The Fremantle Trust

Aylesbury Supported Living Scheme

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Aylesbury Supported Living Scheme 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
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the Safe and Well-led key questions, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People were not always supported to manage their weight and food choices. There was the potential for people to develop health conditions related to obesity. People's views may not always have been sought about the quality of their care, as there were no checks to make sure processes to do this were followed. We have made a recommendation regarding engagement with people and providing them with feedback about actions taken.

People did not receive safe care. Safeguarding concerns had not always been referred to the local authority. Improvements had not been made in relation to on-going concerns about poor medicines practice and people could not be confident their medicines would be given according to their prescriptions.

There were poor infection prevention and control measures in place. Standards of cleanliness were not sufficient, placing people at risk of infection.

People could not be confident appropriate actions would always be taken when things went wrong. Records of distressed behaviour were not always recorded and trends in accidents were not always analysed, to prevent recurrence.

We had not always been informed of incidents which are notifiable. This meant we could not be assured appropriate action was taken in response to these occurrences, to keep people safe.

Monitoring of the service had not been effective in identifying areas of poor practice, to make sure people received safe care. There was a deterioration in standards of care since the previous inspection.

People were cared for by staff who had been recruited appropriately. There was mixed feedback from staff about the support they received from managers.

A community professional spoke positively about the service. Their feedback included "The staff have been working hard to support someone whose needs have changed significantly over the last couple of years and have adapted their support as his needs have increased." Another person told us "All the tenants are cared for on an individual basis, not all treated the same and this is always taken into consideration when they are providing activities. Independence is promoted and encouraged and the tenants are empowered to do as much as possible for themselves."

Relatives spoke positively about standards of care and the support their family members received. Comments included "So fortunate to have such a caring team, they are like family," "The care (the person) gets is first class" and "They look after (name) very well."

Rating at last inspection
The last rating for this service was good (report published 12 January 2018).

At our last inspection, we recommended the service followed best practice by ensuring all staff had been trained and rehearsed in what to do in the event of a fire. At this inspection, we found the provider had made improvements. We also recommended the service followed best practice when handwriting medicines records, to ensure accurate instructions were provided. We did not see any handwritten entries on the sample of records we checked.

Why we inspected
We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of Sate and Well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

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

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people from abuse, ensuring people receive safe care and treatment, notification of incidents and governance of the service at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our Well-led findings below.

Requires Improvement

Aylesbury Supported Living Scheme

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. The manager had been in post for three months and had applied to become registered with CQC.

Notice of inspection
We gave the service less than 24 hours' notice of the first day of the inspection. We contacted the service because it is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 29 December 2021 and ended on 18 January 2022. We visited one of the supported living properties on 5 January 2022 and the location's office on 17 January 2022.

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

During the inspection
We spoke with eight relatives by telephone to ask for their views and experiences of the service. We sent emails to 28 members of staff to request feedback; four replies were received. We observed practice and spoke with staff and people who use the service in the setting we visited.

We looked at a range of records including care plans, staff meeting minutes, service monitoring and audit reports, accident records, staff recruitment files and records of complaints and compliments.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely
• People's medicines were not managed safely.
• This inspection was triggered due to a high number of safeguarding notifications related to medicines practice. We received 26 notifications of medicines errors in 2021 alone, which were directly attributable to poor staff practice. This included overdosing, underdosing, signing before administering and then forgetting to administer and giving medicine to assist with sleeping too early.
• We found one person's medicines were stored in the office safe. We were told this was due to a safety issue regarding the person it belonged to. No one had considered providing the person with suitable storage in their flat or the inappropriateness of non-care staff being able to access the safe.
• We checked six people's medicines records for December 2021 and found three gaps where staff had either not signed or not given medicines. This showed staff had not been following good practice in recording.
• Overall, improvements had not been made following the errors we were notified of. Measures put in place by managers were ineffective in ensuring people received their medicines safely.

This was a 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 people's medicines.

The provider told us gaps we saw on medicines records were identified seven days later during monitoring and action was taken to prevent recurrence.

At the last inspection, we recommended the service followed best practice when handwriting medicines records, to ensure accurate instructions were provided. We did not see any handwritten entries on the sample of records we checked.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. However, staff had not consistently been disposing of used items in a closed bin in one of the settings. This was not identified until the provider carried out a quality audit in November 2021. The provider's action plan stated this was remedied in January 2022. We also observed one person had not ensured their mask covered their mouth and nose.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, we found staff did not wear PPE or cleanse their hands between or after providing manicures. We observed a person touched their nose and mouth whilst they waited for the kettle to boil. There was no disinfection of the kettle handle before the next person used it.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. This was because of the poor standards of hygiene we observed. These included stains on kitchen appliances and a stained shower curtain in the bathroom shared by staff.
● We were assured that the provider's infection prevention and control policy was up to date. However, guidance and learning from staff training had not been put into practice, to ensure there were effective infection control measures in place.

This was a 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 they had appropriate measures in place to control the spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and to some extent, social distancing rules. This was difficult for people with complex needs to adhere to.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.

Assessing risk, safety monitoring and management
• Risks had not always been assessed to keep people safe and reduce the likelihood of harm.
• One person regularly refused to be tested for COVID-19. There was no risk assessment or other measures in place to mitigate the risk. We observed this person sitting at the dining table, coughing.
• Two relatives told us they had concerns their family members had put on a lot of weight. We also read minutes of a staff meeting which noted a doctor had commented another person had put on weight and needed to exercise more. We asked if any healthy eating plans or decisions made under best interests had been carried out, to prevent people developing conditions associated with obesity. The manager was not able to provide any evidence of action being taken.

This was a 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 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.

At our last inspection, we recommended the provider followed best practice by ensuring all staff had been trained and rehearsed in what to do in the event of a fire. The provider had made improvements.

Learning lessons when things go wrong
•The provider and manager had not consistently taken appropriate action when things went wrong, to improve practice.
• We saw a positive behavioural plan was in place to support a person with distressed behaviours. Staff maintained some records of behavioural incidents but there was no accurate log kept of all incidents. The manager told us they did not think the records we looked at were accurate, based on what they had observed at the service. This meant the service would not be able to readily analyse any trends or provide accurate information to external agencies involved with the person's care.
• The provider's quality assurance audit report noted there was no notes of learning from recent accidents and incidents or trend analysis. This meant measures were not in place to prevent recurrence.

This was a 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 people's health and safety.

Systems and processes to safeguard people from the risk of abuse
• People were not consistently protected from the risk of abuse.
• Managers had advised us of some safeguarding concerns; these had also been referred to the local authority. However, the provider's quality assurance audit (November 2021) referred to four instances of unexplained injuries or marks which had not been reported to the safeguarding team until after the events had been identified during the audit. This included bruising and a skin tear. This meant we could not be confident staff had recognised and understood processes for reporting safeguarding concerns.

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, as the provider had failed to ensure systems and processes were established and operated effectively to prevent abuse and immediately investigate any allegations of abuse.

Following our inspection, the provider told us they had taken action to improve practice. It was too soon to see how effective this was.

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.
• There were staff available to support people when they needed assistance. We saw people were supported to go into town and other activities.
• Feedback about staffing included "So fortunate to have such a caring team, they are like family. Staff have been consistent, even if new people come in, they stay," "All the staff are brilliant…(the person) is very well cared for and is kept safe." "The care (the person) gets is first class."

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Managers had not always understood their responsibilities towards meeting the regulations. They had not notified us about all incidents which had occurred during, or as a result of, the provision of care and support to people. We could not be confident appropriate actions were taken if the seriousness of some incidents had not been recognised. For example, unexplained marks and bruising.

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

• Monitoring of the service had not been effective in identifying poor practice and driving improvement. For example, infection control audits did not identify the issues we observed.

• We requested records of service monitoring by the provider for the whole of 2021. We were provided with some records, which included three reports of 'welfare visits', where the primary aim had been to visit a particular setting for reasons such as in response to a complaint or grievance. These reports contained a small section about other aspects of the service which were assessed at the same time. Each report said there were no issues to be escalated.

• A further service monitoring report had been completed by the manager and focused on statistical data. None of these reports identified issues we found during this inspection or which had been identified during the provider's quality assurance audit in November 2021, which rated the service 'Inadequate'. We could not be confident there was sufficient or effective monitoring of the service.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as 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.

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

• There was some engagement and involvement of people who used the service, staff and the public.

• We received mixed feedback from staff about the support they received. Two staff spoke positively about training, said they received regular supervision and there were regular team meetings in the settings they worked in. Another person told us there was little support, they had not received supervision for over two

years and there were few staff meetings.
• There were whistleblowing procedures in place and staff knew how to raise concerns. Whistleblowing is raising concerns about wrong-doing in the workplace.
• Managers told us people were asked what they thought about the service in tenants' meetings and in meetings with their keyworkers. A keyworker is a member of staff who co-ordinates a person's care. We saw some examples of keyworker meetings. There was no process to check these were happening in line with expectations or to check the quality of engagement between people and their keyworkers. This meant there was no oversight of how meaningful these meetings were.
• The provider's recent quality assurance audit noted people were not routinely provided with feedback about any changes that were made if they raised issues or had ideas to improve the service.

We recommend the service follows best practice in ensuring there is meaningful engagement with people about the support they receive and actions taken in response to this.

Continuous learning and improving care; Working in partnership with others
• We were not confident there was sufficient learning from investigations. For example, medicines errors had continued despite measures such as further training and staff meetings to address issues.
• An action plan had been put in place following the provider's recent quality assurance audit. Some improvements were starting to be made.
• The service worked with other organisations to ensure people received the care they needed. For example, healthcare professionals and the local authority.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People's impressions of the service were mostly positive and they felt they were supported to achieve good outcomes.
• Relatives considered their family members received safe and compassionate care. One relative commented "When (the person) has been ill or in hospital, they come in on days off and all sorts, sit in A&E longer than me." Another told us "She's always happy, and I do ask her regularly. She says 'No, I'm happy where I am.'" A further relative said "They look after (name) very well, especially during the pandemic they kept everyone so, so safe, they deserve a medal. They kept him so well occupied, he just accepted it."

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 manager was able to explain their understanding of this requirement and examples were shown of letters sent to relatives after incidents had occurred.

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 allegations of abuse were notified to the Care Quality Commission without delay. Regulation 18 (1)(2) e

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse as the provider had failed to ensure systems and processes were established and operated effectively to prevent abuse and immediately investigate any allegations of abuse. Regulation 13 (1)(2)

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 People could not be confident they would receive their medicines safely as the provider had failed to ensure the proper and safe management of medicines. People were not protected from the risk of infection as the provider had failed to ensure they had appropriate measures in place to control the spread of infection. People were not supported to prevent avoidable health conditions as 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. People were not protected from the risks of accidents and incidents recurring, as the provider had failed to do all that is reasonably practicable to mitigate the risks to people's health and safety. Regulation12 (1)(2) a, b, g, h

The enforcement action we took:

serve warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People did not always receive safe and effective care as 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.

Regulation 17 (1)(2) a, b

The enforcement action we took:

serve warning notice