Livability

Livability Somerset

Inspection report

C/O Oakwood Church
Obridge Road
Taunton
Somerset
TA2 7PU

Tel: 02074522000
Website: www.livability.org.uk

Date of inspection visit:
26 October 2021
09 November 2021

Date of publication:
17 February 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Livability Somerset is a care at home service that currently supports 20 people with learning disabilities and autism who live in four shared supported living settings or their own flats. The people living in the supported living settings share communal areas and have their own bedrooms. 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 15 people were receiving support with personal care.

People's experience of using this service and what we found
People were supported by staff who had been through changes in leadership and organisational structure. The registered manager had left in August 2021. Senior staff within the team had also left during this time and this had impacted on the oversight and support of staff across all the supported living settings.

People who lived in Bridgwater were supported by a team that was chronically short staffed. This had an impact on people's support and staff morale. The senior team were aware of this and had been working to improve staffing.

Management tasks were not always completed: quality assurance actions; staff support and supervision and making statutory notifications had not been completed consistently.

We received mixed feedback from relatives and professionals about their confidence in the support provided to some people. Relatives and professionals highlighted issues around communication as a major challenge with numerous examples of the impact of this on people's shared experiences .

There was mixed evidence regarding how well risks were managed. We identified examples of some risks being identified and managed, however, we also found examples where actions were not taken in a timely manner and risks were not responded to with consistency or sufficiently monitored. People's rights were not always fully considered, and this meant that some risk management included restrictive practices that were not clearly identified and monitored.

People told us they mostly felt safe and we saw that they were relaxed in the company of staff. They were supported by staff who had been trained to identify and report abuse. Staff told us they were confident to report concerns. There was mixed evidence about external reporting of safeguarding concerns.

People were supported to prepare food either individually or with the people they lived with. Where people were at risk of not eating and drinking safely or were at risk of not eating and drinking enough, staff liaised with appropriate professionals.

People told us they had support to access health appointments. Some relatives flagged concerns about the

oversight of health.

Prior to the pandemic people's needs had been assessed before they started receiving support and most people had been receiving their support from the provider and its predecessor for many years. During the pandemic undertaking people's assessments had been more challenging.

People were supported by staff who understood how to wear their PPE to reduce the risk of cross infection. There were enhanced cleaning measures in place as a response to the pandemic.

People were supported by staff who were committed to providing quality support but who did not always have the training and oversight they needed to do this effectively or consistently. People who spoke with us were happy with the way their support was provided.

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.

The impact of staffing shortages and a lack of management oversight meant that the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. There was work ongoing to address this.

Right support:
• People lived in small groups with other people or in their own flats. Their support was designed to enable them to live the lives they chose. However, some decisions were made by staff without reference to people's views about their own support or how they wished their tenancy rights to be manifested.
Right care:
• The support people received was mostly person centred. Staff aimed to promote people's dignity and treat them respectfully, however, some practices were restrictive and people's relationships beyond the organisation were not always fully valued.
Right culture:
• The provider organisation had recently restructured. Senior staff, and staff, were committed to ensuring people were leading more empowered lives. The demands on the time of senior staff meant that checks on culture and practices had been missed.

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

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

Why we inspected
We received concerns in relation to staffing and risk management and made the decision to undertake a direct monitoring assessment. We identified risks associated with staffing, risk management and oversight whilst undertaking this monitoring assessment. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvements.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, safeguarding, staffing, the application of the MCA, person centred care and governance at this inspection.

We served a warning notice related to the governance of the service.

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

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Livability Somerset

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.

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
Two inspectors and an assistant inspector carried out the inspection.

Service and service type
This service provides care and support to people living in a 'supported living' setting, 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 registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. This was because the service is small and people are often out and we wanted to be sure we could access the office. We also wanted to check that the people supported by the service gave permission to us visiting their homes.

What we did before inspection
We reviewed information gathered during our monitoring assessment and information we had received

about the service since the last inspection. This included notifications made by the service and concerns raised with the Care Quality Commission. 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 sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We visited people who lived in two of the three settings where people received a regulated activity.
We spoke with five people about their experience of the support provided. We spoke with relatives of eight people. We spoke with 15 members of staff including managers, senior care workers and care workers. We also spoke with a representative of the provider. We spoke with a health professional and three social care professionals about their experience of the service.
We reviewed a range of records. This included elements of seven people's care plans and care records. We looked at a variety of records relating to the management of the service.
We asked the provider to share a poster asking staff and family and friends to contribute to our inspection.

After the inspection visit
We continued to seek clarification from the provider to validate evidence found. We looked at further records related the MCA, we also looked at records related to staff support and oversight. We continued to gather evidence and talk with staff and managers until 9 November 2021.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things went wrong

● Risk management strategies were not always applied consistently. Plans in place to support a person when they were unable to manage their own emotions and anxiety were not communicated effectively or implemented consistently by staff. Staff told us a change in a person's need for supervision when eating was not communicated effectively, and that staff were not always deployed to ensure supervision was provided. People and staff were at risk of harm because plans were not consistently implemented.

● Training and access to a specific vaccination for an identified health condition that was necessary to reduce identified risks to staff and people was not provided in a timely manner. Risks to staff were identified in September 2020 and appropriate training was not provided for over a year. Some staff had not been encouraged to seek the appropriate vaccination advice until July 2021. Incidents had not been appropriately monitored and analysed to ensure lessons were learned. This failure had meant the need for training and healthcare input for staff had not been highlighted on repeated occasions.

● People had personal emergency evacuation plans (PEEP) recorded. These did not always reflect safe practice. One person had a PEEP that involved them staying in the building when the alarm sounded. There had not been any plan in place to enable them to act safely. We raised this with senior members of the team, and they told us a potential solution had been identified during a change to the way fire drills were managed in the home. The person's PEEP had not been updated to reflect this.

Risks were not being managed consistently. There was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate changes were made to the person's PEEP after this was raised during the inspection. We have not been able to review the implementation of this change.

● Some risks people faced were managed in ways that were not recorded or monitored appropriately. This had led to restrictive practices such as reducing people's choices with food and locking parts of their home without appropriate safeguards. One person was restricted about what they could buy with their own money when out and two people did not have access to their kitchen.

People were not protected from unnecessary control and restraint. There 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.

● Where people needed support for risks that were well known to staff, there were risk assessments and support plans that contained adequate risk measures. For example, where there was a risk assessment for

the person going out without supervision there was a plan in place to include making sure they had identification on them.

Staffing and recruitment

● The service had been experiencing a chronic shortage of staff. This situation had improved for people living in Burnham on Sea but remained challenging for people living in Bridgwater. Staff, people, relatives and professionals all described the impact this had on people's support. A person described how they, and the other tenants, could not go out as much as they would like, "We have not got enough supporters. People are not getting out." Staff described not being able to provide individual support to a person to eat safely, being unable to provide 1:1 time and not having time to ensure keyworker responsibilities were carried out. Relatives and professionals identified that staff did not appear to have the time to communicate effectively.

● Whilst this reflected a national picture in the social care sector, staffing had been particularly impacted as the team in Bridgwater had started to support a person in September 2020 without enough staff recruited to fulfil this. The role of the staff had also changed substantially, without appropriate training, and this had led to increased staff turnover. Staff were tired and told us they felt overstretched and undervalued.

There were not sufficient staff to meet people's assessed needs. There was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider and senior team described the measures they were taking related to recruitment.

● Recruitment processes had been enhanced since our last inspection. This included the introduction of specific roles within the provider organisation to support efficient and safe recruitment.

Systems and processes to safeguard people from the risk of abuse

● During our inspection we identified two situations that had occurred in the six months prior to our visit that should have been considered as safeguarding concerns. Failure to involve the appropriate agencies put people at risk of repeated harm because they did not have access to the statutory systems designed to protect them. People's support plans had not been updated to reflect these risks. This meant people were at increased risk of these situations reoccurring.

The systems in place to identify, investigate and protect people from safeguarding concerns were not operated effectively. There 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.

●Following the inspection the provider described the measures taken to ensure safeguarding systems were operated effectively. They told us appropriate changes had been made to people's support plans. We have not been able to review the sustainability of these changes.

● People felt safe with the service they received and the staff who supported them. One person said, "Staff make sure you're safe. I am safe." Another person said, "I am happy, and content and I feel safe."

● People said they would always talk to someone if they had any worries. One person described how kind the staff were when they shared their worries with them.

● Staff had received training in safeguarding and told us they understood their responsibilities. Staff told us they knew how to recognise and report abuse and gave examples of concerns that they had raised both internally and with statutory agencies.

●There was a safeguarding investigation on going at the conclusion of our inspection.

Preventing and controlling infection

● We were assured that the provider was using PPE effectively and safely.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. There were checks in place that reduced the likelihood of a visitor catching or spreading infections. One relative told us that staff did not seem clear on the expectations for visitors to one of the houses.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were mostly assured the provider was facilitating visits for people in accordance with the current guidance. People were visiting their loved ones and relatives had started to come into the building. However, the risks associated with visitors had not been assessed, agreed amongst people or communicated clearly. The provider had identified in July 2021 that there was no visitor policy available at the Bridgwater service. This remained the case in October 2021 and relatives told us they were not clear on the arrangements in place.

Using medicines safely
● People received their medicines as they were prescribed. The staff who gave medicines had been trained and their competency to give medicines safely had been assessed.
● Where people were able and confident, they took control of their own medicines. Two people self-administered their medicines, but staff carried out checks to make sure medicines were taken in accordance with their prescription. One person told us, "I do my own tablets in the morning, but staff check.
● Medicines were stored safely and securely.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on the authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff had received training about the MCA, however, they had mixed understanding about its application in their work. Some staff spoke confidently about the Act whilst others were unsure about how it was implemented. One staff member commented that they needed to update themselves.
- Restrictive practices, such as a locked kitchen and rules about shopping for food, had not been identified because the MCA code of practice was not embedded in working practices.
- Where people lacked capacity, mental capacity assessments were undertaken related to some decisions such as those related to managing finance and medicines administration. The examples provided to us did not use the MCA capacity assessment form appropriately. The decision the assessment related to was not always clear and the way the best interests decision had been made was not recorded. This meant it was not possible to review who had been consulted or how less restrictive measures had been considered.
- People had not been asked if they consented to the care as detailed in their support plan. Where people could not consent, people who knew them well had not been consulted in line with the MCA.

The MCA was not used as a framework to ensure people's best interests were always reflected or that they had consented to their care. There was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People said they made choices about their care and support and their daily lives.
- Some support plans had been signed by people to show that they agreed for the information to be shared with specified individuals. Where a person was unable to sign there was evidence to show they had been

shown pictures and had understood.
● People had decision making profiles which outlined how to support the person to make decisions for themselves. This included information like how best to offer choice and where and when you should offer the choice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● People had their needs assessed prior to receiving support. During the Covid-19 pandemic more of this assessment process had been done remotely to reduce the risks associated with cross infection.
● Most people living in the services had lived there for a long time. Each person had a support plan. Whilst some people had contributed to their support plans these were mostly written by their keyworkers. Care plans were not consistently seen by people or their families as routine reviews had been suspended due to the pandemic. The support plans reflected varying knowledge and expertise in the staff who had written them. There were examples where the lack of knowledge led to disrespectful statements about people in their support plans.
● Support plans were being transferred onto an electronic system that would allow staff to record onto handsets. When we inspected this was not fully operational although there were plans in place to achieve this. Internet access had also been a challenge. The technological obstacles, combined with a lack of time meant that staff relied on sharing information verbally, through handovers and communication books to stay up to date. A member of staff said, "The care plans are far too complicated for people to really understand and too lengthy for new staff to have time to read."
● Care plans and people's written records were not the main source of agreed information for staff and there were risks associated with this. A member of staff gave examples of how the handover of information did not happen consistently in the main house in Bridgwater. Staff gave examples where information such as what people had been doing, or what they had eaten had not been recorded or handed over verbally.
● Challenges with staffing and communication meant that people did not always have their support outlined in their support plan. Staff gave a variety of examples of support being delivered inconsistently for this reason.
● Staff did not always agree with the guidance set out by other keyworkers. We heard examples of prescriptive support staff did not follow and we also heard examples of support that wasn't provided as per guidance. This included support people received with eating and drinking, personal care and the support people received to maintain their tenancy/home.
● People's preferences were not always respected when they could not communicate them with words. A relative described how their loved one had not been supported to maintain an important relationship. A professional fed back that another person had not had a clear plan in place to support them with their relationships during lockdown.

People's support was not provided within a framework that ensured consistency in person centred support. There was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who were able to communicate their choices told us they were able to make choices about all aspects of their care and support. One person said, "You can definitely do what you like." Another person said, "You can do what you want. I like to walk on the beach, on my own and with staff."
● Some people were encouraged consistently to practice and develop new skills. One person spoke proudly about their developing cooking skills. This person also told us about the consistent and kind support they had received during and after the loss of a close friend. Their friend had been supported to remain in their shared home and continued to also receive support from the staff team who had adapted to their changing needs.

● The provider explained the length of care plans, stating, "The plans may be lengthy but that the length is proportionate to the level of detail required for them to be comprehensive."

Staff support: induction, training, skills and experience

● People were supported by staff who had not always undertaken appropriate training. The staff supported some autistic people. The training around autism had not been mandatory and most staff had not completed it. This meant that staff thinking and discussion, and support plans did not reflect understanding of how people's autism impacted them individually. Communication training was not mandatory, and most staff had not taken this on line course. The people the service supported had assessed needs associated with their communication. Staff told us they had not received positive behaviour support training until very recently. Most staff supporting people in Bridgwater told us they had not felt their training reflected the needs of all the people they currently supported.

● Staff told us they had experienced mixed support. We received feedback that referred to the approachability and kindness of managers and feedback that detailed how staff had felt unsupported. We discussed this with the senior team. They were aware of the current risks associated with staff morale. Some of these issues related to the protracted period of staffing shortages and levels of tiredness amongst staff due to the pandemic. Some of the issues related to specific situations and communication.

● Staff had not been receiving regular supervision sessions due to the issues with ensuring staff numbers. One member of staff pointed out that when they did have supervision it happened in a sleep in room in the shared house they worked in. This room was used like an office and they explained their supervision was constantly disturbed.

People's support was not provided by staff who had received appropriate training and support. There was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had confidence in the staff who supported them. One person told us: "They understand what I need in a nice way."

● Most people were supported by some long-standing staff who knew them very well and had the skills and experience to meet their needs. Staff were individually consistent with people and committed to ensuring constancy in their lives.

● Training was being provided to staff to ensure they had the skills to keep themselves and people safe as we started our inspection site visits.

Supporting people to eat and drink enough to maintain a balanced diet

● People who shared their house usually ate their main meal together. People got together weekly to plan their menus for the week. One person told us, "We all do the menus. Everyone gets a choice."

● Staff told us how eating together had improved the range of foods a person ate, meaning they had a much healthier diet than previously.

● People who lived in self-contained flats were supported by staff to shop for food and prepare their meals. On the day of the inspection visit one person who lived in Burnham on Sea went out to do their food shopping with a member of staff. A person who lived in Bridgwater ordered their main meals to microwave in their flat.

● People received support to cook if they wanted to. One person commented, "I choose my own food, but staff cook it."

● People had risk assessments and support plans in place related to eating and drinking safely. These support plans needed reviewing to ensure people's preferences were reflected.

● One person who had been at risk of malnutrition no longer needed to take additional food supplements

because they had been supported by staff to improve their diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was mixed evidence about how effective staff were in ensuring people had access to healthcare and other professionals to ensure their wellbeing.

● Some people said that staff helped them to attend medical appointments including annual health checks. One person said, "Staff will help you go to the doctors." Staff advocated on behalf of people to ensure they got appropriate access to healthcare during Covid-19 restrictions. This had led to positive outcomes for people.

● Some relatives shared concerns about health and well-being issues being picked up and acted on.

● People were being weighed regularly. We saw monthly weight records for one person but there appeared to be no care plan identifying any issues with the person's weight and no rationale for regular weighing.

● Feedback from professionals was positive about the caring nature of staff and the support they had provided but outlined difficulties in accessing the records they needed and concerns about delays in agreed decisions being actioned.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question deteriorated 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; Continuous learning and improving care

- People received care and support from a staff team who had concerns about changes in leadership and the structure of the organisation. Staff felt that the current manager was 'Overstretched.'
- We discussed the restructure of the organisation with the manager of the two settings we visited and senior managers. The restructure meant managers covered larger geographical areas and administrative support had been substantially reduced. This restructure had resulted in the previous registered manager leaving.
- Computer systems designed to improve internal communication and reporting within the new structure were not fully implemented.
- These changes meant oversight and management functions largely fell to the local manager and team leaders, however, these staff had been required to work on providing direct support due to staff shortages. This meant management tasks, such as audits and supervision, had not been carried out.
- Staff who worked in both Bridgwater and Burnham on Sea said there had been a lack of support for them and felt frustrated about the lack of leadership. One member of staff said, "We have struggled over the past few months with no team leader. You don't get replies from Taunton (office), so you have to contact London (office)." Other staff talked about their views and requests not being passed on.
- Staff were unclear about how quality was monitored. One member of staff said, "Someone did an audit about two months ago." However, no staff knew if any changes had been suggested or if an action plan had been put in place. The manager acknowledged that actions had not been taken to make improvements identified. They explained that they had been told support would be provided due to the scale of action needed. They had not received this support. This meant issues identified during these audits were not addressed and were found in this inspection.
- Oversight of the support planning system had not led to support plans that all staff were signed up to and followed. Support plans had not been reviewed to ensure they were respectful and reflected current good practice.
- Audits had not led to the identification of restrictive practices that had been long standing. This meant people's rights had remained unprotected.
- A new electronic care planning system had been introduced during the summer of 2021, but due to a delay in delivery of handsets and issues with internet access it was not fully operational at the start of our inspection. Staff kept paper records reflecting the support they provided. There were gaps in these records and staff and professionals described the impact of these gaps in ensuring people received the right support.

● Policies and procedures were not implemented that supported the legal status of people as tenants.
● The failings in oversight meant that people received support that was provided in breach of regulation.

Systems to monitor the quality and safety of people's support were not effective. There was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection the provider assured us that staff had received training and support to both carry out new roles following the restructure and to use new computer systems.
● Following our inspection the provider reported that they had acted to reduce the impact of identified risks. They told us risks identified in their audits reported in August 2021 were being addressed through an internal risk mitigation process that they initiated in October 2021. We have not been able to review the impact or sustainability of this process.
● A new team leader had been appointed and some staff were optimistic about the future. All staff told us they loved their jobs and did not let their frustrations change the support they gave to people.
● A peripatetic manager started to support the manager the week after we visited the two settings. We were told they were starting to work to deliver the changes identified in action plans and that issues identified at the inspection would all be addressed. The provider shared a risk assessment and action plan developed by this manager outlining the work they would be carrying out.
● Hand sets and internet were resolved to allow the full implementation of the electronic care planning system to begin before the end of our inspection.

● Statutory notifications had not always been made to the CQC. Notifications are required regarding situations described in the regulation that have an impact on the support people received. Notifications regarding the outcome of a deprivation of liberty and allegations of abuse had not been made.

There was a breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009
● CQC had received notifications following our initial site visit.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People supported in both Bridgwater and Burnham on Sea were happy with the care and support they received. One person told us, "This is home. We laugh and joke. It's a lovely home." Another person said, "I love living here. Other people are my mates. I have independence but help when I need it."
● People and relatives reflected on a caring culture of staff who wanted people to have good lives. We heard numerous examples of the positive impact of this commitment. Staff told us about one person and said, "They have come on leaps and bounds and are now able to enjoy so much more." The person told us, "I am so happy living here." Another person commented, "I'm more confident than I was." Professionals spoke about health benefits and opportunities a person had experienced through support.
● Relatives commented on not being sure who they should speak with and difficulties with communicating. They did not feel confident in the processes in place. One relative reflected that previously the systems in place had been clear but that 'it had all turned into a bit of a mess now'. Another relative described how they felt communication and organisation had become ineffective.
● Whilst staff were clear about their wish to achieve best outcomes for people, a lack of leadership and oversight meant that people's support was not always effective and consistent.

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

●Where mistakes were made, the managers were transparent and acknowledged failings and omissions. They, and senior managers, sought to make improvements and reduce the risk of repeated mistakes.

● The provider had a policy in place to support the duty of candour.

Working in partnership with others

● The staff worked in partnership with other professionals to ensure people's needs were met. This included making referrals to professionals to meet specific needs.

● Professionals fed back that communication was sometimes challenging.

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 There had been a failure to submit statutory notifications. Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not consistently receive appropriate care that met their needs and preferences. Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care had not been sought . Where people did not have capacity to make specific decisions about their care these decisions were not made in line with the MCA code of practice. Regulations 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks people faced were not adequately assessed or mitigated. Staff did not have the training necessary to keep people and themselves safe. Regulation 12(1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to adequately protect people from abuse. Restrictive practices had not been identified and reviewed. Regulation 13 (1) (2) (3) (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified and supported staff available to meet people's needs. Regulations 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 17 HSCA RA Regulations 2014 Good governance Systems of oversight were not operated effectively to ensure the safety and quality of service people received. Contemporaneous records were not always maintained. Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We served a warning notice on 23 November 2021 requiring the provider to meet the requirements of the regulation by 30 May 2022.