Precious Homes Limited

# Precious Homes Hertfordshire

## Inspection report

Oster House
Flat1, Lavender Crescent (off Waverney Rd)
St Albans
Hertfordshire
AL3 5UT

Tel: 01727420761
Website: www.precious-homes.co.uk

Date of inspection visit:
03 May 2022
05 May 2022
23 May 2022

Date of publication:
27 June 2022

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

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

About the service
Precious Homes Hertfordshire is a service providing personal care to ten people living with a learning disability, autism, mental health needs and sensory impairments at the time of the inspection. The service can support up to 15 people. At the time of the inspection 10 people were being supported with personal care.

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.

People's experience of using this service and what we found
Right Support
The service did not always support people to have the maximum possible choice, control and independence.

The provider failed to ensure staff supported people to take part in activities and pursue their interests in their local area.

People were not always supported to have access to health services in timely manner. Where people were involved in health services, actions identified were not always completed. This meant people did not always receive care that was safe and met their support needs. For example, people were not supported safely with managing their epilepsy.

Systems were not robust to ensure people were supported safely with their medicines. We found examples where people did not receive their medicines when they needed them which resulted in harm. There were other examples where staff did not adhere to PRN (medicines required as and when) protocols.

Right Care
People were not supported by a service that had robust safeguarding systems in place to report and respond to safeguarding incidents We found instances where there were safeguarding concerns, and these were not identified by the staff team or management. Leadership was not effective and did not identify that people were put at risk or subject to potential abuse. Where risks and potential abuse was highlighted to the management team, they failed to implement immediate systems to ensure people were safe.

People did not always receive kind and compassionate care. Not all staff protected and respected people's privacy and dignity or responded to people individual needs.

The provider failed to ensure staff were appropriately skilled to meet people's needs and keep them safe. People had limited opportunities to pursue interests that were tailored to them. The service did not give people opportunities to try new things that enhanced and enriched their lives. People did not receive support that looked at their long-term aspiration.

Right culture
The provider failed to ensure staff received appropriate training and support to understand people's individual needs and provide enabling support to people. The support people received was not in line with current best practice guidelines. We found evidence of a closed culture in operation.

Staff turnover was high, which meant people did not always receive consistent care from staff who knew them well.

The provider failed to develop effective governance and quality assurance system to assess the quality and safety of the support people received. There was a lack of effective audits and actions being taken when things went wrong. Actions were not always documented, and it was unclear if actions were completed but the provider. This meant improvements were not always made to improve the care people received.

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

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 October 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.  This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, supporting people with health needs and the overall management of the service. A decision was made for us to inspect and examine those risks.

The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to a safeguarding investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of epilepsy. This inspection examined those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive 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.

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

We have identified breaches in relation to keeping people safe with medicines, safe manual handling, supporting to maintain people's health, providing person centred support, the leadership and governance systems at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Inadequate

The service was not effective.

Details are in our effective findings below.

**Is the service caring?**

Inadequate

The service was not caring.

Details are in our caring findings below.

**Is the service responsive?**

Inadequate

The service was not responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Precious Homes Hertfordshire

**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 2008.

Inspection team
The inspection team was made up an inspector and a pharmacy inspector.

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

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

At the time of our inspection there was not a registered manager in post, however there was a manager in post who was going through the process of applying to be a registered manager.

Notice of inspection
This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with five people who used the service about their experience of the care provided. Where people could not communicate verbally, we used different ways of communication using object and their body language. We spoke with 19 members of staff including the manager, deputy manager, operations' manager and support workers. We spoke with four professionals who have had regular involvement with people using the service.

We reviewed a range of records. This included five people's care records and six medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to have robust system to demonstrate the provider had oversight of improvements needed relating to medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was in continued breach of regulation 12.

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

- People's risk assessments were not clear or coordinated with the information stated in the care plans. There were a number of examples where we saw significant risks had been identified but risk management strategies were not clear or did not indicate how to support people in the key documents. One example being, one person was not supported with safe manual handling, nor did they have the appropriate equipment to support them. Staff described that at times they would manually lift the person to help with transfers. This put people and staff at serious risk of harm if they person was dropped, or staff fell.
- People were at risk of harm where staffing levels were not always sufficient or, there was insufficient deployment within the service. For example, staff fedback that they were not always given breaks which put pressure on them. A number of staff spoke about times where people were commissioned with one to one support due to their epilepsy needs, but staff were either not with the person or were not following correct processes to make sure they were safe. This put people at significant risk of harm.
- People who had epilepsy did not have the correct monitoring in place at night to ensure people were safe. Following partner agency recommendations to put safety measures in place, we found this wasn't embedded, which meant the management team could not be assured staff were supporting people safely at night. We found people did not have the correct epilepsy equipment. We asked for immediate assurance following the first inspection visit, these actions were not completed, we visited a further two times and these were still not embedded.
- Where accident and incidents occurred where people and staff were put at risk of harm, these were not always reviewed to implement improvements. One staff member said, "No debrief, you might get a phone call from the deputy to say are you OK, we do not sit down as there is never a time. Incidents happen after management have left."
- From the first inspection visit, safeguarding's had been raised which were shared with the manager. On the second and third inspection visit it was evident that not all identified concerns had been shared with the staff team nor actions implemented to mitigate those risk reoccurring.

Using medicines safely

- People were not always given medicines as directed by the prescriber. We found a number of examples

where people were either not given medicines when prescribed or they had been administered outside of the prescriber's reason. For example, we found one person had not been given important medicines to stabilise their seizures due to being asleep. Following this the person had a seizure.

● Another example, where a person became anxious staff administered medicine that managed their anxiety, however this record showed that six out of the nine occasions it was administered it was not in line with the protocol in place. Therefore, we could not be assured that staff were administering medicines safely as prescribed.

● Most people had one or more medicines prescribed to be administered when required (PRN). However, PRN protocols did not have the correct information about medicines to support staff to safely administer them. For example, we saw that a person had been prescribed a PRN laxative, however the PRN protocol had information about a different medicine which is used in the management of anxiety instead. Therefore, we could not be assured that staff administered PRN medicines safely and appropriately to people.

● When PRN medicines were administered, we found that staff were not consistently recording the outcome of the administration. For example, we saw that one person was administered a medicine used to manage anxiety, however records of the outcome of the administration were not fully completed. Therefore, we could not be assured that when PRN medicines were administered to people, if the desired therapeutic effectiveness of the medicines had been achieved or not.

● People with epilepsy had specific care plans in place, including emergency medicines administration protocols to support staff. However, we found that the care plans did not always have up to date information about people's current medicines. This could lead to confusion about what medicines people are currently prescribed.

● People were not always supported by staff who were adequately trained to administer emergency intervention medicines. We found during the period of one month (April and May) on 19 occasions untrained staff were lone working with people who were prescribed intervention medicines in the event of a seizure. This meant that there was a risk of delay in the person receiving this medicine, which could cause serious harm or potential death.

Preventing and controlling infection

● People were not protected from the spread of infection. The service did not have effective infection, prevention and control measure to keep people safe. We observed staff not following government guidance when using personal protective equipment (PPE). We found staff either not wearing masks or not wearing them correctly. This put people at risk of cross infection.

● People were not always supported to ensure they lived in an environment with a good level of cleanliness. For example, we found one person's bathroom dirty and outside of the grounds there was rubbish bins overflowing.

People were at risk of harm. Systems were either not in place or not robust enough to demonstrate safety was effectively managed. This is a continuing 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

● People were not always kept safe from avoidable harm or treated with respect and dignity. For example, a person spoke about how they were left at night in a wet bed because staff would not come when they needed support. They go on to say staff would then use disrespectful language which made them feel upset.

● People were supported by staff who either did not recognise or report abuse. Staff failed to recognise potential safeguarding incidents and had not reported these to their manager or to external safeguarding teams. We shared this with partner agencies, this triggered well-being checks for people. In total eight

potential safeguarding's had been identified by us the Care Quality Commission (CQC). For example, medicine management, incidents relating to undignified care and epilepsy management.

● A number of staff raised concerns about the lack of support people received and gave a number of examples where they found staff leaving people without support during the day and night. One staff member said, "The concern is the staff, they are neglecting the service users they are not fit to work. Staff are leaving the service users for longer period of times in the day and night." Another staff member spoke about night staff congregating in the office and not in the flats with people.

● Risk assessments and support practices in some instances included unjustified restrictions. For example, one person's kitchen door was locked without consideration of the least restrictive measure. There were no risk assessments or care plans which detailed the reasoning for this and if this was in the person's best interest.

● Where we raised concerns to the management team actions were not addressed immediately. When speaking with staff, they stated they had raised concerns in the past and these were not actioned. One staff member said, "I feel quite nervous to bring things up. When we had our first team meeting, I had a whole list of things. Some of them were actioned, there were loads that had not been actioned."

● Where safeguarding's and risks emerged, the management did not gather the information to look at the trends and themes. This meant the manager and staff team were not able to learn from these concerns which meant that people continued to be at risk.

People were not protected from abuse. Systems were either not in place or not robust enough to prevent people from potential abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The manager did not always arrange shift patterns so that staff were able to have regular breaks. One staff member said, "If there is a lack of management or staffing you will go through shifts where you cannot go to toilet or go for lunch."

● Staff we spoke with said they were short staffed, and this put pressure on their day, however they tried to do their best by people. This was evident by our observations; staff took an active role in tasks but failed to encourage people's independence with everyday living skills.

● People expressed a wish for regular staff and were anxious when there were short notice changes to the rota. One person said, "Staff going off sick, changing the rota at list minute makes me upset, very upset and very distraught."

● Staff spoke about the high turnover of staff, which meant people did not always receive consistent care from staff who knew them well. One staff member told us, "There is a high turnover, people get fed up. A lot of the people need a lot of emotional support. It feels me with dread who am I working with as they may not know the people we support."

● Staff recruitment and induction training processes were in place, such as references and criminal records checks. One staff member said, "Induction, I had training online and two days face to face and manual handling. I have been on a lot of training since, quite varied and detailed."

Inadequate

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received relevant and good quality training. We found staff to not have essential training for their role such as manual handling and epilepsy. People who had epilepsy were being supported by staff who did not have training in epilepsy or administering emergency intervention medicine. This put people at significant risk.
- People were supported by staff who were performing manual handling where they had not had the correct training. In addition, where staff had training, they did not adhere to safe moving and handling practises.
- People said they felt staff needed additional training to understand their specific health need. One person said, "I think they need to have more training, particularly about autism."
- Staff said they did not always have the right skills and felt this needed to be developed. One staff member said, "I do feel like other staff need epilepsy training, and they need more detailed training, for the service users that we have, not just a generic epilepsy." Another staff member described a time where a person had a seizure and the staff member, they were working with was not able to support the person safely.
- Where there were documented incidents of the use of restrictive practice, the management team did not hold debriefing meetings or reflected on their practice to consider improvements in care.

People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care records were not always updated in a timely manner when changes were made by healthcare professionals. This meant that staff might be following guidance that was no longer suitable for the person they were caring for.
- Care and support plans did not always reflect people's needs and long-term aspirations. Support did not always focus on people's quality of life outcomes or meet best practice guidance. We found examples were care plans did not accurately reflect the health professionals' guidance.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

- People were not always referred to health care professionals to support their wellbeing and help them to live healthy lives. For example, during the inspection we found one person needed an urgent referral

making. When checking if this had been completed on an inspection visit, we found this had not been done.
● Where people had involvement from health care professionals, we found a number of occasions where actions following these appointments had not been completed. One professional said, "Appointments were missed, it seems to be a similar pattern for other therapies. A lack of contact makes it feel is it because staff are not bothering to attend."
● People were able to choose their food, people led planned their meals they wanted. Where people needed support with dietician input this was done. Staff encouraged people to eat a healthy and varied diet to help them to stay healthily.

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 found a lack of evidence of best interest decisions and mental capacity assessments.
● Staff knew about people's capacity to make decisions through verbal or non-verbal means; however, this was not always documented. This meant there was a risk that decisions made for people might be unlawful or not in their best interests.
● Where a Court of Protection application had been submitted there was evidence that this was being chased up by the management team.

Inadequate

# Is the service caring?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People did not always receive kind and compassionate care from staff. People's preferences and views were not always respected. For example, we spoke with two people who said they did not like it when staff were using their mobile phones. We observed staff to be on their personal mobile phones during visits. On one occasion one person was very distressed and the staff member supporting this person had headphones in their ears and not engaging in conversation.
- People did not always feel listened to. One person said, "We do not have conversation we sit there being quiet. I don't like it because they don't know you well."
- We observed a staff member having a conversation with a person where they were expressing concerns about the support they received. The staff member supporting the person at the time called them a "liar".
- Staff did not always respect people's dignity. A number of staff gave examples about how they have found people to be left in wet clothes due to staff refusing to support with personal care. One staff member said, "I often find service user wet as staff refuse to clean service user." Another staff member told us, "[Person] required cleaning, I do that mainly because I do not have the heart to put them to bed without personal care. The other staff will put [person] to bed without supporting them with this."
- Despite this, we had feedback from a number of staff who spoke fondly of the people they supported and shared concerns relating to some of the language and approaches other staff had and shared some examples of this.

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

- People did not get the opportunity to shape their support through residents' meetings. At the time of the inspection the management team were starting to implement this.
- Relatives were involved in the care people received; however, where people were not able to advocate for themselves, they did not have an independent advocate to support them with expressing their wishes and how they wanted to shape their support.

Inadequate

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Peoples care and support plans did not always focus on positive outcomes to improve people's quality of life. There was limited evidence that staff supported people to identify aspirations for the future. Where wishes were identified they were not always personalised or meaningful to the individual.
- Peoples needs were not always met, and people were not supported to persue things that interested them. Care plans and records indicated people did not have the opportunity to do things they enjoyed. For example, one person's care plan stated they enjoyed going out for walks and attending hydrotherapy. During a four-week period they did not do any of these things and records indicated they stayed in their flat listening to music and watching TV.
- Staff did not always consider people's individual needs and promote choice and control. For example, we asked people what they did with their day. One person said, "I don't have a social life, I am not helped to do anything I enjoy. There are no days in a life of me, there is nothing, this environment does not help, and staff do not help."
- Staff raised concerns about how some people spend their time and that people were not always encouraged to do things to broaden their horizons and develop new interests and friends. One staff member said, "In the early evening, I will walk in and [person] will be in bed and staff will be sitting in the other room watching TV." Another staff member told us, "I never see [person] go out, maybe just once a week.
- Professionals gave mixed views with how peoples care was person centred. One professional said, "I do not feel [person's] care is person-centred. I feel [their] care is more box ticking. I would not describe [person] as thriving and staff do not encourage activities or spend time encouraging [person] to try different things."

The support people received was not person centred, did not consider people's individual needs or promote choice and control. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Another professional said. "Overall, I feel the staff there do a good job of supporting the residents to be as independent as possible and fulfil their potentials. Staff will contact me appropriately to review people or report any issues, and I generally feel the communication to be good."

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.

● People said they have experienced times where staff had not understood them. One person said, "Some staff don't understand [person], sometimes they want immediate support and because staff do not understand them, they have an accident."
● Where people required there were visual symbols that were in place for people and staff to use, however staff said this was not always effective. Care plans did not always detail clear processes for people to communicate their care and support needs or cover people's individual communication needs. Staff said the best way was to support the individual and get to know the person's non-verbal cues.
● People's care plans were not accessible for the person. Further consideration was required to ensure people had full access to all information about their care, in an accessible format. The manager had plans to develop this.

Improving care quality in response to complaints or concerns
● People, and those important to them, could raise concerns and complaints. However, we had feedback that actions that had been raised a number of months ago had not been addressed. For example, staff continued to use their mobile phones, people continued to have support that was not responsive to their support needs.

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 now 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 our last inspection the provider's systems were not robust enough to demonstrate the provider had oversight of improvements needed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made in relation to the systems in place. We found additional areas of improvement needed to managing medicines. This meant the provider was still in breach of regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not ensure there was adequate and consistent leadership in the service. The roles and responsibilities were not clear, which meant that actions and improvements were not always implemented.
- The provider did not identify people were supported by staff who did not have the correct training. For example, epilepsy and manual handling. This put people at significant risk of harm.
- The provider lacked oversight of certain aspects of the care and care records being completed for people using the service. Care plans and risk assessments did not cross reference to other areas of people's care.
- The provider's leadership team did not have a robust quality assurance system in place. Audits, monitoring systems, oversight and governance were not effective in identifying or driving improvements needed. For example, the management team failed to identify actions needed in relation to the lack of assistive technology to keep people safe. There was also a lack of clarify in the care plan and risk assessment documents which put people and staff at risk of harm.
- Where immediate actions were requested following safeguarding concerns, the management team had not ensured these were addressed across the service.
- The provider did not ensure they had a manager registered with the Care Quality Commission. During the inspection we were made aware of an application being sent. It was requested this to be completed as part of the inspection process. At the time of writing the report the application form had still not been received.
- Our findings from the other key questions inspected showed that governance processes had not helped to keep people safe, protect their human rights and provide good quality care and support.

Quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This is a continuing breach of regulation 17 (Good

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback from this inspection the provider had implemented additional resources into the service and were working closely with the local authority.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider failed to meet best practice guidance in relation to the supported living model and did not consider key elements relating to right care, right support, right culture guidance.

● Support for staff from the management team was inconsistent and morale was low. Staff said supervisions were not consistent. One staff member said, "Staff welfare is really bad, the staff morale is awful."

● Staff felt they were not always listened to and valued. Some staff described the culture of the service as closed and they did not feel safe to be open about their views. One staff member told us, "I don't feel safe. I do not get any support, there is a lack of communications." Another staff member said, "I sense a huge confidentiality issue where I do not feel safe, even now, disclosing how the service is run. Previously, when people have whistle blown, everyone finds out, managers tell seniors and seniors tell their 'friends'.

● The management team had not recognised support practices did not promote person-centred, open and empowering care and did not recognise the importance of respecting people's homes and staff boundaries. For example, staff did not always use language that was respectful. We observed staff not respecting how people wanted to be supported and recognised the way they were working was not kind or promoted a positive culture.

The culture of the service failed to support the provision of high-quality care and support. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● One professional we spoke with felt that when they were involved in the care for people, staff were approachable, however at times there were a lack of communication between the management team. Another professional said, "It does sometimes take a long time for management to get back to me regarding queries, and despite copying in all management staff. There is only one person that seems to reply with information. I feel [staff] is involved and does know the service users very well, but as the other management staff do not tend to engage with communication, I do not feel they get involved enough." This meant there was a risk of people's care not being as joined up as it could be.