Collaborative Care Solutions Limited

61 Langley Road

Inspection report

61 Langley Road
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24 November 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
61 Langley Road is a domiciliary care agency providing supported living services. The service delivers personal care in 7 settings across the borough of Slough, to people with mental health conditions and associated needs, to people living with learning disabilities and autistic people. The service also provides treatment of disease, disorder or injury for people carried out by or under the supervision of a qualified registered nurse. At the time of the inspection there were 27 people being supported by the service. We visited 2 settings and reviewed the care and support needs of 8 people who received the regulated activities.

People's experience of using this service and what we found
People told us they were safe from harm but systems to protect people from abuse were not effective. Restrictive work practices were not proportionate to the level of risk of harm, where people were not legally subject to control or restraint. Some of these practices were unlawful and failed to protect peoples' rights. Risks to peoples' health were not always identified, managed, and mitigated. Staff were either not trained, or their training had not been refreshed, to enable them to recognise and report abuse.

Staff recruitment checks were not satisfactorily carried out to ensure people received care and support from staff who were suitable for their job role. There were unsafe medicine practices and people were placed at increased risk of being infected with COVID-19 because staff did not use personal protection equipment safely (PPE).

The service failed to work collaboratively with people and their representatives to ensure care and support delivered was centred around their individual needs. Care plans did not provide enough information for staff to understand how to meet peoples' needs. People's nutritional and hydration needs were not always met. The provider did not always work with other health and social care professionals to ensure people received good health outcomes.

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.

Quality assurance systems used to assess and monitor the service were not effective in ensuring people's safety was not compromised. We were unable to assess the effectiveness of the provider's auditing systems because the service did not give us full access as requested during, and after our inspection. Records relating to care and the management of the service were not always accurate, contemporaneous or fit for purpose. The provider failed to notify us when notifiable incidents happened, this is a legal requirement.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make

assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
People were not supported to have maximum choice and control of their lives. Staff did not receive appropriate training to support people who were autistic, living with learning disabilities and with mental health conditions. Care plans did not always contain enough information to enable staff to support people and meet their individual needs.

Right Care:
People were not always supported with care that was person centred, promoted people's dignity, privacy, and human rights. The provider failed to ensure there were enough appropriately skilled and competent staff to meet people's needs and keep them safe.

Right Culture: The ethos, values, attitudes, and behaviours of the provider were not open, transparent or empowering but very restrictive. People's independence was not always promoted, and staff were not empowered to make decisions in order to support people in their day to day lives. The service failed to always work collaboratively with people and those who represented them. The provider failed to have effective quality assurance systems. Therefore we could not be assured that risks to peoples' welfare and safety were identified and managed appropriately. There was evidence of a closed culture.

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

Rating at last inspection
The last rating for this service was good (published 5 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received from local authorities regarding risks to peoples' welfare and safety. A decision was made for us to inspect and examine those risks. This report covers our findings in relation to the Key Questions Safe, Effective and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 Good to Inadequate. This is based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 61 Langley Road on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, need for consent, meeting nutritional and hydration needs, good governance, staffing, fit and proper persons employed and notifying the Commission of change and incidents.

Please see the action we have told the provider to take at the end of this report.

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 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 their conditions of 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 safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

61 Langley Road

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service provides care and support to people living in 7 '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.

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 a registered manager in post. However, they were not able to be present during this inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 17 November 2022 and ended on 24 November 2022. We visited the location's offices on 17, 18 and 24 November 2022 and conducted telephone interviews with two relatives, one next of kin, and one person on 24 November 2022. We interviewed three staff members on 2 December 2022 and sent feedback questionnaires to 21 staff members.

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 is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people, 2 relatives and 1 person's next of kin. During our site visits we spoke with 3 team leaders, an assistant psychologist, the General Manager and the Clinical Director. We looked in detail at 7 care plans, 5 staff recruitment files and the service's staff training matrix. We looked at a variety of records relating to staff recruitment, medicine management, the management of the service, this also included the service's policies and procedures.

We sent feedback questionnaires to 21 staff members and received 2 responses. Telephone interviews were conducted with 3 staff members after our site visits. We continued to seek clarification from the provider to validate evidence found. All information received was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from abuse. Restrictive work practices were not proportionate to the level of risk of harm where people were not legally subject to control or restraint. For example, we saw text messages dating back to October 2021 that showed staff contacting the registered manager to ask if a person could attend activities such as a group therapeutic session, a swimming session to which the registered manager's response was only with his permission if their behaviour had been appropriate and he had refused the person permission to attend the therapeutic session.

● On 3 November 2022, we saw staff had informed the registered manager via text message that a person wanted a staff member to accompany them to the accident and emergency department. The registered manager's response via text message was, ' She must be joking lol' which was inappropriate and suggested this was not going to happen. We found no records to confirm staff had accompanied the person. On 5 November 2022, another person's relative had to ask staff for permission to take the person out for a walk. Text messages showed staff having to obtain the registered manager's permission first. This type of controlling practice is not acceptable and demonstrated the registered manager was failing to protect peoples' human rights.

● Peoples' relatives and next of kin gave mixed responses about whether there were restrictions. Comments included, "No restricted visiting when I go in", "No restrictions when it comes to visits" and "When I do visit they (staff) like you to leave around 7 or 8 pm and this is the other thing, [name] was worried that if I hugged them in front of the staff then this would be an issue". A person commented, "I've got my friend coming tomorrow, long term friend. My mum and step-dad come as and when. I can't remember anything about the hours (visiting) but I've been out to McDonalds with the staff. If I need to go anywhere, they arrange transport or staff come with me or other residents".

● We found some people did not have unrestricted access to their own homes and staff work practices invaded their privacy. A staff member told us people did not have their own front door keys or keys to their own bedroom doors. There was no information about access to keys in people's care plans or any form of assessment to establish if people had the mental capacity to decide if they wanted to have their own keys. We saw another instance where the registered manager had told staff to search a person's room whilst they were out. We viewed the person's care records and did not see any signed agreement allowing staff to check their room when they were absent.

● Language (verbal and written) used in the service could be open to misinterpretation by inexperienced, untrained staff when trying to enforce restrictions upon people. A person's daily care notes, dated 29 September 2022, stated they had a 'formal 1:1 meeting' with an assistant psychologist where they were reminded of 'the rules and regulations'. We asked the staff member and the management team what rules and regulations meant, but they said they did not know, and nothing was recorded about this.

● Another person's 'Supported Living Risk Assessment Management Plan' dated 12 October 2022, stated

'staff to support [name] to manage any form of challenging behaviour positively by enforcing firm boundaries', however, there was no explanation about what these boundaries were or how staff should approach this safely. It went on to state that staff should contact the registered manager with any concerns or issues and 'If necessary, the requirement for a urine drug screen can be discussed as needed given the circumstances.' There was no information about how the person's rights were promoted in relation to this or whether this was part of the contracted care agreement. Another person's 'Resident Profile' undated, stated they 'can become verbally aggressive and firm boundaries are required to manage this'. There was no further explanation about what 'firm boundaries' meant.

● A person, who was not subject to any lawful restrictions or restraints, wanted to know if they could order a takeaway, the registered manager gave permission for them to do so but stated this could only happen once a week. The person told us they were not allowed to have visitors without the registered manager's permission as they would sometimes engage in illicit drug taking with friends who had a bad influence on them. We viewed the person's risk assessment dated 21 November 2021 which had identified illicit drug taking and alcohol abuse as a risk factor, with actions for staff to manage this. There were no specific risk assessments relating to the person's friends visiting them, their nutrition and finances. This meant the person's human rights were infringed because the level of control imposed upon them was not proportionate to the identified risks of harm that had been assessed.

● We viewed the visiting policy, not dated, which stated, 'where a resident is considering taking up a residential place, they and their supporters have the right to access the home, showing respect and dignity towards the existing occupants'. We found this policy was not always followed. During this inspection, we found visitors were only allowed to visit people with the registered manager's permission. People were given rights of access, due to having tenancy agreements but some people had to seek the registered manager's permission before they could leave their home. We have raised a safeguarding alert with the local authority regarding this.

● The registered manager failed to ensure all staff received appropriate safeguarding adults training and were kept up to date with relevant legislation. The service's training matrix showed several staff had not had their safeguarding refreshed for 2 years, whilst others had not undertaken the relevant training at all. Staff comments included, "I received regular safeguarding training, sometimes this is face to face and sometimes this is online" and "I have not received safeguarding training". Therefore, we were not assured staff would always be able to identify different safeguarding concerns and their responsibilities.

● A person's care records documented, they had reported to staff that they were threatened by male strangers whilst out accessing the community. Although staff had reported this incident to the police, there were no records to confirm they had also reported this incident to the local authority's safeguarding team and there were no records to show what further action was taken to make sure the person was kept safe from harm.

● Another person's incident report showed they had self-harmed on 29 October 2022. Three further incidents occurred on 9, 15 and 21 November 2022, when they had placed themselves at risk of harm by leaving the service unaccompanied 'when it was not safe to do so'. This was because the person experienced seizures and required staff to accompany them when accessing the community, in the event they had a seizure and required emergency assistance. Staff failed to consider these incidents as potential safeguarding concerns and report them to the local authority.

We found not all staff had received relevant safeguarding training and, the provider's restrictive practices infringed on people's human rights, which amounted to institutional abuse and unlawful restraint. 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.

● Most of the people we spoke with stated they felt safe. A person commented, "I feel really safe yeah."

Assessing risk, safety monitoring and management

● Risk assessments and risk management plans relating to people' welfare, health, and safety did not make sure they were kept safe from avoidable harm. A person's care plan, dated 29 October 2022, stated they had swallowing difficulties, however, not enough information about how staff should mitigate this risk was documented. The care plan stated '[person's name] experiences temporary swallowing difficulties, hence [they] can only swallow liquid food (Ensure) at this time.' No other actions were recorded about how to mitigate this risk and information about meal preparation was not supported by appropriate advice and guidance from a healthcare professional to ensure this was managed safely.

● Another person's records showed they had been diagnosed with non-epileptic seizure dis-order (NEAD) and vasovagal syncope. However, staff had failed to update the person's care plan to reflect this. During our visit, the person as described by staff, experienced fainting spells, although staff were quick to come to their aid, it took a while for staff to arrange for the person to be taken to accident and emergency. Therefore, the person was placed at potential harm because staff were not aware of their medical diagnosis and appropriate actions to take when they were having seizures.

● Another person had moved out of the service but was still being supported by staff. Their care plan did not reflect this change. There was no documented information to show how staff were to manage the person's identified risks when they were not at the service. A care record entry note dated 30 September 2022 stated it was apparent to staff when the person visited the service, they had been neglecting themselves. However, there was no further information to show what action had been taken to address and manage this.

● Another person also had a history of arson. To manage this risk, staff were advised to remind the person of their tenancy agreement and the consequence if they were to breach it and where the designated smoking area was, if required. There was no risk assessment in place in relation to the person smoking and what appropriate action staff should take to manage this risk.

● Unsafe fire safety practices placed people at harm. For example, in one setting a smoke detector located in a downstairs spare room was covered. The staff office had a bathroom which was currently used for storage, this was full of flammable materials, that were spread all over the floor, which made it difficult for staff to walk through. There was no consideration on how the items should be safely stored to prevent a fire and to avoid injury to staff. We found no consideration was made to ensure there was an emergency grab bag containing records for easy access in case of fire.

● In one of the settings visited, the service had designated the garden gate as an emergency fire exit. We looked at it and found it was padlocked. The key to the padlock was kept with shift leaders but staff did not have a clear understanding of the emergency evacuation procedures and what to do in the event of a fire. We reported our concerns to the fire service.

The service's failure to identify, assess and manage risk, increased the risk of harm to people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We could not be assured staffing levels in the service met people's needs. For example, we asked for evidence of people's agreed support hours, but this was not provided to during or after our inspection.

● Staff told us the rotas did not accurately reflect who was working because they said the registered manager would often move staff between supported living settings. Text messages viewed confirmed what staff told us.

● During our inspection, we found staff delayed taking a person to hospital because they did not have enough staff on duty and needed to wait for a staff member to transfer from another of the provider's supported living settings.

● The service had not established robust recruitment checks to ensure staff were suitable. For example,

records showed employment references were sought from colleagues at previous employers rather than managers and the provider did not always seek references from staff's most recent social care employer. It was also unclear how references had been verified. References were not always received prior to staff commencing work at the service. This was not risk assessed to protect people from unsuitable staff.
● The provider's recruitment policy did not refer to relevant legislation and did not specify what checks were required prior to employment or supporting people.
● The provider did not carry out their own Disclosure and Barring Service (DBS) checks but relied on DBS checks undertaken by new staff's previous employers. The General Manager's DBS was dated 26 June 2016, which was prior to their start date 16 January 2018. The Clinical Director's DBS was dated 15 June 2020, which was significantly prior to their start date 14 March 2022. There was no information about when the service had checked their DBS in relation to this employment or risk assessment in place to mitigate the risk of abuse.

Staffing levels were insufficient and people were not always supported by staff who were safely recruited. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not safely managed. A next of kin when describing how staff supported a person with medicines stated, "[Name] has been left without medication for 4 hours before and they need their medication, they take it like, 4 times a day."
● The staff training matrix showed 11 out of 27 staff listed had undertaken medicines training and 17 staff members' competency to administer medicine was not assessed. Therefore, we could not be assured people would be supported by staff who were competent to administer medicines safely.
● Medicines were not disposed of safely. We found a bag containing prescribed medicines belonging to people who were no longer living at the service, including controlled drugs stored in a spare room that was unlocked. This meant prescribed medicines were easily accessible to anyone in the building which could have led to possible drug misuse or accidental poisoning.
● The registered manager failed to ensure there were protocols in place for 'when required' (PRN) medicines had clear protocols in place for staff to follow. For example, a person was diabetic and prescribed PRN medicines to be administered when their blood sugar was high. Their PRN protocol failed to instruct staff when they should be referred to appropriate health professionals if their blood sugar reading was consistently high. The person's PRN chart showed their blood sugar level readings were high on 10, 12, 14,17 and 19 October 2022 despite remedial action taken by staff to encourage them to drink water or do exercises. Further high readings were taken on 11, 12 and 14 November 2022.
● We viewed the service's office diary and noted the person had an appointment on 15 November 2022 to attend a diabetic review. However, on the first day of our inspection 17 November 2022, the person's PRN protocol had not been updated to reflect the outcome of the recent diabetic review. This would have made sure staff were aware of any changes to enable them to manage the person's diabetes safely.
● Another person's 'when required' (PRN) medicine directions stated, 'one to be taken at night when required for vomiting/nausea', however, the MAR recordings showed this was administered morning, lunch and evening, which was against the prescription direction and without explanation.
● On 18 November 2022, a staff member told us they would administer a person's emergency 'when required' medicine Buccolam 5mg/1ml in the event of a seizure if they were "turning blue". They said there was no time factor involved to determine when they would administer this medicine. The person's hospital discharge summary, dated 24 October 2022, stated the same medicine should be administered for seizures lasting greater than 5 minutes, which was inconsistent with what the staff member had told us. This medicines direction was not recorded on the person's MAR dated 25 October 2022 to 21 November 2022,

and there was no written medicines protocol for staff to follow in an emergency. The same MAR stated, 'max twice in one week when required'. However, there was no information about what to do if the maximum dose has been administered.

● Records completed by staff showed the person had experienced seizures lasting for more than five minutes without staff administering Buccolam. This put the person at increased risk of harm from prolonged seizures.

● On 24 November 2022, we asked to see examples of other peoples' PRN medicine protocols. The General Manager and Clinical Director told us they had all 'gone walk abouts' and said the Clinical Director was in the process of writing them all again.

● Another person's MAR chart, dated 3 to 30 November 2022, had several medicines recording gaps. Staff also used the key code '0' for several dates without any explanation about what this meant. Two medicines were not listed on the person's emergency grab sheet which could have had a severe impact if the emergency services had to provide the person with medical treatment.

The provider's management of medicines did not ensure safety, quality, and consistency of care. This was because the provider did not follow their own medicines policy, national guidance, and best practice. This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The service's current work practices placed people and staff at high-risk of being exposed to the COVID-19 virus. This was because the service failed to follow the Department of Health and Social Care's (DHSC) 'COVID-19 PPE guide for adult social care services and settings' dated 11 October 2022. There was no offer of hand sanitiser before we entered the settings and no suitable hand drying facilities in staff toilets. The provider failed to have an appropriate COVID-19 policy and procedure in place. COVID-19 training was not listed as essential training on the staff training matrix and there were no training certificates in staff files to confirm they had received the relevant training.

● The service's COVID-19 risk assessment, dated 8 October 2022, stated there was a high risk due to high levels of infection in the local area. However, it did not address whether a person was at increased risk due to their own person-factors such as race, age or health conditions. The risk assessment did not address how the person should be supported to isolate in the event of a positive test. It instructed staff to follow government guidance and said the person should be encouraged to have 'random' lateral flow tests and temperature checks 'to monitor possible hidden symptoms of C-19'. This was contrary to government guidance which does not advise asymptomatic testing.

● Peoples' COVID-19 care plans and risk assessments also instructed staff to only wear face masks when people displayed symptoms of COVID-19. This instruction was not in line with government guidance. During our inspection we observed staff were not wearing face masks. Learning lessons when things go wrong the Clinical Director told us this was normal practice and had been the case since they had commenced working at the service on 14 March 2022. They told us the impact of COVID-19 was known to have reduced which was why it was not required.

We found no evidence people were harmed. However, the provider's failure to follow the most recent government's guidance relating COVID-19 in adult social care setting, increased the risk of people being infected with the COVID-19 virus. This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Opened food was labelled to indicate expiry dates to protect people from infection.

● The environment appeared clean and there was a general staff cleaning rota in place for communal areas.

Learning lessons when things go wrong

• We were not able to establish if there were effective systems in place to ensure staff reported incidents or near misses in order for the service to manage risk or learn lessons to improve care.

• This was because we were not given full access to accident and incident records. Please see further information relating to this under the Well-Led section of this report.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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

- Assessments of people's needs were carried out but did not always show how the service worked in collaboration with people or their representatives when completing them. For instance, notes taken at the time of the assessment were not contemporaneous, did not always reflect what people or their representatives said and failed to document whether people had understood the care and support choices available to them.
- A person's profile documented a diagnosis of Prader-Willi syndrome. However, there was no information about this or associated symptoms such as over-eating or floppiness caused by weak muscles in their care plan, dated 1 November 2022 and updated 20 November 2022. This meant there was not enough information for staff to understand how to meet the person's care and support needs.
- Another person's local authority (LA) assessment, dated 9 May 2022, stated they would benefit from having a Positive Behaviour Support (PBS) plan in place. However, we found the service had not acted upon this at the time of our inspection and there was no PBS plan in place.
- Care and support plans developed from information gathered from care needs assessments, were not always person-centred and did not always capture people's life stories, likes and preferences. At the time the inspection, the general manager told us the service was in the process of updating care plans into a new format. We viewed some updated care plans and found they still lacked person-centred information relating people's aspirations, including who and what was important to them. Some people had an' interest checklist' which listed social activities they liked to participate in with action plans showing how staff should support them. However, interest checklists were not found in all updated care plans viewed.

The service did not consistently work collaboratively with people or their representatives to ensure, the care and support delivered was person-centred, and accurately reflected peoples' views and care needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not receive timely, adequate or ongoing training and support to ensure they were knowledgeable and equipped to meet peoples' needs. There was no clear training pathway for different roles or levels of responsibility, such as higher-level safeguarding training for managers and leaders responsible for making safeguarding referrals and decisions about how risk was managed. Staff were not supported by the service to attain vocational qualifications relevant to their role and the service could not evidence that staff received regular supervision about their performance and development.

● The registered manager had not arranged mandatory learning disability training as required, or mental health awareness training to ensure staff supporting people day to day understood their needs.
● Staff had not received epilepsy or specialist medicines training for a person's emergency medicine. This meant staff did not have a consistent or appropriate understanding of how they should respond to the person's seizures and manage their after care.
● Assistant psychologists were expected to deliver specific therapeutic approaches such as Dialectical Behaviour Therapy (DBT) to people without specific training as required. We found 2 out of the 5 Assistant Psychologists had received 'External DBT' (provider/name of trainer not provided) training on 4 October 2021.
● Staff did not receive training in de-escalation and disengagement techniques, such as 'breakaway' training. This would have equipped staff to work effectively when people displayed distressed behaviours.
● Some staff had attended an 'All in one Mandatory Training Course' on 11 May 2022. This included 12 distinct areas of care such as safeguarding, moving and handling, basic first aid, infection control and food hygiene. A staff member told us this had not included practical moving and handling training, which was required to meet some people's care and support needs.
● An assistant psychologist records showed they had commenced their employment on 14 June 2022 and had only completed risk assessment training 2 November 2022 and Mental Capacity Act on training 19 November 2022.
● Assistant psychologists were responsible for conducting peoples' initial assessment of need, care plans and risk assessments prior to receiving appropriate training and support. The first risk assessment training arranged by the service was 2 November 2022 in response to concerns raised by commissioning authorities.
● Supervision notes reviewed showed 2 assistant psychologists on 13 September 2022, had raised concerns about the level of responsibility they had been given without appropriate training or support.
● Staff new to care were not supported to achieve the Care Certificate as part of their induction. This sets standards for the induction of health care support workers and adult social care workers. There was no evidence about how staff performance was monitored and assessed according to these standards.

The provider failed to ensure staff were effectively inducted, trained and supported to be able to meet peoples' needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The registered manager failed to ensure staff worked in accordance with the Mental Capacity Act 2005 and

its Code of Practice.
● There was no documentary evidence to show whether people or those who represented them had given consent to various aspects of care. For example, people had not given consent for care to be delivered, medicines to be administered and consent for their personal details to be shared with relevant agencies.
● A person's 'Supported Living Risk Assessment and Management Plan', dated 12 October 2022, stated that staff should perform room searches for any signs of illicit substances. There was no information about whether this was an agreed condition in accordance with their hospital discharge leave, or whether they had consented and how their right to privacy was considered and upheld by the service. There was no evidence about how the person's consent was gained, such as their signature or other documentation in their care file.
● The same person's care plan, dated 8 October 2022, stated, "I will have a COVID-19 test if required by the company as per government guidelines. If I do leave my specified area staff are to maintain firm boundaries.' There was no information about how the service had considered the person's right to refuse a COVID-19 test, or what was meant by 'firm boundaries' or how staff would implement this. There was no evidence about how the person's consent was gained.
● We found the service did not routinely record or hold best interest decision meetings or discussions on behalf of people who were unable to consent to care and support. Where 'Best Interest' decision meetings were held and documented, significant others, such as relatives or advocates were not always invited to be involved.
● We found senior managers and staff designated to conduct mental capacity assessments lacked understanding of the MCA and relevant training undertaken was not specific to their job roles.

The service failed to act in accordance with Mental Capacity Act 2005 and its Code of Practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● The service failed to effectively identify or meet peoples' nutritional needs. For example, staff had not followed-up support for a person from dietary and nutritional specialists in response to a hospital admission between 12 September to 24 October 2022, which involved nutrition and swallowing difficulty concerns. This put the person at risk because of poor monitoring and management of food intake.
● The person's hospital discharge summary, dated 24 October 2022, referred to a nutrition plan, however this was not captured in the person's care plan, dated 01 November 2022. The person's previous care plan, dated 29 October 2022, was still on file and stated the person's swallowing difficulties were 'temporary', however, there was no reference to where the temporary' status came from. There was no food chart in place and staff were not routinely recording food, fluid or Ensure supplement intake in the person's daily notes.
● We checked the person's physical health monitoring chart' which recorded the person's weight. The weight records showed the person had lost 8.8kg between the 26 July and 25 October 2022. There was no guidance about how frequently the person's weight should be monitored or what further action should be taken.
● Another person's care plan stated their weight should be regularly monitored. A monthly weight chart recorded they had lost 7.7kg between 30 March 2022 and October 2022. However, daily records showed staff did not consider this as an issue even though they were regularly, documenting and monitoring the person's food-intake, due to their diabetes. The person's relative commented, "The big problem with [name] is the diabetes but they (staff) have said to me that every time she goes home her sugar levels are high...but I know my daughter, she has a very strict diet. She does not eat anything she isn't supposed to." This meant the person's nutritional needs were not effectively monitored to prevent weight loss and control their blood

sugar levels.
● Another person's care plan stated they needed support with nutrition intake and healthy eating and said staff should monitor and record weight monthly. There was no information about whether the person was at risk of malnutrition and weight loss or any rationale about why the person's weight needed to be recorded monthly. We found no evidence of weight records or a MUST assessment in the person's care file. We saw a food chart, dated 3 to 11 November 2022 which recorded the person was 'in the community' or 'asleep' against every mealtime. This was not effective monitoring in accordance with their care plan.

Peoples' nutritional needs were not effectively managed by staff where poor hydration and nutrition needs were identified. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
● A relative commented, "I've said monitor her hearing but her GP, opticians, her appointments have not been changed. No one is listening." A review of the person's care records showed staff were not prompt to address the person's hearing impairment but medical letters confirmed the person had now been seen by the relevant hearing specialist.
● The registered manager did not ensure staff always made prompt and appropriate referrals to relevant health and social care professionals to obtain good health outcomes for people. For example, during our inspection, we found poor health outcomes for people who were diabetic, had epileptic seizures and who were losing weight, as a result of the care and support provided by the service.
• A person's LA assessment, dated 9 May 2022, identified that an occupational therapist assessment was needed to support the person to complete weekly shopping as part of daily living skills. There was no information in the person's care plan about whether this health referral had been followed-up and implemented by the service. There was no information in the person's care plan about how the service was supporting them to maintain and develop independence skills.

Staff lacked a general of understanding of how to support, monitor and manage people's health and support needs. This meant people's health needs were not always met. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A person commented, "They (staff) are very good at helping you to get access to other health professional."
● The service's work diary and people's care records showed when people were supported by staff to attend various medical appointments.

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 our last inspection we rated this key question good. At this inspection the rating for this key question has changed 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.

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

- The registered manager did not operate effective systems to ensure the service met the fundamental standards. During the course of our inspection, we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems and processes in place promoted restrictive practices which did not respect people's rights. Evidence of this is cited in the safe domain of this report.
- Staff were not empowered to make decisions and had to get the registered manager's permission before they could carry out daily tasks. This meant staff were unable to work pro-actively with people they provided care and support to day to day and, decisions could not always be made to support peoples' preferences and meet their needs effectively.
- The service did not meet the statutory guidance right support, right care and right culture. It is a requirement for services supporting people with a learning disability and autistic people to follow this guidance. On 17 November 2022, we asked a team leader and Clinical Director, about their knowledge and understanding of this expectation, but they were not aware of this guidance.
- The service model was more like a residential care home than a supported living service. There was a large sign on the façade of one setting which identified it as providing care services. A team leader referred to the service as a care home and to people as residents. However, people did have their own tenancies.
- We could not be assured the service implemented national guidance 'The Real Tenancy Test' which is applicable to supported living services. This framework stipulates people can change providers without finding alternative accommodation. We asked to look at service users' tenancy agreements with the landlord and were told by the management team these were not available. We asked the management team to provide this information electronically by 2 December 2022, however, they failed to do this without explanation.

The provider's established quality assurance and monitoring systems were ineffective in identifying and managing risks to people's welfare and safety. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems or processes established and operated did not effectively help the service to be compliant with relevant legislation. Records relating to care and the management of the service were not always complete, accurate or up to date. Two staff members described a person was experiencing 'vacant unresponsive'

seizures. However, this was not reflected in the person's care plan or risk assessment. There was insufficient information in the care plan in relation to their nutrition and swallowing difficulties. Swallowing difficulties were recorded as 'temporary' without any follow-up or assessment with a clinical professional such as their GP or Speech and Language Therapist.

● Policies and procedures were not always dated, in line with current legislation, national guidance and current best practice. Medicines policies did not provide staff with detailed information about PRN protocols. The complaints policy and signage on display in communal areas informed people how to raise concerns. They were not written in an accessible format such as, incorrectly advised people they should raise their complaints to the CQC and did not provide other relevant external agencies contact details. They were not checked for accuracy, for example, some were still showing the name of another service provider.

● A staff member told us staff rotas were not up-to-date and did not reflect actual staff working patterns because the registered manager would instruct staff to move to support service users at another service at short notice. Work mobile phones confirmed this. This meant there was a poor audit trail to demonstrate how settings were appropriately staffed and lacked a continuity of care.

● Audits used to assess, monitor, and improve the service were not made available to us during this inspection. On the first day of our inspection, we emailed the Clinical Director a list of documents we wanted to review. The General Manager told us audits were either archived or unavailable to review as they were placed in storage when the service had moved in August 2022. A review of your undated 'record keeping and retention policy' showed there was no specific timescales for when records relating to care should be archived.

● Records were not always accessible to authorised persons as legally required. Our inspection was delayed as the General Manager did not give us access to records relating to safeguarding and accidents and incidents. The lead inspector had requested to review these records on 17 November 2022. On the third day of our visit, 24 November 2022, the General Manager continued to prevent access stating the files were not in order. We were eventually given limited access to the requested records. Therefore, we could not be assured there were effective systems to ensure records relating to safeguarding and accidents and incidents, were completed and staff had taken appropriate action.

● Daily care records referred to as, 'clinical records' were either illegible or sometimes hard to understand. The notes contained, all forms of information from 'service user monthly evaluations', assistant psychologists' therapeutic work, social care and health professionals' visits and communications with service users' relatives. This made it difficult to locate specific information, identify patterns and required follow up to ensure people' needs were met.

● A staff member told us medicine audits were completed every Monday. We saw medicine audits sent to the registered manager via text message by shift leaders. However, the audits only consisted of the names and dosages of medicines, and number of tablets remaining. There was no correspondence relating to what had been found, areas for improvement, with timescales for any identified actions to be completed. In addition, these medicine audits were ineffective as they failed to pick up the concerns we found during our inspection.

● There was no supervision matrix for management to ensure staff received appropriate one to one support. Although the service' action plan had identified staff required to be supervised, it failed to show what specific action was taken to ensure those responsible for conducting supervision were appropriately trained to carry out this task effectively.

● Funding authorities shared concerns with us relating to how the service supported people with identified risks and how the registered manager engaged with health and social care professionals. In response to these concerns, the registered manager had sought support from an external consultant and an action plan dated 14 November 2022 was devised to help identify, address and make the necessary improvements.

● A 'clinical file update' form dated 14 November 2022, documented the names of people whose care records had recently been updated. However, during this inspection, we found some of these care records

were not updated to reflect changes in peoples' health or changes in circumstances. A person who had been 'fainting', attended hospital on 19 May 2022 and was diagnosed with a medical condition. Another person had not been living in the service for several months. This information was not reflected in their care plan that was updated on 12 November 2022.

● The service's quality assurance systems failed to highlight people who were subject to Court of Protection (CoP) Orders, and what staff needed to do to be compliant with relevant legislation. A person had moved into the service on 29 March 2022 and was subject to a CoP order. However, the service's application to apply for CoP order, sent to the supervising authority, was only submitted on 31 October 2022. This meant some aspects of working practice were unlawful.

● We gave the management team up until 2 December 2022 to provide us with documents we had requested through our inspection. Some of the requested information received before this deadline, did not reflect work that had completed before our visit. The 'incident analysis report' dated 1 September 2022 to 28 November 2022 covered incidents that occurred after our visit on 24 November 2022. This meant the information sent to us was not an accurate reflection of what we found during our visit.

The provider's quality monitoring systems were ineffective and records were not managed effectively. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people.

● Where incidents happened that involved the police, providers are legally required to notify us. We found the service failed to do this. For example, daily care records dated 17 August 2022 stated a service user had reported to the service that whilst out accessing the community, they had been threatened by male strangers. Although the service had reported this incident to the police, they failed to submit the relevant statutory notification.

● A person experienced epileptic seizures and needed to be accompanied when accessing the community. An incident report showed on 29 October 2022, they had self-harmed and left the service unaccompanied on 9, 15 and 21 November 2022. These were reportable incidents, but the service failed to submit the relevant statutory notifications.

● The general manager shared correspondence which showed on 24 November 2022, a social care professional had informed them of an incident involving the same service user. This incident was being investigated by the police, but the service failed to notify us by submitting the relevant forms. This demonstrates the registered manager did not fully understand their legal responsibilities and was non-compliant with this legislation.

The service did not always notify us of notifiable incidents. This is a legal requirement. This was a breach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

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

● There was a limited approach to sharing information with and obtaining the views of staff, service users, relatives and those who legally represented them, external partners, and other stakeholders.

● For example, the registered manager's decision to install and use closed circuit televisions (CCTV) in some of the settings. 'Resident' group meetings were facilitated by staff to publicly discuss peoples' plans for the day and any concerns, however there was no evidence about how this fed-into the development of the service or progress towards peoples' goals and aspirations. Feedback was not sought through individual

questionnaires or surveys as part of an open and transparent approach.

The service failed to seek and act on feedback from relevant persons, health and social care professionals and other persons on the services provided, for the purposes of continually evaluating and improving the service. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave positive comments about management such as, "I've met the (registered) manager yeah, he's really funny, a right laugh. I see him around quite regular and he's got WhatsApp and a work phone. The staff, the management...it's just like everywhere I've gone they're like 'yeah you can text and I'll text back' and strict professional but these guys have a heart and they actually care as well" and "Here is quite good, when you talk to [name of registered manager] he sort things out, if you stay with your issues and don't discuss it, it won't get sorted out. They (staff) give you a level of freedom and have a good knowledge of me." Relatives' comments included, "Every time I go in there, there is a different person with (family member), from what I've seen they are just part timers...it's like picking up a stone. They pick her up and just put her in another place" and "If something isn't getting done the manager gets things done – will text even if in a meeting. He's really firm but I can tell he runs a tight ship."
● Staff comments included, "The management are good" and "I talk to my direct line manager, we work together. I would recommend the company to work for."

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service did not always notify us of notifiable incidents. This is a legal requirement. Reg (18) (1).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 5 HSCA RA Regulations 2014 Fit and proper persons: directors Staffing levels were insufficient and people were not always supported by staff who were safely recruited. Reg. (19) (1).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not consistently work collaboratively with people or their representatives to ensure care and support delivered was person-centred, and accurately reflected peoples' views and care needs. Staff lacked a general of understanding of how to support, monitor and manage people's health and support needs. This meant people's health needs were not always met. Reg. (9) (1).

Regulated activity	Regulation

Personal care

Treatment of disease, disorder or injury

Regulation 11 HSCA RA Regulations 2014 Need for consent

The service failed to act in accordance with Mental Capacity Act 2005 and its Code of Practice.

Reg (11) (1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to identify, assess and manage risk, increased the risk of harm to people. Management of medicines did not ensure safety, quality, and consistency of care. This was because the provider did not follow their own medicines policy, national guidance, and best practice. The service failed to follow the most recent government's guidance relating COVID-19 in adult social care setting, increased the risk of people being infected with the COVID-19 virus. Regulation 12 (1), (2).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all staff had received relevant safeguarding training and, the service's restrictive practices infringed on people's human rights, which amounted to institutional abuse and unlawful restraint. Regulation 13, (1) (2) (3) (4) (5).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

Treatment of disease, disorder or injury	People's nutritional needs were not effectively managed by staff where poor hydration and nutrition needs were identified. Regulation 14 (1), (2), (4).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service's established quality assurance and monitoring systems were ineffective in identifying and managing risks to people's welfare and safety. Records were not managed effectively. The service failed to seek and act on feedback from relevant persons, health and social care professionals and other persons on the services provided, for the purposes of continually evaluating and improving the service. Regulation 17 (1) (2).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to ensure staff were effectively inducted, trained and supported to be able to meet peoples' needs. Regulation (1), (2).

The enforcement action we took:

Warning notice.