered manager was defensive and had obstructed senior managers from visiting the service. Although we could not corroborate this with the registered manager as they had since left, there was a lack of evidence to demonstrate there had been regular senior management presence and oversight at the service until November 2019.
● Despite the provider's awareness of the issues at the service in June 2019, there had been a lack of a clear strategy. The service development implementation manager told us there had been a change of area manager and the issues identified in the provider's June 2019 quality audit had been not been addressed.
● There was evidence of divisions within the staff team. The service development implementation manager and manager were now fully aware of these and determined to unite and drive the staff team forward together.
● The service development implementation manager was very open and honest throughout the inspection about the extent and scope of the issues they had identified and the actions they were taking to drive improvements.

Working in partnership with others

● The service has not worked effectively with other services to ensure suitable people whose care could be met within the service provided were given tenancies. The service development implementation manager told us they had informed Social Services they could not take any further admissions; however, this needed to be formalised to provide assurance the issues would be addressed before anyone new was provided with the service.

● There was a lack of a clear agreement with commissioners about who was suitable to be accommodated in this supported living location, where people with significantly challenging behaviours could not be safely managed. Based on our findings, the environment, staffing numbers and staff training were not suitable for two people who had been placed. This had led to an inappropriate mix of people at the location.

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

● No safety incidents had occurred which were notifiable safety incidents which triggered the duty of candour. No person cared for had died or experienced an injury likely to last more than 28 days or experienced prolonged psychological harm. The service development implementation manager understood their legal responsibilities to be open and honest with people when things went wrong.

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 failure to submit all statutory notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to demonstrate information about people's care had been provided in format suitable for them was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to obtain people's consent for their care or ensure legal requirements were met where they lacked the capacity to consent to their care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

	The failure to provide safe care and treatment safely and to manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate effective systems to ensure compliance with Regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure all of the pre-employment information required was obtained was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions were placed upon the providers registration at this location.