The Sandwell Community Caring Trust

Sandwell Community Caring Trust

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

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
Sandwell Community Care Trust is located in West Bromwich in the West Midlands. It is a charity run trust and supports people who live in their own home. It is registered to provide personal care to people who have a learning disability and autistic people. At the time of the inspection Sandwell Community Care Trust provided support to 150 people.

People's experience of using this service and what we found
Right Support
The service had not always supported people in a safe way when staff tested positive for COVID-19. On two occasions staff who had tested positive for COVID-19 had isolated with people in their own homes. One staff member had isolated with a person who had recently tested positive for COVID-19 and another staff member with a person who was displaying symptoms of COVID-19. Although the provider had completed a risk assessment and made a best interest decision this meant staff were working without a break and everything possible had not been done to minimise the risk of infection. This increased the risk to people of receiving unsafe care. When we discussed our concerns, the management team gave us assurances this would not happen again.

People were supported by staff to pursue their interests. Lots of people and relatives told us about holidays they had been on and activities they carried out. One person told us, "I go line dancing, Zumba, swimming, bingo, yoga and walks." Another person liked technology and enjoyed going on their iPad and laptop. We observed staff helping them to update their laptop after they had been having difficulties so they could use it again.

Right Care
People's care, treatment and support plans did not always accurately reflect their needs. In some people's care plans, there was different guidance for staff on how to support people, and it wasn't clear which one was the correct one. However, staff did know people's needs well.

People received personalised care and staff understood and responded to people's individual needs. People and most relatives spoke very highly of the support received, their comments included, "They make me feel everything is in hand," "Couldn't wish for better care and service" and "I would give 10 out of 10 as it's what I need to live a full life."

Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. People and most relatives told us they felt safe.

Right culture
The management team were making changes to ensure they were a reflective organisation with a learning culture to ensure people received good quality care and support. This culture needed to be further embedded to ensure they reflected on decisions and involved other professionals as appropriate.

Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. Staff listened to people and supported them to do the things they liked to do. People told us about different activities and holidays they had undertaken supported by staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 23 November 2021) and there were breaches of regulation. The provider completed an action plan and sent monthly reports to show what they would do and by when to improve. At this inspection we found improvements had been made to consent to care, safeguarding and staff competency and training. However, enough improvement had not been made in governance and we identified a breach of safe care and treatment.

The service has been in Special Measures since 21 September 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced focused inspection of this service on 10 June 2021. Breaches of legal requirements were found. The provider completed an action plan and monthly reports after the last inspection to show what they would do and by when to improve consent, safeguarding, governance and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified a breach of regulation in relation to safe care and treatment. Please see the action we have told the provider to take at the end of this report.

We have identified a continued breach of regulation relating to governance. We will continue to monitor the improvement within the service through existing conditions we have placed on the providers registration. This includes the provider sending a monthly report of the action they are taking to make improvements within the service.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Sandwell Community Caring Trust

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 carried out by two inspectors, a specialist advisor (who was a qualified nurse), an assistant inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 66 supported living settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This meant we could be sure the registered manager would be in the office to support the inspection and we had access to the records we required.

Inspection activity started on 01 February 2022 and ended on 14 February 2022. We visited the office location on 01 and 08 February 2022.

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 who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited seven people in their own homes and spoke with them about their experience of the care provided. We spoke over the telephone with a further eight people who used the service and 13 relatives about their experience of the care provided.

We spoke with nine members of staff including five senior carers, two managers, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care records and five medication records. We looked at three 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we looked at training data. We spoke with one professional who regularly visited the service.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection; Assessing risk, safety monitoring and management

- The provider had not always followed government guidance in relation to isolating when staff tested positive for COVID-19. On two occasions staff who were COVID-19 positive had continued to work and isolated with people in their own homes
- The provider told us the decision had been made because of shortages of staff and to ensure the people received consistent support from staff who knew them well. A best interest decision had been carried out and where appropriate family members had been included in this. However, this meant the staff were working for ten days without a break and the provider had not ensured they had done everything possible to reduce the risk of infection transmission. After discussing our concerns with the management team, they assured us they would follow government guidance when staff tested positive for COVID-19.
- We reviewed the care plan for one of the people who was supported by a staff member who had tested positive for COVID-19. Their risk assessment said they needed support from two staff to safely move using equipment. Whilst the staff member was isolating with the person there were some occasions when only one staff assisted the person with moving. Although the provider had carried out a risk assessment, and after the inspection told us this had been agreed by the relevant professional, we were not presented with any evidence of this agreement. This meant we did not have assurances that this method of supporting the person was safe.
- People's care records were not easy for staff to access because of the amount of information in them. Some of the information was from a long time ago and not relevant any longer. We found some care plans had more than one set of guidance for staff and the guidance was different with no date so it wasn't clear which one should be followed. Staff did know people's needs well, but there was a risk for any new staff that they may not understand how to support people.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. Some staff were trained in the use of restraint to keep a person safe, however they supported the person in a less restrictive way giving the person the space to express their feelings. We spoke to a professional who regularly visited the person who told us, "They have been absolutely amazing with [person] and are not using restraint. [Person] seems quite happy and has built a relationship with staff."
- Staff used personal protective equipment (PPE) effectively and safely. We observed staff wearing PPE

when supporting people and staff told us they had received training on how to put it on and take it off in the correct order. People and relatives confirmed this, one person said, "They always wear masks, no problems. Staff keep us safe, follow procedures." A relative told us, "When I visit unplanned, they are all wearing PPE. People are very well protected and looked after."

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had not ensured people were protected from the risk of abuse. 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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. One person told us, "I am 100% safe living here, I know the staff would do anything to keep us safe." A relative said, "Yes [person] is safe and if things go wrong, I think they respond appropriately."
● Staff had training on how to recognise and report abuse and they knew how to apply it. One staff explained about how a change in a person's mood or not eating could be a sign something was wrong. Staff described what they would do if they had concerns, this included reporting to their manager. One staff member said, "If it is not dealt with by managers, I would take it further, and would come to CQC."

Using medicines safely
● Staff did not always review each person's medicines regularly to monitor the effects on their health and wellbeing. One person had received an 'as required' medicine on a regular basis and staff had not asked the doctor for a review. The family had identified this and raised with the doctor as a concern.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Staff used other strategies to support people that were less restrictive and ensured medication was reviewed on a 6-monthly basis.
● People received support from staff to make their own decisions about medicines wherever possible. Some people had chosen to take their own medicines and staff supported them to be as independent as possible. People and relatives told us that medicine management was a task carried out together with people.

Staffing and recruitment
● The service had enough staff, including for one-to-one support for people to take part in activities. One person told us how staff supported them to take part in the activities they enjoyed. They told us, "I go swimming, shopping and fishing in the summer."
● Staff induction and training processes promoted safety. Staff told us the training gave them the skills to understand people's individual needs, wishes and goals. People and relatives spoke positively about staff. One relative told us, "The staff are just brilliant, they know [person] as well as I do."
● Observations we made of staff, provided assurance of their knowledge and skills supporting people with their communication needs. For example, one person used some Makaton and their own sounds to communicate. We observed staff supporting the person to express their views and wishes, the person was relaxed and smiling with the staff member.
● The registered manager and provider checked that new staff were suitable to work with people before

they started and had carried out all necessary recruitment checks. Each staff member had references from previous employers and a disclosure and barring check (DBS) in place. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Learning lessons when things go wrong

● The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. For example, after an analysis of falls across the service, a new system to capture falls information had been put into place. This included looking in more depth at the circumstances of the fall to try and find out why the person fell and to help with plans to reduce the risk of it happening again.

● Staff raised concerns and recorded incidents and near misses and this helped keep people safe. People and relatives told us that staff kept them up to date with any concerns. One relative told us, "They go out of their way to keep me informed, for example they informed me about a fall recently."

Good

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 inadequate. At this inspection this key question has now improved to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had the required skills and competencies. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18(2).

- Training for staff was ongoing as there had been a gap during the COVID-19 pandemic when training had not been taking place. Staff were now receiving relevant and good quality training. The management team were reviewing training every two weeks and booking staff onto further training. Staff told us if they identified a training need, which was individual to a person they supported, managers would arrange relevant training.
- The service checked staff's competency to ensure they understood and applied training and best practice. Medicine competencies had been carried out on all staff who were administering medicines. The registered manager told us competencies would be carried out every year to check staff skills and knowledge.
- Staff could describe how their training and personal development related to the people they supported. Staff shared with us how they had put into practice learning from recent mental capacity training, and how they supported people to make decisions. A visiting professional who worked with a group of staff confirmed their knowledge in this area. They told us, "Their understanding of mental capacity is very good. They understand that it is decision specific."

At our last inspection the provider had failed to ensure the service had worked within the requirements of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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.

● For people that the service assessed as lacking mental capacity for certain decisions, staff recorded assessments and any best interest decisions. For some assessments it was not clear about how each separate decision had been assessed. We fed this back to the management team who agreed to share the learning with staff.
● Staff empowered people to make their own decisions about their care and support. People told us they were involved in decisions. One person told us, "The staff discuss everything with me first and more important they listen to me." Another person said, "Everything gets discussed with me as I can make decisions about what I need."
● Staff had received training and had a good understanding of the mental capacity act. One staff told us, "You don't assume that someone hasn't got capacity. Some people have capacity in some areas and not others." They went on to share an example about the decisions a person could make and explained how they needed to support the person in the least restrictive way.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had care and support plans that were personalised and holistic. Although support plans did not always include clear pathways to future goals and aspirations, people told us they were supported to achieve them. For example, one person told us how staff had supported them to go on a cruise, another how they had become more independent with travelling to see their friend who lived in another part of the country.
● People and most relatives told us they reviewed plans regularly with staff. One person told us, "Yes my care is reviewed with me as I have capacity, there was one recently." Some relatives told us there hadn't been a recent review because of the pandemic but they were happy with the ongoing communication with staff.
● Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. We observed staff supporting a person with their communication, listening to them and enabling them to express their views and wishes.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people to be involved in preparing and cooking their own meals in their preferred way. For example, one person told us they had learned to cook spaghetti bolognaise and were learning to cook more meals. Another said, "I like the food and enjoy helping with the cooking."
● Staff encouraged people to eat a healthy and varied diet to help them to stay at a healthy weight. One person shared how staff had helped them to lose weight through supporting them to eat a more balanced diet. They told us, "I have lost lots of weight. I feel a hell of a lot better in myself." The person was smiling when they told us and obviously felt proud about their achievement.
● People were involved in choosing their food, shopping, and planning their meals. One person told us, "We

go shopping, we bring it back and cook it."

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

● People were supported to attend annual health checks, screening and primary care services. Care records showed people had annual checks with the GP and dentist. Each person had a hospital passport which gave key information about how the person was to be supported if they went into hospital.

● The service ensured that people were provided with joined-up support so they could travel, access health centres, education and or employment opportunities and social events. For example, one person was having difficulties accessing transport, so staff were working with a health care professional to look into access to a car and support the person to understand and make a decision about this.

● People were referred to health care professionals to support their wellbeing and help them to live healthy lives. Staff supported people to attend appointments and referrals were made in a timely way when there were observed changes in health needs. People and relatives spoke positively about the support given. A relative told us, "The carers sort out all the appointments [person] might need, they know [person] so well they can tell a mile off if something is amiss." A person said, "I can say if I feel unwell and staff help to arrange appointments."

Requires Improvement

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 has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection there were insufficient systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

● Governance processes were not always effective to hold staff to account, keep people safe and provide good quality care and support.
● There was no effective system to check care records were up to date and information was difficult to find as there was lots of historic information which was no longer relevant. We found care records included inaccurate and duplicate information and there were some gaps in monitoring records. Although staff knew people's needs well, it was important for information to be up to date and easy to find to ensure safe and consistent care.
● Although systems around monitoring of infection control practice had improved since the last inspection, the management team had made the decision for staff who had tested positive with COVID-19 to isolate with people in their homes. They had not adhered to government guidance and made this decision without talking to the relevant professionals about the situation. They had not taken all steps to minimise the risks to people.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate effective monitoring of the quality of the service or ensure complete and accurate records were kept. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Systems to ensure staff had relevant training had improved but some information about relevant training had not been captured. Although staff told us they had attended more specialised training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, this information was not recorded on the provider's training matrix.

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

● Staff felt able to raise concerns with managers without fear of what might happen as a result. One staff member told us, "I would report concerns straight away regardless of whether I get on with my colleague. For any sort of process, managers are very confidential."

● Managers promoted equality and diversity in all aspects of the running of the service. People from the lesbian, gay, bisexual and transgender community were supported. Staff had supported one person to explore their sexuality and have the relationship they wanted.

● Since the last inspection the management team had worked hard to set a culture that valued reflection and learning and welcomed fresh perspectives. They had introduced a registered managers audit so there was an improved oversight of the service, enabling them to identify areas for improvement and take the appropriate action.

●The provider had also commissioned a consultant to work with the service to give feedback and advice to improve the service further.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 provider sought feedback from people and those important to them and used the feedback to develop the service. A survey had recently been sent out to relatives to gather views. People had key workers and some people told us they attended meetings to voice their views. At the meeting, holidays, decoration of their home and activities were discussed.

● The service apologised to people, and those important to them, when things went wrong. We saw a recent complaint had been responded to in a timely way, a phone call and written response was given with an apology and action to address the concern.

● Staff gave honest information and suitable support, and applied duty of candour where appropriate. People and relatives told us they felt confident to raise concerns with staff and the manager who was responsible for the staff where the person lived. Some relatives were not aware of the complaint's procedure or the management structure of the service.

Working in partnership with others; Continuous learning and improving care

● Since the last inspection the provider had been working with the Local Authority and the quality team to improve care and support for people using the service. The management team told us they were going to use information from the quality team to improve people's care records.

● The service worked in partnership with health and social care organisations, which helped to give people using the service a voice. One visiting professional said, "They have been very proactive in working with me."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all steps to mitigate risks when staff tested positive for COVID-19.