Coghlan Lodges Limited

Coghlan Lodges

Inspection report

335b High Street
Slough
Berkshire
SL1 1TX

Tel: 01753535921
Website: www.coghlanlodges.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Coghlan Lodges is a 'supported living' service. The service provides 'personal care' to people living in nine 'supported living' settings, so that they can live as independently as possible. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

At the time of our inspection, the service provided support to five people received 'personal care' in three of the nine 'supported living' settings.

People's experience of using this service and what we found
The provider had taken action in response to our previous inspection but this was not effective. The lack of comprehensive and robust oversight by the provider meant shortfalls had been missed and action was not taken to prevent the service from falling below an acceptable standard. This meant people's quality of life suffered. We received mixed feedback from staff about senior management; some felt supported and others did not always feel listened to. The provider did not analyse or produce outcomes from information gathered from people using the service or staff to develop the service.

We have made a recommendation the provider develops systems which encourage and respond effectively to feedback from people, staff and other stakeholders.

People did not receive safe care and support. Fire risk assessments and safety measures were not adequate to reduce the risk of harm. People's specific needs were not risk assessed effectively. The provider did not operate systems effectively to ensure safe staff were employed. People were not supported by sufficient numbers of staff. Infection control measures were not followed by staff and chemicals were not always stored safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's needs were not always assessed or delivered in line with current guidance. Staff did not co-ordinate effectively with each other or other agencies to provide consistent, effective, timely care. People did not benefit from suitably trained staff to meet their needs.

We have made a recommendation that the provider updates care planning documentation to reference appropriate nutritional guidance and ensures information is provided to people about healthy food options.

The provider did not ensure people received care which consistently promoted their privacy, dignity or independence. People and their relatives were not always involved in decisions about their care. People told us they were satisfied with staff with comments such as, "Staff are alright, doing the best they can" and "Staff

are generally caring and always pleasant." We observed staff were caring in their interaction with people.

People were dissatisfied with the lack of personalised activities at the service and opportunities participate in the community. Information contained in people's care plans was sometimes generic and did not respond to their individual needs. People's care plans included information about their communication needs but strategies to support people were not always fully developed. There was a complaints procedure and complaints were followed-up by the registered manager. The service explored with people their end of life preferences.

We have made a recommendation the registered manager seeks information from a reputable source about the Accessible Information Standards (AIS) to ensure people are given information in a way they can understand.

The service did not always 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; limited inclusion and lack of choice and control. For example, people felt they did not have enough opportunities to participate in the wider community. The provider could not evidence how people were included in decisions about their care or how the service was run.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 18 December 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations and remains inadequate. We also found new concerns at this inspection.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coghlan Lodges on our website at www.cqc.org.uk.

Enforcement
At this inspection we have identified breaches in relation to, person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding people from abuse and improper treatment, good governance, staffing levels, safe staff and informing the Commission of incidents.

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means

we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

We met with the provider after the inspection to gain assurances that action was being taken to address the immediate risks to people. The provider submitted their action plan to us and kept us informed of progress made to reduce risk.

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?

Requires Improvement

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

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.

Coghlan Lodges

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
The inspection was completed by one inspector and one specialist advisor (registered mental health nurse) on days one and two. Days one and two were completed by one inspector and the specialist advisor, day three was completed by three inspectors and days four and five were completed by one inspector.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on day one of the inspection and the remaining four days were announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

We used all of this information to plan our inspection.

During the inspection
We visited three locations and spoke with four people who received personal care, one person's representative, four care workers and an area manager. We visited the office and spoke with the registered manager, who was also the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the service manager, the business development executive, the finance manager and a quality and compliance consultant. We wrote to eight commissioners and received five replies. We received feedback from four safeguarding local authorities, three quality monitoring teams and three social workers.

We reviewed parts of five people's care records including care plans, risk assessments and medicines administration records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including staff rotas and policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

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

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from abuse. Systems and processes were not always established or operated effectively to prevent abuse of service users. This was a breach of regulation 13 (Safeguarding service users form abuse and improper treatment) 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 still in breach of regulation 13.

• People were not protected from the risk of financial abuse. The provider had reviewed and developed a new financial procedure in April 2019, however this was not fully embedded or followed by managers or care workers. For example, care workers and managers failed to sign finance records which was against service policy. One person's finances were not reconciled for the month of May 2019 because the service manager said he did not have the time to take the finance book to the office. This meant the service did not monitor the person's finances and check they were not subjected to financial abuse.
• During our visit we found £30 of a person's money was unaccounted for in their finance records. A care worker told us they had reported this to the area manager that morning but had not recorded this anywhere. The service manager later told us a member of staff had taken the money to make a purchase for the person, however, they had not recorded this. We noted that only money spent was ever recorded rather than money taken out. There was no audit trail or account of when or how much money was taken or by who, which meant people were not effectively protected from the risk of financial abuse.
• People were at risk of physical and emotional harm because of neglect. For example, one person was assessed as needing staff support when out in the community. The person's care plan outlined that staff needed to support them to withdraw from arguments with members of the public and to calm down. However, there was no guidance or support strategies about how to achieve this. We found an allegation of abuse was made against the person in the community in May 2019; staff did not witness the incident or intervene because the person was not within their line of sight. A care worker said they would "hide" from the person if they became distressed or aggressive in the community. This did not meet the person's needs and put them and others at risk of harm.
• Staff were not clear about crisis intervention strategies to protect people and others from the risk of harm. One member of staff told us they would "get between people" to stop physical aggression but they were not trained in this. People had known behaviours that challenged and there were recorded incidents of physical

aggression between people using the service and towards staff. The provider neglected to consider their duty to intervene to prevent the risk of harm.
• The registered manager was the service safeguarding lead, but they had not received safeguarding training at a level proportionate to their role. This was important to make sure the service was up-to-date with legislation and guidance and had the skills to effectively assess, plan, intervene and evaluate the needs of people where there were safeguarding concerns. Staff received safeguarding training and said they would report to the manager, but staff were not familiar with the correct reporting procedures to the local authority.

The provider failed to establish and effectively use safe systems to reduce the risk of financial abuse. The provider failed to protect people who required behavioural and emotional support. This was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they planned to fully implement the finance procedure with immediate effect. They planned to review the person's care plan and staff support strategies, to meet the person's needs and prevent neglect. It was too soon to judge at this inspection whether these actions would be effective in keeping people safe.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff employed were of good character and had the correct qualifications and experience for their role. The provider also failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were employed. These were breaches of regulation 19 (Fit and proper staff employed) and regulation 18 (Staffing) 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 still in breach of regulations 18 and 19.

• The provider did not operate systems effectively to ensure suitable staff were employed. Recruitment checks for staff were not always in place. For example, there were gaps in employment history for four staff; only one reference on file in three cases without further exploration of the person's 'good character' and references were not always signed or dated. This was important to be able to check that references were credible and received before the provider allowed staff to support people.
• Interview questions were generic and documentation was incomplete with some questions left unanswered so it was not possible for the interviewer to satisfactorily assess the candidate's suitability for the role. Interviews were sometimes completed by the service administrator alone, which management told us and we saw was not in line with their policy.
• Recruitment procedures had been reviewed and developed since our last inspection and staff had checks via the Disclosure and Barring Service (DBS) at the time of our inspection. However, we found two occasions where staff had initially commenced work without a DBS check or risk assessment in place.

Recruitment procedures were not operated effectively to ensure checks were consistently made to ensure safe staff were employed. This was a continued breach of regulation 19 (Fit and proper staff employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and confirmed they planned to fully embed recruitment procedures to ensure safe staff were employed.

• There was no recorded method of calculating staffing levels on the rota to meet people's needs in line with agreed care packages, staff support hours or administrative duties such as staff supervision and training. The provider did not use a dependency tool to monitor, evidence or respond to people's changes in need to ensure the right level of support was provided.
• Two members of staff were employed at each of the three services at weekends which impacted negatively upon people because access to the community was restricted as a result. One location had two sleep-in staff, however this was not in accordance with people's care package which indicated one sleep-in and one waking staff were required. The registered manager told us the sleep-in staff would wake-up if people required support, but this was not the same provision as a waking night staff. This placed people at risk of not promptly receiving the care they required at night.

The provider did not ensure sufficient numbers of suitably qualified, competent skilled and experienced staff were employed. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action after our inspection to develop a method for calculating staffing on the rota and monitoring staffing levels.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Learning lessons when things go wrong
• The service did not effectively risk assess people's specific needs or identify fire hazards associated with people's needs. The provider did not have an effective system to manage risks in the premises. For example, we found urgent risks in relation to people smoking, unsafe storage and use of flammables and damage to fire protection equipment. A sharp kitchen knife was found in a place accessible to people where this was a known risk.
• Two people's risk assessments were not updated to include their current use of mobility equipment. Checks were not in place to make sure equipment was in good working order. Another person's risk assessment referred to a high risk of choking but did not list safe measures. Acute risks associated with one person's health diagnosis were not considered or documented.
• Chemicals including bleach were not stored safely in line with the control of substance hazardous to health (COSHH) legislation or the service's health and safety risk assessment.
• We found hot water in a bathroom at one premises fluctuated to a high temperature which put people at risk of scalding. A care worker reported this to management to take appropriate action. There were no records to evidence that staff checked the temperature of water or took remedial action where people required support with personal care.
• The provider did not operate effective systems to manage people's medicines safely. There was no procedure for staff to check and document received medicines. Medicines were not stored securely in line with legislation.
• There were gaps on a person's medicines administration record (MAR) chart during May 2019, which indicated they may not have received their medicine as prescribed.
• One person's emergency 'when required' (occasional) medicine was not printed on the MAR chart. A care worker was not aware the person had any 'when required' medicine. Allergies were not always recorded on people's MAR charts in line with national guidance policy.
• The training matrix indicated staff received training in medicines and the service manager told us staff were assessed as competent, however completed competency assessments were not recorded or evident in staff personnel files. We asked a care worker if their competency for administering medicines was assessed but they did not know what we meant. They did not know the procedure for managing spoiled medicines.
• Infection prevention procedures were not effective. Cleaning schedules were not adequate, the cleanliness of communal areas was not of a good standard; there were several flies in the kitchen and lounge area at

one property.
• There were no hand drying papers or toilet paper available in any of the communal toilet and bathroom facilities at one property. The business executive manager told us people kept toilet paper in their private rooms as one person was prone to blocking the toilet with paper. However, this was not recorded in the service infection control risk assessment and no consideration was given to how people should dry their hands.
• The infection control policy and procedure did not refer to the difference between infected and soiled laundry. Staff did not follow safe procedures for washing soiled laundry; we found soiled clothes soaking in a bucket of water outside the kitchen door at one property. The service manager said staff should have taken it to the laundrette.
• Incident reports were completed and reviewed by management who then documented some recommendations. However, records were not always accurate and investigations were not thorough. For example, where we reported the MAR chart gaps the service manager concluded this was a recording error rather than an omission of medicines. It was impossible to be sure about this as the person received liquid medicines and there was no stock control of bottles to check.
• We received feedback from local authority professionals and a person's representative that the service did not learn lessons when things went wrong. For example, poor and unsuitable transitions between services where people received regulated activities were repeated, which potentially put people at risk of harm.

The lack of effective risk assessments and systems to meet people's care needs, non-compliance with health and safety requirements and poor medicines managements was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They took immediate action to rectify urgent fire hazards. We prompted other actions needed to be in a timely manner which the provider responded to. The service reviewed people's risk assessment, arranged for safe storage of medicines and planned to review their procedures, secured chemicals in safe storage and improved cleaning procedures.

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 not inspected. The previous inspection rating was good (17 September 2017). 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

• People's health conditions and diagnosis were not adequately assessed or recorded accurately. One person's learning disability was incorrectly recorded in their care plan under 'Psychiatric diagnosis'. There was no epilepsy risk assessment or management plan for another person. At the time of our visit the person had been admitted to hospital following an epileptic seizure.

• One person, identified as being at high risk of choking, was not referred to a speech and language therapist for a swallowing assessment. Another person's eating and drinking care plan referred to out-of-date guidance for different levels of texture required to meet people's needs.

• People did not receive continence support in line with national guidance; the impact of moisture upon people's skin integrity was not considered which put them at risk of developing wounds.

People's needs were not adequately assessed to meet their needs and care was not always delivered in line with legislation and national guidance. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were suitably qualified, competent, skilled and experienced to perform in their role. This was a breach of regulation 18 (Staffing) 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 still in breach of regulation 18.

• People did not benefit from suitably qualified staff. Only one care worker out of 46 had gained a relevant vocational qualification and two other care workers had completed certificates for individual topics. Staff were not up-to-date with training. The provider told us they had improved the induction mandatory training this year from one day to three days, however a large proportion of staff had still not completed this training. The service manager said that updates were planned but this was not recorded on the training spread sheet the service gave us.

• Staff did not receive specific training to meet people's needs, such as dementia and epilepsy. Senior

management told us staff received a type of self-defence training. Two care workers, who supported people who were known to be violent and aggressive, told us they had not received this training. Staff said they felt they needed more training to meet people's specific needs.
• When staff completed their three-day induction training the external trainer issued staff with a Care Certificate. The Care Certificate is an agreed set of 15 standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. These standards need to be observed and assessed in the workplace rather than in the classroom. There was no system in place for the service managers to assess staff new to care against the Care Certificate standards.
• The provider had started to supervise staff from April 2019. We could not check for sustained and continuous improvement. There was no evidence of staff receiving appraisals.

Staff did not receive adequate support, training, professional development, supervision and appraisal to enable them to carry out their roles. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action after our inspection and confirmed they planned to arrange specific training to meet people's needs and planned to enrol staff for vocational learning in line with their role in September 2019.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans for people's eating and drinking needs were in place and referred to dietary and nutritional information, however it was not clear where the information came from. For example, one person's plan recommended they consume 2000 calories per day but there was not reference to a dietitian care plan.
• Menus were planned with people and we were told people could choose alternatives on the day. However, it was not evident how the service provided information to people about healthy options. Staff told us that one person ate ready meals most days and we saw another person's care plan stated they had a 'takeaway' meal every lunch time.
• People told us they were satisfied with meals with comments such as, "It's quite nice" and "Food is five star, [staff] do it well", but commented they had not had access to biscuits for a month. We saw some dried food including biscuits and cereals in the kitchen cupboards but no fresh fruit. Staff told us people were regularly supported to complete their grocery shopping and we saw some daily notes that supported this.

We recommend the provider updates care planning documentation to reference appropriate nutritional guidance and ensures information is provided to people about healthy food options.

Staff working with other agencies to provide consistent, effective, timely care
• The service did not always provide people with co-ordinated support when they transitioned between different services. We received feed-back from local authorities the service did not co-ordinate with others or consider the compatibility of people before transitions occurred.
• One person's representative said their hospital care plan was not up-to-date with correct contact details which impacted upon the person's discharge. We received feedback that a physiotherapy referral in April 2019 did not happen as the service did not co-ordinate the appointment effectively and so the person was discharged and required a new referral from the GP, which led to delayed treatment for the person's mobility difficulties.
• The service did not follow-up medical investigations outcomes where a person was suspected of having diabetes or follow-up a new prescription for dementia treatment. This led to a delay in the person's treatment for dementia by three weeks at the point of our inspection. After our inspection the registered manager confirmed the outcome of the person's medical investigations was the person did not have diabetes.

• People's healthcare appointments such as opticians and dental appointments were not always recorded. The service could not be assured of whether people had attended or when a follow-up was due.

The provider's ineffective co-ordination with staff internally and ineffective collaboration with external agencies, meant people did not always receive an appropriate assessment of needs for their care. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider took action during and after our inspection to make sure systems to co-ordinate people's care effectively were in place and followed by staff.

• We observed the area manager was prompt to arrange a review with a person's care co-ordinator due to a change in their mental health condition. Another person was supported to attend regular six weekly meetings with their care co-ordinator to review their needs.

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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

We checked whether the service was working within the principles of the MCA.

• The service did not comply with MCA legislation to gain informed consent from people about their care. All people signed service consent forms for "non-medical routine personal and social care." This occurred without the service completing decision specific mental capacity assessments where there was reason to doubt people's capacity.
• One person received continuous supervision and control inside their home and in the community and there were indications they may lack capacity to consent. The service had not considered or liaised with the person's local authority to apply to the Court of Protection for legal authority to deprive the person of their liberty.
• The service completed financial mental capacity assessments for people in response to our previous inspection. One person's capacity assessment referred to a diagnosis of dementia which was incorrect according to their care plan. There were no records of how the service had involved people in decisions by sharing or adapting information to meet their needs. A tick chart indicated one person could not understand, weigh-up, retain or communicate the decision without any explanation of how these outcomes were reached. This approach was not in line with the MCA code of practice as it would be reasonable to expect a record of how people were involved in decisions about their care.
• The service manager told us they liaised with the local authority and relatives about applications for legal authority to manage people's finances, which were underway. However, the best interest process and decision were not recorded. The service manager was one person's financial appointee as an interim agreement, but the documentation they submitted to us as evidence was not the appropriate form from the

Department of Work and Pensions (DWP). This meant they were not authorised to take responsibility for the person's financial affairs.
• One care worker said they received MCA training and told us they would record any issues but could not tell us what this meant when supporting people in practice.

The service did not seek informed consent in accordance with the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action after our inspection to assess people's mental capacity in line with the MCA.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was not inspected. The previous inspection rating was good (17 September 2017). At this inspection this key question has now deteriorated to requires improvement.

This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• We observed a care worker open a person's bedroom door without knocking, which was not respectful of their privacy. At a different household we had to prompt the business executive director to seek a person's permission before they offered us access to their bedroom.
• During our visit we observed building contractors, who had been on site for a number of days, use people's garden to take their break, smoke and play music from a stereo. This appeared intrusive and disrespectful towards people who lived there. We asked if people were consulted about this; the business executive director's response was to tell the contractors to stop, which indicated to us the service had not considered people's permission.
• People's care plans did not document their abilities and instead focused upon what people could not do. For example, people's abilities to prepare and cook meals or complete domestic tasks were not addressed in their care plans. Care plans documented a generic goal for people to be "encouraged to do simple tasks" but did not break down what skills people wanted to learn or the steps required for staff to support them.
• The service had a system called 'resident of the day' once a week. Guidance stated staff should; "Ensure the client has had personal care on his day…For male; Shaved, Haircut, shower…Make sure the resident's room is clean – STAFF…Make sure they have food." This generic approach did not promote personalisation, empowerment or people's independent skills beyond basic care needs and people could experience this as being uncaring.

People's privacy, dignity and independence was not always maintained. This was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and after our visit. They confirmed staff would receive support from managers to uphold people's privacy and dignity.

Supporting people to express their views and be involved in making decisions about their care
• A person's representative told us they were not kept fully informed by the service of changes in the person's needs. As a result, they were not as involved as they wanted to be in checking the person's healthcare treatment and progress.
• The service did not keep their own records of people's care reviews; there was no evidence that people were involved or how in decisions about their care. One person told us they had not seen their care plan. There was no evidence of how people were involved in consenting to decisions about their care.

• The service did not always gather information about advocacy services for people. We were told there had been previous attempts to engage one person with an alcohol advocacy group in the past, which they declined although it was still referenced in their care plan as an activity.
• The service manager told us people were consulted with and chose not to go out at weekends which was why additional staff were not rostered on to support community access. There was no documentation to evidence people's involvement in this decision. We asked people who told us they wanted to go out more.

People and other relevant persons were not always supported to be involved in making decisions about their care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action and confirmed they planned to review processes to include people in decisions about their care and capture this in their care records.

Ensuring people are well treated and supported; respecting equality and diversity
• People and a representative told us, "Staff are nice", "Staff are alright, doing the best they can" and "[The person] is happy. Staff are generally caring and always pleasant."
• We observed care workers and the area manager were caring in their interactions with people using the service. People appeared relaxed in staff company. Care workers we spoke with were not always familiar with people's needs or hobbies.
• Staff received training in equality and diversity to promote and protect people's rights. The service had recently introduced performance spot checks to monitor staff interaction with people.

Requires Improvement

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 not inspected. The previous inspection rating was good (17 September 2017). At this inspection this key question has now deteriorated to 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; 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

• The service did not make sure that people's care plans reflected their physical, mental, emotional and social needs. One person's care plan included a generic statement about autism spectrum disorder (ASD) but did not detail what this meant for the person and did not refer to staff support strategies. There was another generic statement about epilepsy but no personalised information about the type of seizures.

• The service did not assess whether people required a call system for staff to respond to their needs promptly. For example, there was nothing in place for people to alert sleep-in staff if they required support at night.

• People's care plans had sections about their personal history and preferences, however protected characteristics under the Equality Act 2010 such as religion were not always included.

• People's fluid and nutritional intake was not adequately recorded in their daily notes; it was not possible for the service to monitor the welfare of people who were identified at risk of malnutrition.

• There was evidence of institutional practice. People had to queue-up to access their medicines at one household as the office was in a separate unit in the garden. No-one had a medicines cabinet in their private spaces; assessments were not completed by the service to find out if people could manage all or part of their medicines requirements.

• Activities were not personalised. At each location every person had breakfast club on a Saturday and roast dinner on Sunday recorded on their activity plans. Staff presented these to us as social opportunities and to build upon people's skills, but there was no evidence of how people were involved or how they benefitted.

• Three people we spoke with at three different locations were dissatisfied with activities, with comments "No activities are run by staff", "Don't get to go out much. It's boring."

• There was some information provided about local groups such as yoga and Zumba, but staff told us people did not access these.

• One person who received 24 hour one to one support was supported to use public transport, however, staff told us they had to wait outside local shops due to their social needs and mobility difficulties whilst staff went inside to make the purchase for them. The service had not explored reasonable adjustments in the community to enable the person to access amenities.

• The provider did not have procedures to ensure full compliance with the real tenancy test. This is a quick test to be used in supported living services to determine if real tenancy rights are being met. For example, it says that for the tenancy to be genuine there needs to be a tenancy agreement in place and that the tenant has control over where and who they live with; how they are supported; and control over what happens in

their home. The provider had arranged a separate tenancy agreement in response to our previous inspection and requirement actions. However, other aspects of the test were not considered. For example, tenants at one property were restricted access to the lounge and kitchen at night as a sleep-in staff slept in the communal lounge on the sofa. Staff locked the lounge door to prevent people from accessing this communal area, which was also a through way to the kitchen.
• The provider's policies and procedures and newsletters were displayed on notice boards and the provider's inspection rating was displayed in the entrance hall of people's homes, which was not required by regulations. The registered manager told us tenants were consulted with about prospective new tenants, however, when we asked they could not evidence records or systems in place that considered people's views. The households felt like residential care homes rather than people's own home.

The service did not carry out a holistic assessment of people's needs. Care was not designed to achieve people's preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service took action after our inspection to review people's care plans and preferences in line with their needs.

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.
• Staff did not receive communication training. The registered manager was not familiar with the AIS and thought this was about data protection.
• Care plans included a summary of people's communication needs and staff strategies such as the use of pictures. There were photos of evening time meals on menu plans; the service manager said more work was needed to build-up a bank of suitable pictures to aid communication.

We recommend the registered manager seeks information from a reputable source about the Accessible Information Standards (AIS) to ensure people are given information in a way they can understand.

Improving care quality in response to complaints or concerns
• The service had a complaints process and we saw evidence this was followed and complainants received responses from the registered manager.
• Information about making a complaint was displayed to people using the service. One person told us they did not have any concerns about staff but would not know how to if they did.
• The registered manager reviewed complaints for themes which were; Person-centred software (for people's daily notes and appointments) not working or not understood by staff, lack of review of people's care, concerns about quality of care provided, and poor transitions between services. Actions were put in place to address these themes.

End of life care and support
• The service was not supporting anyone at the end of their life.
• There was an end of life policy and procedure and the service explored people's preferences and choices as part of their initial assessment.

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 inadequate. At this inspection this key question remained the same.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to assess, monitor and improve the quality of the services provided. Systems were not in place to identify and respond to the health, safety and welfare of people using the service and others who may be at risk. The registered manager failed to maintain securely people's records. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

• The provider sought external support in April 2019 to improve their quality systems and address required actions from our previous inspection. Procedures for people's finances and recruitment checks had since been developed. We found the provider was not monitoring managers or care workers to check they followed this new procedure correctly and had therefore not identified prior to our inspection systems to keep people's money safe was not always effective. The business executive manager told us the service was still in the process of embedding the procedures. However, this was not reflected in the service development plan which stated these areas were "Actioned and closed."
• The provider had developed quality audits for people's care planning documentation, their environment and health and safety in April 2019. Audits were completed on 22 April 2019, but these failed to identify many of the issues we found during our inspection. Audits were not completed in May 2019 because the service manager said they were "overwhelmed" due to an area manager vacancy at that location. We were later told another area manager had stepped down from their position. This meant the provider missed opportunities to identify shortfalls in the service and the potential risk this posed to people and therefore prompt action was not taken to keep people safe.
• Medicines audits completed in March and April 2019 for one individual stated that 'allergies' were recorded on the MAR chart. However, this was not the case as the allergies section was left blank on MAR charts for April, May and June 2019. Medicines audits did not identify that staff were not checking and recording medicines upon receipt.

• At the time of our visit the service development plan did not internally identify the need to review fire risks assessment or the system in place with the Landlord to address maintenance and compliance issues from the fire inspection deficiency notices. This meant people were at potential risk of harm.
• Areas of concern identified by local authority (LA) quality monitoring reports were not included in the service development plan and were not addressed. For example, an LA visit dated 30 April 2019 at one location identified a suitable medicines cabinet was needed and staff epilepsy training was required to meet a person's needs. Neither of these had been completed by the service at the time of our visit.
• The provider had audited people's daily notes for April 2019 and produced a list of actions to improve the quality of information to accurately reflect the support provided, which we saw was circulated to staff. We saw there was some improvement in May 2019, however, the one person's personal care was still not recorded and there was little information about their meals and drinks which was important to monitor due to their risk of choking. We checked daily notes for June 2019 and there was a deterioration; staff were not able access to the provider's electronic system during June 2019 and were supposed to complete paper daily notes, but we found these were not implemented consistently and where they were used the quality of relevant information was poor.
• People's care records and management records were not contemporaneous, accurate, easily accessible or kept in good order. We were provided with three different versions of a staff list, which did not match accurately to the staff training, planned rotas or staff who actually worked on shift at the service. The service did not have adequate contingencies in place for the event of the person-centred software not being accessible. Paper records were either not in place, not completed or not accessible during our visit. By the end of our inspection the service had been without electronic records for four weeks. The service told us they planned to move to a different software provider but did not have a planned date and this was not identified on their service development plan.
• There was a closed culture at the service. Managers were not always open with us during the inspection about issues before we found them. Local authorities told us the provider did not always inform them or delayed telling them about events or concerns. The incident log did not include all incidents we were made aware of from other agencies including the police. This meant risks were not always identified and shared with other agencies to take action to make sure people were safe.
• Prior to the inspection we received whistleblowing concerns regarding people's safety and staff working conditions. Managers told us this was due to disgruntled staff rather than addressing the concerns raised.

Provider oversight and governance systems were not adequate or effective to assess, monitor and improve the quality of all areas of the service provided. The provider did not fully understand or implement registration requirements for delivering the regulated activity in supported living services. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and after our inspection. They confirmed they planned to fully implement systems and procedures to ensure they were complaint and continued to work with external support to make improvements.

At our last inspection the provider had failed to notify the Commission, without delay of any incidents specified in the regulation. This was a breach of regulation 18 (Notifications of other incidents) of the Registration Regulations 2009.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18.

• The provider delayed reporting an incident which occurred 24 April until 12 May 2019 without any

explanation. During our visit we became aware of an event that stopped the safe running of one of the households which occurred on 6 June 2019, however we were not notified of this. This meant we could not effectively monitor the safety of the service and any impact upon people's care.

This was a breach of regulation 18 of the Registration Regulations 2009.

The provider assured us they would follow their procedure and guidance on when to submit notifications of incidents.

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
• The duty of candour regulation legally requires the provider to share information with people using the service, their representatives, CQC and the local authority when things have gone wrong. The registered manager understood their duty of candour and we saw examples where they had informed people of notifiable safety incidents and provided written apologies.

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

• We received mixed feedback from staff about the service. Prior to our visit we received anonymous information of concern that staff morale was low due to staff not being paid on time. They said this led to staff unreliability and shifts that were regularly short of staff, which they felt impacted negatively upon the quality of care received by people. During our visit we received information from staff that corroborated late payments and there was evidence of staff working in excess of the five consecutive days, which was what the management team told us was the limit. There was no system for the provider to monitor staff working hours to ensure they were fit to perform in their roles.
• One member of staff said they felt motivated to do their job but not supported by managers and felt more staff on duty were required meet people's specific needs. They also said, "…Because [managers] do not have information of things, ideas are not taken on board or implemented." Other staff we spoke with said they felt there was enough staff on duty and they received support from the management team commenting, "Senior staff always support us" and "[The area manager] is very supportive, whenever I have a problem she is always there for me."
• We received feedback from local authority commissioners, safeguarding, and care coordinators that service did not always communicate effectively with them or early enough to identify concerns and respond to changes in people's needs.
• A person's representative told us staff working on shift were not able to answer queries about people's care. They said managers were not easy to contact and there was confusion about who was in charge at each location.
• Staff and people's surveys were completed and generally demonstrated satisfaction with the service, however, there was no analysis by the provider or outcomes to develop the service further. We asked to see records of staff team meetings and residents' meeting minutes, but these were not provided with no explanation.

We recommend the provider develops systems which encourage and respond effectively to feedback from people, staff and other stakeholders.