The Fremantle Trust

Aylesbury Supported Living Service

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aylesbury Supported Living Service provides support for 27 adults with learning and physical disabilities across four sites in the Aylesbury and surrounding areas. Each property blends in with other housing in the area and is indistinguishable as a care setting. At one of the sites, night time support is provided by another service which is separate to The Fremantle Trust. This is a contractual arrangement with Buckinghamshire Council. People are supported in individual flats and shared houses which are owned by a housing association. People's care and housing are provided under separate contractual agreements.

People's experience of using this service and what we found
People were not always protected from avoidable harm. Specialist advice was not always followed to prevent choking. A risk assessment had not been put in place for someone who was at risk of choking and for another person who was on anticoagulant therapy. Anticoagulants are used to thin the blood.

People did not always receive their medicines as directed by the prescriber. In one case, staff were giving medicines on an 'as required' dose rather than the regular dose the doctor had prescribed. The medicines were to treat constipation. Staff had stopped recording bowel movements for the person and although they had noted they had a swollen and distended stomach they did not seek medical advice until requested by inspectors to do so.

People's consent to their care and treatment was not always sought. In 1 of the supported living properties, people contributed to a household fund. Some of the people lacked mental capacity to agree to this. Best interest meetings had not been held with their next of kin or other relevant persons to agree to the contributions. People had been paying higher contributors to the fund previously and it was identified by the provider in July 2022 a refund was due to them. No refund had been made at the time of the inspection. One person received a contraceptive injection on a regular basis. The provider was unable to tell us if the person could give informed consent for this.

We had not always been informed about significant events the provider was required to tell us about, although we could see appropriate actions had been taken at the time these occurred.

Governance systems were in place and there had been regular monitoring of the service by the provider. However, these were not effective in ensuring improvements were achieved in all required areas. There was inconsistency of care and record keeping between the different supported living properties and a lack of management oversight to ensure systems were used effectively. The provider was not meeting the duty of candour requirement, which requires providers to act in an open and transparent way when things go wrong.

Improvements had been made to infection prevention and control practice. Standards of cleanliness had improved overall. Some minor issues in a shared bathroom and laundry were brought to the provider's

attention and action was taken. We have made a recommendation to ensure standards of cleanliness are maintained.

Improvements had been made to protecting people from the risk of abuse. There were procedures in place to respond to allegations of abuse and staff received safeguarding training. The provider made appropriate referrals to the local authority about people's welfare and co-operated with any investigations. Recording of accidents and incidents had improved.

People were supported by workers who had been robustly recruited. The provider was trying to fill vacant posts and in the meantime used agency staff to cover gaps in the rotas.

Feedback from people was positive about standards of care. Typical comments included "We have had such good support from them, kind respectful and dignified," "There have been some changes in the last year but on the whole the staff are brilliant," "They are kindly and respectful to her every time that I have seen them, she's always very happy being there." Another relative told us "They really are lovely staff. They've got him to come out with others and take part more in the community." Some relatives commented communication could be improved and they had concerns about staff turnover and agency worker use. This was more in context of consistency of familiar faces rather than concerns that people did not receive the care they needed.

The provider was not able to demonstrate how they were meeting all of the underpinning principles of Right support, Right care, Right culture.

Right support
Staff did not always follow or act in accordance with the Mental Capacity Act 2005, as consent was not always sought. Staff did not always support people with their medicines in a way that effectively managed health conditions.

Right care
People received kind and compassionate care and staff protected and respected their privacy and dignity. However, there were some instances of institutional care in how one of the supported living settings was run.

Right culture
People's quality of life was not enhanced by a culture of improvement. Managers did not have effective oversight of practices in all of the supported living settings, leading to inconsistencies in care.

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

Rating at last inspection
This service was registered with us on 17 February 2022 and this is the first inspection after the location moved to new office premises.

The last rating for the service was Requires Improvement, report published on 10 February 2022.

Why we inspected
We carried out an announced focused inspection of this service on 5 and 17 January 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding people from abuse, meeting

regulatory requirements and good governance.

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 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 Requires Improvement to Inadequate. 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 Aylesbury Supported Living Service on our website at www.cqc.org.uk

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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led key questions of this full report.

Enforcement and Recommendations
We have identified breaches in relation to medicines practice, managing risks to people's health and safety, consent to care and treatment, governance, acting in an open and transparent way and reporting incidents at this inspection.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Aylesbury Supported Living Service

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.

This was a focused inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 Safe care and treatment and Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors. An Expert by Experience made telephone calls to relatives. 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 4 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was no registered manager in post.

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

Inspection activity started on 8 November 2022. We visited the location's office on 8 December 2022. Visits were made to 2 of the supported living properties on 8 December 2022, 9 December 2022 and 19 December 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals 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 contacted staff by email and received one reply.

The Expert by Experience had conversations with 10 relatives.

We used this information to plan our inspection.

During the inspection
We met and had discussions with 2 quality managers, the manager, deputy manager and 2 operations managers. We also spoke with a care worker and team leader.

We provided a questionnaire for staff to complete when we visited the office location. We requested the provider contact staff to encourage them to respond to the email we sent, which they did.

We looked at 7 people's care plans, risk assessments and a sample of medicine administration records. We checked records of audits and monitoring carried out by the provider. Other records we read included accident and incident logs, staff training records, recruitment and staff development files.

After the inspection
We requested and received additional records and evidence after the site visits and continued to review these until 9 January 2023.

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 Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure they had assessed the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 12.

• People were not always protected from avoidable harm. For example, staff did not always follow specialist guidance for people who were at risk of choking. We found there was no risk assessment in place for 1 person who was at risk of choking. We discussed this with the provider and an assessment was put in place shortly after our inspection.
• We observed another person was provided with a meal which did not meet the guidance provided by the Speech and Language Therapist (SALT). The food was not of the consistency and texture recommended for them by the SALT, which could cause them to choke.
• Risks relating to medicines were not routinely and consistently identified. People prescribed anticoagulant medicines are at higher risk of excessive bleeding and bruising. The risks around this had not been considered or mitigated for 1 person who was prescribed this type of medicine.
• Risks to people's safety had not always been mitigated. We found a blind cord in a communal bathroom which could be a strangulation risk. We also found aerosol cans and disinfectant in the bathroom were accessible on the windowsill, which could be ingested by people.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to do all that is reasonably practicable to mitigate the risks to the health and safety of people.

The provider took action to remedy risks by the time of our second visit.

• We found a range of other risk assessments had been completed. For instance, supporting people with epilepsy, supporting with meal and drink preparation and accessing the community.

Using medicines safely

At the last inspection the provider had failed to ensure the proper and safe management of people's

medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 12.

• People were not routinely and consistently supported with their medicines as directed by the prescriber.
• One person was prescribed 2 medicines for on-going concerns about constipation. However, records showed the person was not being given both by staff, contrary to the doctor's instructions. Staff were giving the medicine on an 'as required' basis. Staff and the manager were unable to provide any evidence the doctor had agreed to any changes to the prescription.
• There was a period between 28 November and 8 December 2022 when there was no record of the person having their bowels open. Staff were unable to provide verbal confirmation whether they had or not. On 4 occasions between those dates, staff had recorded the person had a 'quite distended stomach,' 'distended stomach' or 'swollen stomach.' Due to our level of concern about the person, we asked the manager to contact the GP surgery straight away to seek advice.
• One person was prescribed paracetamol. The prescription was for 'one tablet twice a day when required'. The medicine administration record showed 2 tablets had been given to the person as a single dose on 4, 9 and 15 November 2022, contrary to the prescription.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure the proper and safe management of medicines.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person who is supported in their own home need to be made to the Court of Protection (COP). We checked whether the service was working within the principles of the MCA.

• We found there was inconsistent practice regarding adherence to the code of practice of the Mental Capacity Act 2005.
• A monthly manager's report carried out in August 2022 identified a review was required of people's financial contribution to a household food fund, which was in place at 1 of the properties. We asked to see copies of mental capacity assessments and best interest meetings held about this. We were initially told there had been discussion with families and agreement to this. When we discussed this at a later date, we were told meetings with families were about to take place and consent forms would be signed then. This meant the contributions had so far been taken without consent.
• One person's finance support plan dated 7 November 2022 stated they had "No understanding around the value of money." The financial contributions for this person had therefore been taken without proper authorisation or consent.
• One person's records indicated they had chosen to take 1 form of their prescribed medicine over another. However, we were not assured they were able to weigh up the consequences of each medicine for themselves. There were no records to show how they were able to make their decision.
• We found there were no records to show how best interests decisions had been made for 2 people who

lacked capacity to be vaccinated against COVID-19. We found they had been given the vaccine on 7 December 2022.
• We read a healthcare record which said a person received a contraceptive injection. We asked whether they were able to consent to this and understand what it was for. We were told it was not clear if the person understood. The provider said they would "Do some work on this to try to make it simple and see if this gives her the understanding." There was the potential for the person to be receiving the injection without informed consent being in place.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure care and treatment was only provided with the consent of the relevant person.

Preventing and controlling infection

At the last inspection the provider had failed to ensure they had appropriate measures in place to control the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12.

• Overall, we were able to see improvement to standards of cleanliness.
However, we found the level of hygiene in a communal bathroom required improvement. We found stains on a free-standing toilet frame and stains on the floor at the base of the toilet. The sink in the bathroom was full of matted hair and the towel rail was rusty. The provider told us people did not use this room as they had their own en-suite rooms.
• The laundry room in one setting was dirty and parts of the tumble drier had been removed and were placed next to the machine. We found a large gathering of dirty debris and a dirty duster beside the tumble drier.

The provider acted upon our feedback and had arranged for improvements to be made to the communal bathroom.

We recommend the provider ensures environmental checks are routinely carried out to ensure standards of hygiene are maintained.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had failed to ensure people were safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Relatives told us they felt people were safe. Comments included "I am convinced he's safe now," "In terms of safety she's not unsafe at all. She knows what's happening, they take her where she needs to go, she knows what's going on" and "He's safe on a day to day basis."
• There were procedures to follow if staff needed to raise safeguarding concerns.
• Referrals had been made to the local authority safeguarding team when required.
• Staff had received training in how to recognise abuse and protect people. Staff were able to demonstrate how they would use the training in practice to support people. Staff told us "Be watchful, have a good relationship with service users, check if there is anything to look for, changes in behaviour or routine, report immediately" and "I would know how to raise a safeguarding and how to record it."

Learning lessons when things go wrong

At the last inspection the provider had failed to do all that is reasonably practicable to mitigate the risks to people's health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12.

• We found examples where the provider used events such as safeguarding investigations to make changes to practice to prevent recurrence. For instance, a new handover process and guidance on night time responsibilities had been developed. However, we found the handover processes was not routinely and consistently followed. Staff told us this was because they could not access the handover template on the computer when they needed to, due to problems with IT infrastructure.
• There were improved records of incidents and accidents covering the whole service, so that any trends could easily be seen.
• A positive behavioural support plan was in place to provide a consistent approach to a person when they were distressed. There was supporting information from a community professional about known causes of anxiety and stress for the person and how to help them on these occasions. Records of incidents were maintained and showed the person had not experienced any recent episodes of distressed behaviour.
• The provider responded to our feedback throughout the inspection and implemented guidance for staff on issues raised, where required.

Staffing and recruitment
• People were supported by staff who had been recruited using robust processes. This included Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Gaps in staff working history were explained and noted. References were obtained prior to new staff commencing work.
• We observed there were enough staff to support people with their chosen activities. Staff told us "There is good energy, everyone supports each other," "Levels of staff are good, we co-operate with each other and support as required." A third member of staff told us "At the moment staffing level is on right level."
• We observed some staff were working excessive hours and there was a reliance on agency staff to cover the rotas.
• Six relatives mentioned use of agency staff or referred to the service being short staffed, although we did not observe the latter. Comments from relatives included "A lot of it seems to be agency staff…it's more difficult to find anything out and liaise with anybody," "I just don't like the idea of all these agency staff they have at the minute. (Name of person) likes his routine and staff that know him. He really gets attached to staff and it's important to him the company keep them." Another person commented "The staff on the floor

are very kind and respectful, it's the long term staff loss and where we go from here with the recruitment that's the worry."
• The provider told us they were trying to recruit permanent care workers and had some new starters already, with a couple of others due to join after all recruitment checks were back.

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 Requires Improvement. At this inspection the rating 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.

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

At the last inspection the provider had failed to ensure all allegations of abuse were notified to the Care Quality Commission without delay. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made and the provider was still in breach of regulation 18.

• The provider failed to routinely and consistently notify us of events it was legally required to. This meant we were unable to see in a timely manner whether action was taken where people experienced injury or harm.
• We found the provider had been delegated a safeguarding investigation by the local authority. Although they had undertaken the investigation, they had failed to inform us of the safeguarding incident.
• We had not been informed about some other incidents. These included 2 unexplained marks on people, an incident where a person slapped someone else and a choking incident. There had also been 2 incidents where staff had not administered a person's antibiotic medicine.

This was a continued breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009, as the provider had failed to ensure all incidents were reported to the Care Quality Commission without delay.

At the last inspection the provider had failed to ensure systems and processes were established and operated effectively, to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 17.

• The provider's systems were still not operated effectively to assess, monitor and improve the quality and safety of the service.
• We found the provider had not followed their supervision policy to support staff with personal development. Members of the quality team told us they were aware supervision meetings had not been

happening in line with the policy. A tracker system to record when supervision had taken place had not been kept up to date. The purpose of this was to provide management oversight. An operations manager searched through staff development files to find any paper copies of records and then updated the spreadsheet during the inspection.
• We found record keeping at 1 site to be disorganised and had the potential to put people at risk of harm and inconsistent care. For example, where risk assessments were in place, they did not always accurately identify the level of risk.
• One person had an undated swallowing and choking risk assessment. The staff member who completed it had ticked 'never' to a question about whether there was a diagnosis of reflux. Acid reflux is caused by stomach acid travelling up towards the throat and causes a burning sensation in the chest. However, a health and medication care plan dated 8 November 2022 and the medicines administration records showed the person was prescribed medicine for acid reflux. The inaccurate way the assessment was scored could have affected the outcome of it and the subsequent actions to be taken.
• We read a skin integrity risk assessment (Waterlow) dated 10 November 2022. The staff member who completed it had highlighted the person had broken areas of skin, graded 2 to 4. This form of grading is intended to be used to indicate severity of pressure wounds. None of the staff on duty staff were able to confirm if the person had pressure wounds. We noted the assessment tool had been calculated incorrectly; 3 different scores were noted on the form, although this did not alter the level of risk or actions required.
• Records relating to people's medicines were not always accurate. We found the numbers of medicines recorded on medicines administration records (MARs) were not correct. For instance, 1 person's records showed there were 77 sachets in stock of 1 of their medicines on the 8 November 2022 and 16 on the 9 November 2022; the record indicated only 1 sachet had been administered between the 2 days.
• We found discrepancies in records of another person's medicines. They were prescribed 2 capsules of 1 medicine, to be taken each day. The MARs recorded they had 24 capsules in stock on the 21 November 2022 after the daily dose had been given. On 22 November 2022 the records stated they had 18 capsules left after the daily dose had been given. This meant 4 capsules were unaccounted for if the records were correct.
• We found staff had not kept a record of contact with the GP surgery regarding concerns about a person's welfare. We had been told by the manager staff completed health intervention sheets to log the communication. However, these records were not in use at the service and the information had not been recorded elsewhere. This was completed in retrospect after we raised concerns.
• We found inconsistency in the expectations of record keeping across the service. We found the lack of cohesion led to some risk assessments and care plans being omitted. We discussed this with 1 of the quality managers, who agreed and said they were attempting to standardise paperwork.
• Staff told us there was unreliable access to the internet to be able to receive and send emails. This also affected being able to log on to the provider's system to download documents. Staff told us this was a known problem which had been reported to their IT department and was receiving attention. However, it meant there was delay in contacting and following up replies from external agencies such as the GP. For example, on 19 December 2022, we asked if a reply had been received from the surgery regarding a referral made on 9 December 2022. The member of staff told us they had not been able to access emails to check this. This meant there were delays which could affect people's care.
• There was no registered manager at the service. A registered manager from a service run by the provider nearby was overseeing it. There had been changes to managers and senior managers since the last inspection. We found quality assurance processes were not effective in ensuring there had been consistency in people's care and that sufficient improvements were made.
• Managers at all levels were co-operative with the inspection and fully assisted inspectors. However, management changes meant no 1 person had complete knowledge of practices at the service and across the different premises. Managers needed to confer with each other to respond to inspection queries and information requests. Several times we were told practices were in place and this was later found not to be the case. For example, use of health intervention records, mental capacity assessments and consent for

contributions to the household fund.
• The service felt uncoordinated. The individual premises were reliant on the skills and knowledge of the team leader in charge rather than robust management oversight. For example, in 1 of the premises, managers were unable to explain how some practices had occurred or when they started or stopped. This included the inappropriate use of baby food in response to a medical need for a pureed diet and stopping bowel monitoring for someone at high risk of constipation.
• Regular audits were carried out of the service. Where actions were needed, these had not always been followed up in a timely manner to ensure improvements had been made. For example, an action from an audit dated 12 July 2022 was for use of the household fund to stop at 1 of the premises as it was institutional practice. However, it was still in use at the time of the inspection. The audit report also referred to refunding people excess money they had previously paid into this fund (£60 per week at one point). This had not been done. We asked the provider about this and they said the matter was being dealt with by their accounts department. No date was provided for when this would be completed by.
• We read the report of the provider's annual internal quality audit dated 1 September 2022. This rated the service as inadequate. Although an action plan had been completed and there was commitment from the provider for improvement, it was concerning to read the service was performing poorly 8 months after our last inspection. The provider had failed to act upon the warning notice we issued and make the necessary improvements to people's care.

This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems or processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the service.

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
• Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
• The provider's quality manager confirmed to us the service was not fully meeting the duty of candour requirement. They stated "All duty of candour (incidents) have generally been completed verbally over the phone. Moving forwards written duty of candour will be completed for any serious incidents. Contact/discussion sheets will be reintroduced to record any conversations with family and/or friends including duty of candour for minor concerns."
• No evidence was provided of any records of conversations with people or their families after notifiable safety incidents occurred. We were therefore not able to see the service had acted in an open and transparent way when things had gone wrong.

This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to act in an open and transparent way and meet the requirements of the duty of candour regulation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection we recommended the service followed best practice in ensuring there was meaningful engagement with people about the support they received and actions taken in response to this.

• We found different levels of engagement in the individual supported living settings. In 1 there was evidence of regular meetings with people to ask them for their ideas about, for example, activities, outings, consulting about soft furnishings and discussion about keeping safe and healthy eating. In another setting, meetings had only recently been introduced and 2 had taken place. These mainly planned the menus for shared meals. There was therefore a difference in the amount and quality of engagement with people and seeking their views about the service.
• We observed members of the senior management team were well known by people and staff in the supported living settings and were able to engage with each other easily.
• One person told us "[Name of staff] and the team are brilliant."
• Staff who provided feedback told us they thought the manager was approachable and fair to all staff. One staff member told us "Friendly atmosphere, easy to approach managerial staff."
• Staff told us they knew how to raise safeguarding concerns and the types of things they would report. Safeguarding posters were displayed in the premises.
• We asked staff if it was a good place to work and what they liked and disliked. Comments included "Yes. Good energy, everyone supports each other and kind" and "Yes. I enjoy being able to support people to live the highest quality life."
• We found evidence of staff meetings occurring, where staff shared information about good practice.
• People who provided feedback said they knew how to raise concerns and would speak with managers or keyworkers. A keyworker is a member of staff who makes sure people have the support they need, in a co-ordinated way. The role often involves liaising with families and healthcare professionals on the person's behalf, if required.

Working in partnership with others
• The staff within the service had good relationships with relatives.
• Some relatives commented on communication. For example 1 said "Communication could be better about what's going on," another told us staff were "Really caring and kind it's just communication could just be a lot better."
• The provider and staff within the service worked with external healthcare professionals. They had engaged with the local authority in their monitoring of the service and had undertaken delegated safeguarding investigations when required.
• Where required, people were referred to specialist healthcare professionals. For instance, speech and language therapists and physiotherapists.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure all incidents were reported to the Care Quality Commission without delay. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure care and treatment was only provided with the consent of the relevant person. Regulation 11

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to act in an open and transparent way and meet the requirements of the duty of candour regulation. Regulation 20

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that is reasonably practicable to mitigate the risks to the health and safety of people. The provider had failed to ensure the proper and safe management of medicines. Regulation 12

The enforcement action we took:

issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the service. Regulation 17

The enforcement action we took:

issued a warning notice