Coghlan Lodges Limited

Coghlan Lodges

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

At the time of our inspection, the service provided support to four people who received 'personal care' in three of the nine locations.

People's experience of using this service and what we found
People did not receive safe care and support. People's specific needs were not risk assessed effectively. The provider did not operate systems effectively to ensure staff were recruited safely. People were not supported by sufficient numbers of staff. Infection control measures were not followed by staff. Safeguarding concerns were not always reported to the local authority.

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

The provider did not ensure people received care which consistently promoted their privacy, dignity or independence. People and relevant others were not always involved in decisions about their care.

The provider did not respond appropriately to complaints. The complaints log did not show outcomes or actions taken in response to complaints. The service did not always provide personalised care; people's end of life preferences were not recorded in the event of sudden death.

Provider oversight and governance systems were not adequate or effective to assess, monitor and improve the quality of all areas of the service provided. The management structure did not provide sufficient oversight of services to ensure safety. Risks to people were not always identified or responded to by the provider to protect people from harm.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; limited inclusion and lack of choice and control. The provider could not show us how

people were included in decisions about their care or how the service was run.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 29 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations and remains inadequate.

This service has been rated inadequate for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, injuries sustained through falls and the provider's management of risk. A decision was made for us to inspect and examine those risks. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

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

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

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Coghlan Lodges

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by two inspectors.

Service and service type
At the time of our inspection the service provided care and support to people living in eight 'supported living' settings, so that they can live as independently as possible. Since our inspection the number of supported living settings has reduced to six. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service did not have a manager registered with the Care Quality Commission at the time of our inspection. The previous registered manager deregistered in November 2019. A new manager was in post and applied to register after our inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 16 November 2019 and ended on 22 December 2019. We visited the office location on 16 and 18 November 2019. We received information of concern about complaints on the 10 January 2020, which we followed-up with the provider and have included as part of the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
Some people being supported had complex needs and were therefore unable to provide us with feedback. We used observations of care to help to understand the experience of people. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing. We spoke with one relative, six care workers, the manager, the area manager, the finance manager and the business development manager. We received feedback from four safeguarding local authorities, three quality monitoring teams and three social workers.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff rotas, care planning documentation and a number of management records. We received email questionnaire responses from four staff. We spoke with another professional who was involved in one person's care and support.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from abuse. Systems and processes were not always established or operated effectively to prevent abuse. This was a breach of regulation 13 (Safeguarding service users form abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

• People were not protected from the risk of abuse. The provider did not always report or respond appropriately in line with safeguarding policies and procedures where incidents had occurred.
• One person had sustained serious injuries as a result of falls and experienced a choking incident. Another person's antibiotic medicine was delayed by four days. None of these incidents were reported to the safeguarding or people's funding authorities. We raised this with the business development manager who said an area manager was at fault (since resigned), however the provider did not have an effective system in place to check incidents were reported to the safeguarding authority where required. The provider had taken action to prevent future risks. However, this was not always effective or followed-up by the provider. For example, the manager explained a swallowing assessment had not occurred as when the specialist contacted the service staff told them the person no longer required an assessment, which was not the case. The manager had made a new referral in November 2019 which was not a timely response to the choking incident in July 2019.
• Staff told us they received safeguarding training, however they were not able to demonstrate they took necessary action to prevent and respond to abuse. During our visit we observed an incident of physical abuse whilst people were left unsupervised in the lounge. This was against peoples' risk assessments, which stated people needed to be supervised by staff to avoid this known risk. The member of staff did not record or report this incident to the manager (who arrived at the address 10:24) because they said they were too busy.
• There was a risk people were being deprived of their liberty illegally. All people receiving regulated activities required continuous staff supervision at home or in the community. We asked a member of staff if they had any concerns about safety, they replied "Not really, working with mental people is the only worry, so [staff] make sure that everyone is in at 11pm." Only one member of staff was deployed at the service between 20:00 and 08:00 which meant the person who required one to one support in the community was unable to leave their home. At a different setting staff told us they locked the doors between 18:30 - 19:00 for security purposes. There was no evidence that people had consented to this restriction, or whether their capacity to consent to this restriction had been assessed and appropriate authorisation had been sought. This meant the service was illegally depriving people of their liberty.

• The manager responded immediately during and after the inspection. They reported allegations of abuse to the safeguarding and funding authorities and took action to avoid reoccurrence.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff employed were of good character and had the correct qualifications and experience for their role. This was a breach of regulation 19 (Fit and proper staff employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations 19.

• Staff records did not always contain evidence of the required recruitment checks. For instance, some records did not include candidates' full employment history, explanations for any gaps in employment, or references from previous employers. There was no evidence this had been followed up by the service when the candidate was interviewed.
• We found information in the public domain that indicated one member of staff may not be suitable to work with vulnerable adults as they had been struck-off a professional bodies' register due to a criminal conviction. This wasn't identified by the service because they did not check the person's last place of employment in line with requirements. This placed people at risk of harm.
• The manager took immediate action to safeguard people and followed their disciplinary procedure for staff involved.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection we found the lack of effective risk assessments or systems to meet people's care needs, non-compliance with health and safety requirements and poor medicines managements was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations 12.

• People did not always receive their medicines as prescribed. Management systems for the ordering, receipt and storage of medicines were not always adequate. We observed staff practice when administering medicines was unsafe and put people at risk of harm.
• Not all staff had received medicines training or competency assessments before being authorised to administer medicines. This meant the service could not be assured that staff understood or followed medicines procedures to make sure people received their medicines as prescribed and to avoid risk of harm.

• A staff member prepared two people's medicines (tablets) at the same time. They then gave both medicines pots to a person using the service and asked them to give the medicine to the other person who was sat in the lounge. The staff member told us it was usual for the person to do this as they liked to help. This was not safe practice; only trained staff should administer people's medicines, medicines pots could be mixed-up, the member of staff could not be sure that the person received their medicines as prescribed if they do not administer medicines directly. There was a potential risk the other person could take the medicines themselves, waste or destroy them.
• We found medicine, prescribed 9 July 2019, in an unlocked filing cabinet, which was accessible to people using the service and placed them at risk of harm. The manager investigated and said it should have been returned to the pharmacy.
• In October 2019 a visiting social worker found a person's MAR chart had not been signed by staff for three days for their epilepsy medicine. The agency staff member said this was because the service had run out of

stock. They had failed to report this to management and had not sought advice from the pharmacy or GP surgery. We were told the person's health did not deteriorate as a result, however they were placed at risk of harm. At our previous inspection in June 2019 we found gaps in the same person's MAR chart for their epilepsy medicine. The more recent error showed lessons were not learned by the service to avoid risk of reoccurrence.

• We observed staff administer a person time-specific medicines two and a half hours late. This was due to day staff arriving late on shift, general disorganisation of medicines systems, lack of staff co-ordination and staff medicines errors. This put the person's welfare at risk; staff told us it was important they received their medicines on time to help them feel calm.

• MAR charts did not always contain accurate information about people's allergies. For example, a MAR at one setting stated "none known" in hand writing. However, a hospital discharge summary for the same person stated they were allergic to "Codeine Linctus". The person had recently been prescribed co-codamol which contains codeine for pain relief. We reported this to the manager who took action and sought advice from the GP who confirmed the person was allergic to codeine linctus. No serious harm came to the person, however, this shows the service did not complete sufficient checks to find out if the person had an allergy and put the person at risk of harm.

• Personal Emergency Evacuation Plans (PEEPs) were in place but were not always reviewed and updated when people's circumstances changed. This was evident for one person whose mobility had deteriorated and now required a wheelchair to enter and exit the building.

• Staff we spoke with were not familiar with general fire evacuation plans. One staff member said "If there's a fire we go straight outside. I am not sure about a fire point, as long as everyone goes outside."

• At another setting we found both the front and back doors had been left wide open by the only member of staff on duty who had left the property with one person who wanted to go to the High Street shops, leaving two people in the service unsupervised by staff. Staff told us people's care and support needs meant staff needed to be present in their home at all times. This was neglectful of people's needs and posed a security risk to peoples' safety.

• At the previous inspection the provider did not effectively manage risk in relation to a person smoking cigarettes inside the property. At this inspection management who told us it was not always possible for staff to prevent this from happening. This was because the person sometimes bought their own cigarettes and lighter (although supervised by staff) and sometimes refused to smoke outside. They said the person sometimes became too challenging for staff to take possession of the cigarettes and lighter for their safety. This was not identified in the person's risk assessment and strategies were not in place for staff to reduce the risk of fire and harm to people.

• People were not always supported by enough staff to meet their needs which put them at risk of harm. Significant staff lateness during our inspection meant people were left unsupervised. One person was supported with personal care by one staff member rather than two to meet their mobility and personal care needs safely.

• At one setting there was a lack of personal protective equipment such as gloves. There was a malodour of urine in the kitchen where incontinence pads were disposed of in the kitchen bin. There was lots of debris on the carpet of a person's bedroom floor which looked like smalls pieces of incontinence pad. When the hoover was used a powerful malodour of urine came from it. Staff said this was reported to managers, but no one had cleaned it. This put people at risk of infection.

• Unresolved maintenance issues placed people and staff at risk. For instance, maintenance logs showed an office door handle was broken and reported by staff on 27, 29 and 30 September 2019. However, this had not been followed-up by managers. During our inspection we found ourselves locked in the office as the door handle had fallen off when we tried to exit. The manager was able to contact the staff member on their mobile phone to get them to open the door.

• At another setting we found that a fire exit was non-operational and another fire escape route was blocked in the garden due to a gate being padlocked. This put people at risk of harm from fire.

• The manager responded and made a plan to address the issues raised to reduce the risk of ongoing harm.

Inadequate

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At the last inspection we found people's needs were not adequately assessed or met and care was not always delivered in line with national guidance. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

• People's health conditions and diagnosis were not adequately assessed or accurately recorded. One person's learning disability continued to be incorrectly recorded in their care plan as a 'Psychiatric diagnosis'. The person had a diagnosis of epilepsy, however there was no epilepsy risk assessment or management plan for staff to follow.
• People did not always receive the correct staffing levels for moving and handling according to their care plans. People's care plan did not provide any guidance about moving and handling techniques, which meant people were at risk of harm. Staff were also at risk of harming their backs.
• The service did not provide continence support in line with national guidance. For example, one person's care plan stated, "I would occasionally require support to change my incontinence pad." There was no other information for staff to follow in relation to personal hygiene products. Neither was there an assessment about the person's skin integrity to identify whether they were at risk of developing wounds or sores. We found a similar issue in another person's care plan. This meant people were at risk of avoidable harm due to care and support not being in accordance with national guidance and best practice.
• The service did not work effectively with healthcare professionals to make sure people received timely support to meet their needs. For example, in response to a person's choking incident in July 2019 it took the service until November 2019 to co-ordinate a swallowing assessment. There was no reference to the choking incident in the person's care plan or risk assessment or safe measures to reduce the risk. Another person's eating and drinking care plan continued to refer to out-of-date guidance and terminology for the texture of food required to meet people's needs.
• Poor co-ordination between staff and management meant people did not always respond to people's needs in a timely manner. For example, staff did not always receive timely handovers and were not always familiar with where to find equipment and records which resulted in delays to people's day-to-day care and support.

Staff support: induction, training, skills and experience;

At our last inspection the provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were employed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

• There had been a high turnover of staff. This meant people at one setting were supported exclusively by agency workers who were all new to working at the service. This meant people did not receive consistent care.
• One staff member had worked solidly since 28 October 2019 working 08:00-20:00 and then a sleep-in between 20:00-08:00. They told us, "I have not gone home as yet because we are short staffed. I will be going home hopefully this Monday (18 November)."
• Staff did not have access to rotas at two setting. Rotas provided to us after our site visits were inaccurate; they were not updated to reflect staff who had actually worked. Only staffs' first names were recorded on the rota and it was not recorded who were permanent staff and who were agency workers. We were concerned this made it difficult to track who was working at the service to make sure they were suitable.
• People were not supported by a staff team with an appropriate mix of skills. Only one support worker had a relevant vocational qualification. We were told at the last inspection that several staff would be enrolled for social care vocational qualifications in September 2019. However, this had not happened and management had no explanation for this.
• There was no system in place for the service managers to assess whether staff, new to care, were competent to meet people's needs as part of their induction to care.
• Staff training records showed significant gaps for e-learning and some information was inaccurate. For example, on the 16 November 2019 one member of staff, who was new, told us they had not received any face to face or e-learning training. The manager checked their e-learning record the same day and confirmed they had not completed any training. When the provider later sent us a list of staff training attendance, records showed the same staff member had completed all face to face training on the 4, 5 6 November 2019 and five e-learning courses between 3 and 13 November, however this was not the case.
• Staff told us where they had attended face to face training this was very basic and they felt more in-depth training would help them feel more confident to do their job. For example, the provider had not arranged epilepsy training to meet a person's needs.

The manager responded to our concerns and arranged staff training and supervision.
• At one setting staff reported they felt supported by the new manager and told us supervision and appraisals were now underway or booked for the near future. Due to this being a new progression we could not assess whether this was sustainable across all settings.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

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

At our last inspection the service did not seek informed consent in accordance with the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 11.

• The service did not consistently comply with the Mental Capacity Act 2005 to gain informed consent from people. People's care plans stated they had cognitive impairments and could not understand risks and in one case had communication difficulties. This indicated that people would benefit from mental capacity assessments for specific areas of their care and support. However, with the exception of financial management, these were not in place.
• Staff did not always demonstrate a sound understanding of the Mental Capacity Act and what this meant when they were supporting people day to day. For example, when asked what it meant to them one staff commented, "Means it's stressed, their mood can change, they can be calm and then change."
• When we asked the business development manager about continuous supervision and applications for DoLS they stated this was not required for one person as they did not "force their way out of the service." This showed a general lack of management awareness of the mental capacity code of practice, which is about a person's mental capacity to consent and not about their 'compliance'.
• Another person's care plan stated they lacked capacity for 'big' decisions such as medical treatment and investigation, however there were no mental capacity assessments or best interest decisions recorded for recent medical interventions. The same person's care plan stated they had capacity to consent to the service using their photos for marketing purposes. Their care plan also stated they lacked any understanding of hazards, so it did not follow they would be able to understand the risks associated with their identity being used for the provider's marketing.
• The manager responded and said they would review these issues and liaise with local authorities to apply to the Court of Protection for DoLS.
• The service had begun to co-ordinate with one person's social worker to assess their mental capacity.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people to meet their nutritional and hydration needs. However, staff said food shopping was not well co-ordinated which meant they had to make emergency purchases.
• At one setting the fridge on the ground floor was broken. There was a working fridge on the first floor which was stocked with food, however, one person was not able to access this due to their mobility difficulties which meant they depended upon staff.
• Daily records showed people's food and fluid intake were monitored. Care plans documented how staff should try and encourage a balanced approach where people preferred 'junk' food and takeaways.
• At one setting the manager had bought a new dining room table and equipment to encourage people to prepare homemade soup. Staff told us meals were now more nutritious and people had started to sit and enjoy meals together socially.

We recommend the service implements an effective system to make sure people are supported to purchase food and to maintain equipment to promote people's access to food.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity.

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

At the last inspection people's privacy and dignity was not always maintained. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 10.

• People did not always receive care and support to maintain their dignity. A member of staff told us they were concerned about people being generally unkempt due to lack of appropriate staff support. They said people did not receive support to iron their clothes and one person did not have a trouser belt. We saw this person was continually pulling their trousers up, which was not dignified for them.
• People did not always receive personal care in a dignified way. Staff told us a person was supported to wash using a bowl of water in their bedroom, which they felt was not enough to meet their personal hygiene needs. During our inspection we observed a different member of staff prepare a bowl of water to support personal care in this way. The persons' care plan stated they should be supported to have a shower. We raised this with management who said staff should be providing a shower and could not give us any explanation.
• At another setting one person did not receive personal care due to being short staffed and accessed the community in urine-soaked clothes. We asked a member of staff to show us where personal hygiene products such as wipes were kept. They showed us an empty packet from the person's bedroom door which was labelled as surface/furniture wipes, unsuitable to use on skin. There was no other stock of suitable wipes at the setting. This meant there was no way to support the person with their incontinence hygiene.
• At one setting a person using the service had access to other people's private and confidential information in their care plans. During our inspection the person regularly accessed the office unsupervised including the unlocked records cabinet and looked at other people's records left on the desk. At another setting we found a person's daily record book was left by staff unsupervised in the kitchen which was accessible to other people using the service as well as visitors. This meant people's privacy and confidential data was not protected.
• The house keys, including keys to the settings and offices, medicines keys and record cabinets, were regularly left lying around the settings unsupervised by staff. On one occasion they went missing and staff commented that one of the people using the service liked to move them. At a different setting keys were left hanging from the records cabinet in an unlocked office when the only member staff had left the premises. This meant people's personal information was not kept secure.

• Staff we spoke with showed concern about people's wellbeing. However, when speaking with us staff sometimes referred to people using derogatory terms such as "mental", which was disrespectful.
• People's protected characteristics were not always considered or provided for. For example, the service had not considered a person's physical disability when assessing their needs for emergency evacuation. The same person was prevented from accessing the community as they did not have suitable equipment in place.
• The manager responded to our concerns and said they would take action after our inspection to make sure people's privacy was protected.
• A relative told us that two care workers at one setting were kind and caring towards their family member and they had built trust and a positive supportive relationship with them. Staff told us they were supporting the person to develop life skills and confidence by regular access to the community.
• At the same setting, where the new manager was based, staff appeared relaxed and friendly. We observed a more stable and calmer atmosphere at this setting compared with other settings.

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

At the last inspection people and other relevant persons were not always supported to be involved in making decisions about their care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 9.

• Relatives and professionals involved in people's care were not always consulted with in a timely manner when people's needs changed. For example, on two occasions a person's funding authority were not informed of serious injuries at the time they occurred.
• A person's relative told us the service did not contact them and would wait until they called or visited to inform them of significant events, including when the person sustained an injury.
• Key worker sessions were not consistently held with people to gain their views about their care. One person's last session was in August 2019. Staff did not always facilitate regular residents' meetings. We saw the last meeting at one setting was in August 2019. There was an entry for September 2019 with one comment which said, "All visitors to comply with house rules." There was no information gathered about people's meal preferences or activities.
• Some care plans were written in the first person; "I know how to ask for support." However, there was no information about whether this was the person's own words throughout the report or how they had been involved in writing it.
• The provider informed us after the inspection they would take action to make sure relevant people were informed of changes in people's needs.

Inadequate

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support; Meeting people's communication needs;

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last inspection the service did not carry out a holistic assessment of people's needs. Care was not designed to achieve people's preferences. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 9.

• Personalised support was not always planned by the service or understood by staff which meant people's needs were not always met.
• Staff were not always familiar with people's backgrounds, interests or needs. For example, one member of staff, who was the most experienced staff, working at the setting that day, told us "[Person] is nice and friendly. We make [the person's] meals, [they] need support with meds. I don't know anything else." They told us a person informed them they were restricted to go out by themselves, but the staff member could not tell us why. Another staff member told us, "[Person's name] has a memory problem, but I don't know what it is."
• A healthcare professional told us during their review of a person's eating and drinking needs and support, staff were unfamiliar with the person's guidelines and equipment which had been in place for over a year. This put the person at risk of harm from choking.
• A person's care record stated they liked to take a walk around the local area and required staff to accompany them to do this due to a deterioration in their cognitive abilities. The care plan stated a structured programme of activities should be in place to provide them with a means of social inclusion. However, there was no structured activities programme in place for this person.
• Staff told us there were several occasions over the past two weeks where a person had become extremely distressed because they wanted to go out into the community. They were prevented from doing so due to being short of staff and because their wheelchair was broken and not safe to use in the community. Staff told us the wheelchair had been broken for over a month. The manager showed us they had arranged for a

new wheelchair so they could access the community safely.
• The service did not document in people's care plans their end of life preferences. The service was not supporting people at the end of their life, however, they did not know people's wishes in the event of sudden death.
• Where people had identified communication needs, care records did not document how they should be supported. For instance, when referring to a person they supported a staff member commented, "[Person] is not able to read or write but they can understand. They will use standard words to communicate." However, their care plan did not include how the person could express themselves or receive and understand information.
• One person's care plan stated they were receiving input from a Speech and Language Therapist (SaLT) for their communication needs. However, when we spoke to SaLT they explained they were only assessing the person in relation to their swallowing needs. This showed a lack of understanding of the professional's role by staff and management, which meant the person was not receiving specialist support to meet their communication needs.
• The manager responded to the concerns we raised and took action to review people's needs with staff supporting them. They showed us they had arranged for a new wheelchair for one person so they could access the community safely.

Improving care quality in response to complaints or concerns
• The provider did not effectively investigate or take action in response to identified failures by the complainant or investigations by others.
• The Parliamentary Health Service Ombudsman (PHSO) are an independent complaint handling service. The PHSO investigated and upheld a complaint made by a person who had used the service for regulated activities. The PHSO final report, dated 17 Dec 2019, found multiple failings in the care provided by the service. This included the provider's own investigation which did not recognise failing in care provided by its staff or provide a remedy to the complainant. The PHSO recommended the provider arrange a remedy with the complainant by way of a letter of apology and a financial award for the distress caused.
• The provider did not respond to the PHSO report recommendations or respond to several attempts by the complainant to make contact with them following the final report. We spoke with the manager about this who told us the provider had not informed them of the PHSO findings. This was concerning as there were multiple failings and learning points for the service to act upon to avoid reoccurrences. We contacted the provider who acknowledged they had received the report, but they had not responded to the report recommendations and could not offer any explanation for this.
• We viewed the provider's complaints log. This did not provide information about outcomes and action taken in response to complaints. The provider could not show how they had handled or responded to complaints as required.

The service failed to operate an effective system to handle and respond to complaints. This was a breach of Regulation 16 (Receiving and Acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider gave us assurances they would contact the complainant at the earliest opportunity to arrange the remedy. They said they would make the payment award by the end of January 2020, although this was after the recommended month set by the PHSO.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

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

• Provider oversight and governance systems were not adequate or effective to assess, monitor and improve the quality of all areas of the service provided. The provider had submitted regular action plans to CQC in line with conditions of their registration imposed following a previous inspection. However, we found that many of the actions had not been completed or were not effective in improving the safety or quality of the service.
• The provider's quality audits were not effective; they had not identified the areas of concern we found during our inspection. The service continued to have a reactive approach rather than taking proactive steps to internally identify and address gaps in the quality and safety of care. The provider relied on other agencies' knowledge and quality monitoring to identify areas for improvement.
• Where the provider had taken action in response to concerns from the previous inspection this was not sustained. For example, where the provider has addressed maintenance of fire doors, we found another fire door was unfit for purpose which the provider had not identified.
• Records of people's care and for the management of the service were not always kept secure and were not always contemporaneous, accurate, easily accessible or kept in good order. Rotas continued to be inaccessible at settings and when they were provided they were inaccurate. People's care plans and risk assessments did not always include all of their needs and specific risks. Records showed that staff training attendance was falsified by the provider.
• There was a closed culture at the service. The provider was not always open with us during the inspection about issues such as staff-turn over before we raised them.
• Prior to the inspection we received whistleblowing concerns regarding people's safety and staff working

conditions. Managers continued to tell us this was due to disgruntled staff rather than reflecting on their own failings or address the concerns. For example, several staff complained they had not been paid by the provider and had stopped working. This had been going on for several months. The provider did not have a contingency plan to pay staff. This had a serious negative impact on people's continuity, quality of care and safety.

• The provider's business continuity was out of date and had not been reviewed according to the provider's schedule. For instance, since our last visit there had been changes in the management structure. This meant there was a possibility in the event of an emergency the service could not respond effectively to ensure people's safety.

• Since our last visit in July 2019 we found no structured program in place for staff supervision. Spot checks to ensure staff provided people with good, safe and effect care by following best practice did not consistently happen. We looked at the spot check record carried out on a person on 28 August 2019. The document did not identify the name of the staff who was being assessed and was partially completed. No further spot checks had been carried out by new staff members assigned to work with the person.

• We received feedback health and social care professionals the service did not always communicate effectively with them or early enough to identify concerns and respond to changes in people's needs. They said when they raised concerns the provider did not act promptly and staff working on shift were not able to answer queries about people's care and care records were not available. For example, accident and incident reports and staff rotas were not kept at the settings and were not provided as part of their quality monitoring visits. Managers were not easy to contact and there was confusion about who was in charge at each location.

• Since our last inspection people using the service were not provided with opportunities to be involved in the development of the service.

• One setting showed some swift improvements in November 2019 where the new manager was based; this was supported by feedback from the local authority. This staff team was more stable than the other settings and staff told us they felt supported by the new manager and demonstrated they were knowledgeable about people's needs. However, other settings had not received this level of input and there was no strategy from the provider about the oversight of the other two settings to improve safety and quality of care. The new manager told us there was too much work and high-risk priorities for them to respond to in a timely manner. They had not realised the extent of issues particularly in relation to staffing.

• The provider did not have procedures to ensure full compliance with the real tenancy test. This test is a quick method which must be used in supported-living and tenancy-based supported housing, to determine if true tenancy terms. The provider's policies and procedures, newsletter continued to be displayed on notice boards and the provider's inspection rating was displayed in the entrance hall of people's homes, which was not required by regulations. The supported living settings presented like residential care homes rather than people's own homes.

The provider took action during and after our inspection. They rearranged the management structure so each of the three managers were responsible for one of the regulated settings.

At our last inspection the provider had failed to notify the Commission, without delay of incidents specified in the regulation. This was a breach of regulation 18 (Notifications of other incidents) of the Registration Regulations 2009. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

• The service failed to notify CQC of all incidents that met the criteria for reporting. For example, a medicines delay was not reported to the local safeguarding authority or CQC.

• Other notifications were delayed and contained inaccurate information. For example, we were told delays occurred because an area manager had resigned. In two cases we were informed the service had liaised with

the local safeguarding authority and placing authority. When we followed this up neither had been informed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The duty of candour regulation legally requires the provider to share information with people using the service, their representatives, CQC and the local authority when things have gone wrong. The service had failed to notify the relevant person about two incidents that met the criteria for this until this was highlighted by CQC.

This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.