Care Quality Commission

St Elizabeth's Centre

St Elizabeth's Domiciliary Care Agency

Inspection report

South End
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Date of inspection visit:
14 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Elizabeth's Domiciliary Care Agency is a supported living service for people with learning disability and autism. The service was provided to adults in shared accommodation on their college site and in individual flats.

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 the inspection 32 people were supported with the regulated activity.

People's experience of using this service and what we found
People were put at risk of harm due to the lack of safeguarding processes and effective systems in place to implement improvements where risks had been identified. Care plans and risk assessments did not correlate and identify fundamental information to ensure people were supported in a safe way. People did not always receive their medicines in line with their care plans. There was a lack of staff trained to administer medicines, which had an impact on delivery of care.

People did not always get the dedicated support commissioned and this meant people were not always provided with safe support and were unable to experience new things or meet their aspirations.

People were not always 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.

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 service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People did not receive support that was person-centred and gave them autonomy on their life. Relatives felt there needed to be a stronger focus on people's interests and ensuring their support was meaningful to them. People did not have choice of who they were supported by. Support did not focus on people's quality of life or follow best practice.

Staff told us and records confirmed there needed to be additional training to ensure there was enough appropriately skilled staff to meet people's needs.

The management team did not always offer the support and leadership required for the staff. Staff felt there was a lack of communication between staff and management. The provider and manager had a governance system in place, which included various audits and monitoring, however, these were not effective and did not identify the issues we found.

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 September 2019).

Why we inspected
We received concerns in relation to the management of safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. 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 inadequate. This is based on the findings at this inspection.

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

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

Following the inspection visit the nominated individual met with CQC to discuss their evaluation of the inspection and what actions they will be starting to take following the visit. The nominated individual stated they were to develop an action plan following the inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Elizabeth's Domiciliary Care Agency on our website at www.cqc.org.uk

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 safe management of medicines, management of risk, developing care that is person centred and the governance oversight 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 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

St Elizabeth's Domiciliary Care Agency

Detailed findings

Background to this 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 team was made up of 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 eight '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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and partner agencies who worked 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
We spoke with seven people who used the service and 12 relatives about their experience of the care provided. We spoke with 16 members of staff including the registered manager, deputy manager, senior care workers and care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including 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 and quality assurance records. We spoke with one professional who had input with the service.

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.

Using medicines safely

- Medicines were not always stored safely. Medicines cabinets were locked when not in use. However, temperature-controlled cabinets were consistently recorded under the recommended range. Staff had failed to escalate this when recording daily temperature monitoring. We asked the provider to escalate concerns to the supplying pharmacy to ensure medicines were still suitable for use.
- Documents to help staff to administer when required (PRN) medicines were not in place. There were no records in the medicines folders explaining why a PRN medicine had been administered or if it had been effective. When a medicine used for the management of agitation and aggression was administered, staff were not following the care plan in place nor the provider's policy to ensure this was logged on the incident reporting system and reviewed. This resulted in the person being given medicine outside of scope of the prescription.
- There was an out of date intervention protocol in place for one person at the service. It advised staff to follow a treatment regimen and administer a medicine that was no longer prescribed.
- Records showed there were some gaps in people's medicine administration records (MAR). We could not be assured medicines had been administered as prescribed. Medicines administration times were not always conducted at the same time each day. With the nature of people's individual health needs there could be significant implications due to not taking the medicine in a timely manner.
- People's support did not promote person centred care and did not consider the least restrictive. For example, staff told us people would be woken up to be given their medicines. There was no consideration with partner agencies to see if their medicines could be administered at a different time to fit in with the person's lifestyle.
- At the time of the inspection training records confirmed that only 17% of staff were trained to administer emergency intervention medicines. Although, the registered manager ensured there was someone available across the provider, this could mean staff having to leave another bungalow to administer the intervention medicines. This also needed to be a consideration when leaving the site where people would need support in the event of having emergency intervention medicines.
- The professional indicated that medicines were an area of concern and required additional attention from the management team. They said, "Medicine errors would be a concern. This has been raised a couple of times. There should be no reason why people are running out of meds and at times this happens. They should pay for some senior pharmacist training."

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff did not always anticipate and manage risk in a person-centred way. We found support practices that

were disproportionate on people's liberty. For example, within one building we found that people had their front doors open whilst they were sleeping. This meant the staff and the other people living within the building could see this person.
● The service provided 'blanket rules' which resulted in inappropriately restricting people's choice and control. For example, the service locked bathroom doors so they could not be accessed freely. There was no consideration on how they could look at the least restrictive measure for people.
● People's risk assessments were not clear or coordinated with the information stated in the care plans. There were a number of examples where we saw significant risks had been identified but were not clear or did not indicate how to support people in the key documents. One example being, where someone had been identified with a choking risk, this was not clear in the care plan or risk assessment. However, there was a speech and language guide within the person's home identifying the person needed modified food.
● People were at risk of harm where staffing levels were not always sufficient. Accident and incidents occurred where people and staff were put at risk of harm and could have been prevented. For example, due to staff changes a staff member was on their own and was supporting someone else. During this time a person put their hand on the hob of the oven. This person's risk assessment indicated they should have one to one support when in the kitchen.
● Staff were knowledgeable about how to raise safeguarding concerns. However, we found where safeguarding's were identified, these were not always sufficiently prioritised. Partner agencies visited the service and found safeguarding's in relation to keeping people safe at night. Safe practices had been suggested. When we visited, we found that the suggested improvements had not been embedded. This meant that people continued to be at risk.
● There was a lack of shared lessons learnt with the whole team and the wider service. Where safeguarding's and risks emerged, the registered manager gathered the information relating to accident and incidents, however, did not effectively look at the overall trends and themes. This meant the registered manager and staff team were not able to learn from these.
● Although when speaking to people they felt safe, there were mixed views from relatives about the safe care of their family member. When asking relatives if their family member was safe, one relative said, "No there have been numerous drug errors, the staff levels. There were no boundaries, there was no continuous team, a lot of agency staff. When I phoned to see how [relative] is they didn't understand what I was asking. [Relative] has epilepsy and didn't have the rescue pack when I visited which could have proved fatal." Another relative said, "Yes most definitely, I know the carers quite well, she has been there for some time, we all consider ourselves as family, we feel she is safe with them."

Preventing and controlling infection
● We were not assured that the registered manager and staff were making sure infection prevention procedures were managed effectively. We observed staff not following government guidance when using personal protective equipment (PPE).
● The provider had systems in place to ensure that where visitors arrived, they had processes in place to prevent visitors from catching and spreading infections. However, staff were deployed across all of the supported living services and did not cohort staff teams, which increased the risk of spreading infections.

People were at risk of harm. Systems were either not in place or not robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The nominated individual was very open about their staffing levels and the difficulties there have had to face. The provider had recently put actions in to try and increase recruitment and retention within the

organisation. However, it was evident that due to the staffing shortages, this had an impact on people's care.
● Records showed that at times there were reduced staffing. People's records showed that they had limited opportunity to try different experiences and there was no evidence that people were able to enjoy any new experiences during the evenings.
● Staff we spoke with said they were short staffed, and this put pressure on their day, however they tried to do their best by people. One staff member said, "I think currently we don't have enough staff. When I started we had enough staff to support every person. We are now understaffed. We still manage to do what we can. We are more rushed." This was evident by our observations, staff took an active role in tasks and failed to encourage people's independence with everyday living skills.
● Many of relatives we spoke with felt there was a staffing issue which impacted on their relative's care. One relative said, "They say there are enough staff, but I don't think there are enough staff. There was a fight between [person] and another resident which I think could have been avoided if there were more staff around." Another relative said, "There are not enough staff, I don't trust the staff from the feedback I'm getting. There are a lot of agency staff and I am concerned with their level of training." Although some relatives felt there was adequate staffing. One relative said, "There are always enough staff and managers are visible, always around."

People were not able to have the opportunity to have a fulfilling life with dedicated time to develop their independence. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been through a recruitment selection process. This included all pre-employment checks, such as references and a criminal record check.

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

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

●People's care records were not always updated in a timely manner when changes were made by healthcare professionals. This meant that staff might be following guidance that was no longer suitable for the person they were caring for.

● Care and support plans did not always reflect people's needs and aspirations. Support did not always focus on people's quality of life outcomes and met best practice. We found examples were care plans did not triangulate with health professional's guidance.

● Relatives were involved in the care people received; however, where people were not able to advocate for themselves, they did not have an independent advocate to support them with expressing their wishes and how they wanted to shape their support.

● People did not have an active role in maintaining their own health and wellbeing. People were referred to internal professionals such as occupational therapy and speech and language where appropriate. However, when speaking with the nominated individual they explained that these services were from their in-house therapy team and was a part of the agreement for people being supported by St Elizabeth's Domiciliary Care Agency. This included the choice of support. This meant people did not have choice and control of who and what services to use.

● People and staff had support from the internal therapy team to develop specific social stories when required. However, people's care plans were not in accessible format and there was no consideration as to how people can be kept informed about the information kept about them.

● Overall, relatives felt staff would be able to recognise deteriorating health. However, there were examples of where staff may have not recognised where their family member needed support. One relative said, "When I pick [person] up I report changes, but they don't know about them. I picked [person] up and they were pointing at their stomach. I knew what to do but they didn't say or do anything."

● Relatives felt their family member was not supported to get involved in local events in the local community. Records confirmed this. One relative said, "It is terrible. Now [Person] is on holiday they spend all day in the bungalow. [Person] rings me 15-20 times per day because they are bored and not being engaged in anything. There is no exercise, sometimes they go for a walk on the grounds." Another relative said, "There are no opportunities to go out." Although some relatives felt the staff were aware of people's social responsibility and encouraged this.

● People were able to input into choosing their food and planning their meals. However, staff did not always

support people to be involved in preparing and cooking their meals. People could have access to snacks, we found that where some cupboards were locked. We found an example of where staff were putting food out of reach from someone to deter them from eating.

The support people received was not person centred and people were not able to have choice and control about the services they received. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People did not always receive support from staff who had the relevant training, including around learning disability, autism, mental health needs and human rights. Staff were provided with an induction programme which included epilepsy training, however records and staff confirmed that once they had completed this training, this was not revisited.
● Although staff felt they had the right skills to support people, they fed back specific training for individuals would be beneficial. One staff member said, "If I had to use MAPA I don't know what I would do. I feel like regular MAPA training in that situation what am I meant to do. I do think a booster session is needed. I had it when I first started, and I have not had any refresher. I was going to do intervention training and that has been cancelled and I assume that will be an epilepsy training. Epilepsy is another thing that I need some more training on, I don't really know how to deal with it for each person."

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

● Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Standards. For people that the service assessed as lacking mental capacity for certain decisions, staff recorded assessments. One staff member said, "People are assessed to see if people are able to make their own choices. If people are not able to make their own decisions. Family, people working with them would help with the capacity assessment." However, we found example of where staff did not look at the least restrictive practice. There was a lack of consideration in protecting and promoting people's rights.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had developed a new strategy with their key values; however, this did not consider key elements relating to right care, right support, right culture. The provider did not meet best practice guidance in relation to the supported living model.
- The provider failed to be a provider that promoted choice and control when people developed their support network. There was a stipulation that if the person was to live in the accommodation the person had to have the support from the provider and use the associated therapies the provider supplied. There was very little input from outside professionals.
- St Elizabeth's Domiciliary Care Agency made good use of the wider health care professionals who worked within the centre. However, lack of input by healthcare professionals from external providers did increase the risk of a closed culture developing within this service.
- Support for staff from the management team was inconsistent. Staff supervision records were not consistent, and staff felt there needed to be more team meetings. One staff member said, "They are hardworking great people just too busy themselves and I know they wish they could do more. I have not been asked once in the last 6 months how are you doing by my bungalow manager." Another staff member said, "Yes I do feel supported. We communicate via email and they come into the bungalow regularly."
- The management team had not recognised support practices did not promote person-centred, open and empowering care and did not recognise the importance of respecting people's homes and staff boundaries. We found staff using parts of people's kitchens for their own property. For example, using people's cupboards and locking items of food so people could not access this.
- Staff spoke in a compassionate way when talking about the people they supported and enjoyed working with people at St Elizabeth's Domiciliary Care Agency. We observed people being supported by staff who came across kind and patient when supporting them.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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; Continuous learning and improving care

- The provider did not adequately distinguish between the roles and responsibilities of its own staff and those employed by other providers located in various areas of the St Elizabeth's Centre. It was heavily reliant upon the support of nursing staff employed with in the provider for the completion of tasks that should be

managed by people being supported.
● The provider ensured staff completed training courses, however staff had not completed specific training relating to people's individual support needs. For example, learning disability and autism training. This training could improve staff understanding and adapt their way of working to improve the overall culture of the service.
● The provider lacked oversight of certain aspects of the care and care records being completed for people using the service. Care plans and risk assessments did not triangulate.
● Where partner agencies had requested immediate actions following a safeguarding concern, the registered manager had not ensured these were addressed across the service.
● The provider and registered manager did not have a robust quality assurance system in place, where audits and actions were completed, the management team did not have clear oversight that these were actioned. In addition to this the management team failed to identify some significant improvement needed in relation to assistive technology to keep people safe and the lack of clarify in the care plan and risk assessment documents.
● There were mixed views from relatives about the approach of the provider. Some relatives felt the management seemed to lead well and they were satisfied with management. Whereas there was a number of relatives that felt there was significant improvements that need to be made. One relative said, "There is a serious problem with management. They don't communicate and they are short staffed." Another relative said, "There is room for improvement with regards to communication between the people in the bungalow and the management. They are all busy. I feel they need a review by someone experienced."
● Our findings from the other key questions inspected showed that governance processes had not helped to keep people safe, protect their human rights and provide good quality care and support.
● The registered manager said they analysed accidents and incidents. However, this did not pick up the overall trends and themes but looked at singular incidents. For example, there was a number of incidents relating to people becoming physically aggressive towards staff. There was no consideration as to the support or training staff may need or if staff were adequately trained to deal with all situations that may occur.

Governance systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider had an internal therapy team as well as nurses. This meant that people were referred to these services which mean little collaboration with external services.
● The professional we spoke with felt that when they were involved in the care for people staff were approachable and gave an example of where they influenced a best practice within the internal services St Elizabeth's Domiciliary Care Agency provides.

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 9 HSCA RA Regulations 2014 Person-centred care The support people received was not person centred and people were not able to have choice and control about the services they received.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not able to have the opportunity to have a fulfilling life with dedicated time to develop their independence