Chenai Holistic Home Care Agency Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chenai Holistic Home Care Agency Ltd is a domiciliary care agency. It provides personal care to people living in their own houses or 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 115 people were receiving personal care from the service.

People's experience of using this service and what we found
People and their relatives were not always positive about the service. Concerns were raised about staff punctuality and duration of visits, lack of communication from the service and staff approach and training.

The service did not have effective systems in place to monitor or improve the quality and safety of the service provided. There was a lack of oversight by the provider in relation to risks and regulatory requirements.

Risk assessments did not always reflect all possible risks to people using the service to ensure they were safe. Staff were not deployed to ensure people received care at the correct time and by the numbers of staff required to carry out their care safely. The service did not always learn lessons when things went wrong.

Medicines were administered safely however, audits did not identify shortcomings regarding information included on medicine administration charts.

People's needs and choices were not always assessed to achieve effective outcomes for their care and support. New staff were not inducted effectively and their competency was not appropriately checked before working with people using the service. Staff received refresher training annually and had one-to-one supervision meetings to discuss any concerns. However, some staff did not feel supported in their role.

People were supported with maintaining nutrition and hydration. However, people's dietary needs were not always detailed in their care plans.

Care plans were not always personalised or detailed and we found inconsistencies with some care plans. People's communication needs were not always met. The service did not always respond to complaints in a timely manner. We have made a recommendation about including people's preferences regarding care at the end of their life.

Safe recruitment practices were followed to ensure staff were suitable to support people safely.
People told us they felt safe using the service. Staff knew about safeguarding and whistleblowing. However, we found systems were not in place to ensure people were kept safe from the risk of abuse because the provider did not demonstrate oversight where any form of abuse was suspected.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 10 January 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. However, the inspection was prompted in part due to concerns received about medicines management, poor scheduling and duration of calls, lack of communication with customers, care not provided in line with people's needs and staff training. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. The provider had not taken effective action to mitigate the risks. Please see the safe, effective, caring, responsive and well led sections of this full report.

Enforcement
We have identified breaches in relation to risk assessments, personalised care, staffing, staff training, safeguarding service users form abuse and improper treatment, receiving and acting on complaints and leadership of the service at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Chenai Holistic Home Care Agency Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector who was supported by two Experts by Experience to carry out telephone interviews with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission who was also the provider of the service. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority professionals who work with the service. This information helps support our

inspections. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 18 people who used the service and 12 relatives about their experience of the care provided. We spoke with 14 members of staff including the provider, two field care supervisors, seven care workers, a care co-ordinator, a recruitment and training officer, an administrator and a compliance officer.

We reviewed a range of records. This included 12 people's care records and four medication records. We looked at ten 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, policies and quality assurance records. We spoke with the commissioning team who have contact 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 Requires improvement. 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

At our last inspection the provider had failed to assess and appropriately manage the risks relating to the health safety and welfare of people in relation to people's health conditions. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risk assessments were not always robust. The service had failed to consistently assess individual risks or act on identified risks relating to the health and safety of people using the service. Risk assessments for people living with chronic health conditions did not always include guidance for staff to minimise and mitigate risks associated with the condition. The service used a list of generic symptoms associated with people's health conditions but failed to explore which of these symptoms was experienced by the person and how it affected them.
● We found risk assessments for seven people were not detailed and failed to provide staff with relevant and accessible information about how people were affected by their health condition and the associated risks. For example, two people had a history of diabetes. Their risk assessment did not contain the relevant information to guide staff should the person experience complications relating to the condition such as high or low blood glucose levels, and what actions staff should take to ensure they were treated.
● Another person had nutrition administered through a Percutaneous Endoscopic Gastronomy (PEG) tube. Although staff did not administer the nutrition, we found there was no information regarding the risks associated with infection control around the PEG site when delivering personal care, which may have exposed the person to risk of harm.
● Some staff were not aware of risks assessments and told us they did not know where to find them. When asked about risk assessments, one staff member told us, "We have the care plans and a book I don't know about risk assessments." Another staff member said, "Risk assessment? Not sure if they are in the house."
●These findings meant that people were not always kept safe from harm when they received care and support, because not all staff involved in their care knew where to access information regarding their individual risks.

Learning lessons when things go wrong

● The service did not always learn lessons following incidents. For example, late or missed calls were not always thoroughly investigated to identify what went wrong so effective measures could be put in place in a timely manner to prevent re-occurrence. This put people at risk of harm.

Using medicines safely
At our last inspection the provider had failed to manage medicines safely. The provider failed to take proper steps to ensure that each person was protected against the risks of receiving care and treatment that is inappropriate or safe by not ensuring medicines will be managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 relating to medicines management.

● At the time of the inspection the service supported 39 people with medicine administration. The management team told us they supported five people. The service did not provide additional medicines records for people using the service. This lack of oversight placed people at risk of unsafe and inadequate care.
● We looked at medicine administration records (MAR) for four people using the service. We found no gaps in the administration of medicines however, we found one MAR did not contain the month or the year and another did not contain the start date of the record. We spoke with the registered manager about this. They were unable to explain how this had not been identified.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed in relation to risk assessments, medicines management and learning lessons when things go wrong. This placed people at risk of harm. These findings were a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did not raise concerns about their medicines and told us staff supported them with medicines. One person said, "[Staff member] prompts me to take my medication and checks I have taken it." A relative told us, "They always record medication.
●Policies and procedures were in place to ensure medicines were administered safely. Staff explained the principles of medicines administration and had completed training.

Staffing and recruitment;
At our last inspection we recommended the provider reviews procedures for late calls and rotas to ensure the risk of missed or late calls was minimised. The provider had not made improvements.

● Sufficient numbers staff were not deployed in order to meet the care and treatment needs of people using the service.
● We looked at the electronic system used by the service to deploy staff, monitor staff punctuality and duration of visits. We found staff were allocated to provide care to people, including people who required two staff to support them. However, we found one person who required two staff had care provided by one staff member on two occasions because the second staff member failed to attend. This meant they may be at risk of harm when receiving personal care.
● People and their relatives told us staff punctuality was "Erratic." People using the service were not always satisfied with the punctuality of staff. One person told us, "They do not come sometimes or they are very late. It happened frequently last weekend." Another person said, "When they don't come on time it's the

office's fault, send people to the wrong address or get the time wrong."
● Relatives of people using the service were also not always satisfied. One relative said, "They are sometimes late. They don't let you know. I have to ring, maybe once a week. If they are running late they tend to do a shorter time." Another relative told us, "They are nearly always late, as always needs two carers and one has to wait for the other. Issues with leaving early if start late as they sometimes rush the job."
●Staff were concerned about the way staff were deployed. They told us there was not enough travel time between calls, and they were often late. One staff member said, "I don't get enough travel time. It's changed a little bit better but I'm still late to visits." There was a lack of oversight regarding the travel time staff needed to arrive punctually which meant there were delays in people's care while they waited for a second staff member to arrive. One staff member said, "The office doesn't organise the distance between calls for [second carer] to make it on time. It makes me stressed out when I am late." Rotas showed staff were allocated to support people living in similar postcode areas. However, on occasion there was 15 minutes between calls during busy travel times. We noted there were nine late calls between 14 January 2020 and 21 January 2020, eight of which were due to delays with travel.
●The registered manager told us they were aware of issues with punctuality and had started taking action against staff. However, we found they had not reviewed their processes to ensure staff had enough time for travel. This meant people using the service were at risk of not receiving safe care and support at the time they required it from the correct number of staff.

We found no evidence that people had been harmed however, people were potentially at risk of harm because their care or support was delayed or not carried out by sufficient numbers of staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Effective recruitment practices were carried out by the service. This meant the service could be assured that staff employed were suitable to provide safe care and support. Checks had been carried out during the recruitment process such as criminal record checks, employment history, references, proof of person's identity and eligibility to work in the UK.

Systems and processes to safeguard people from the risk of abuse
● The service had records of four safeguarding concerns that had been raised with the local authority. However, we found they had failed to record a further 22 safeguarding concerns and investigations raised by the local authority or notify the Care Quality Commission, which they are required to do. We contacted the provider about safeguarding alerts and they were not aware of all 22. The provider did not demonstrate oversight regarding where any form of abuse is suspected. This meant people were not protected from the risk of abuse.

This demonstrates systems and processes were not established and operated effectively to prevent abuse of people using the service and is a breach of Regulation 13 (Safe guarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some relatives told us they had concerns about the safety of their loved ones. One relative told us they had concerns about the safe treatment of their loved one. During our inspection we raised this with the local authority.
● However, people using the service told us they felt safe. Staff knew about safeguarding and whistleblowing. They gave descriptions of their knowledge of types of abuse. The service had up to date policies and procedures to guide staff.

Preventing and controlling infection

- Systems were in place to reduce the risk and spread of infection and staff were aware of their roles and responsibilities in this area.
- People and staff confirmed the service provided a supply of protective clothing for staff to wear including gloves and aprons.
- Records confirmed completed training in prevention and control of infection.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection we recommended the provider seek best practice guidance on delivering training. This included specialist training and ensuring staff understand the contents of the training. The provider had not made improvements.

- Induction training sessions for new staff were not consistent or a robust assessment of the staff's knowledge. We had concerns about new staff not being adequately trained.
- Before the inspection we received information of concern about poor training, induction and issues with staff being given answers during training in order to pass training courses. We discussed this with the registered manager. They told us staff were not given the answers to assessment questions during induction. The providers training records showed staff who had been in post for over a year had completed refresher training courses annually and staff confirmed this.
- However, we sat in on a staff induction session on 21 January 2020 and saw that the four attendees had been given the answers to the assessment questions in advance. The attendees confirmed they had been given the answers to the training sessions.
- We spoke with the registered provider about these findings. They told us it was not standard practice to give attendees the answers. However, this was inconsistent with information given by staff.
- We asked the registered manager about their induction process. They told us the duration of induction was five days which included training modules, for example person centred care, safeguarding, and health and safety. Watching DVD's, group discussions, completion of training workbooks and two days shadowing senior staff members. However, there were inconsistencies in staff feedback about the duration of induction. Two staff members told us they had received three days training and two days shadowing staff. This was not consistent with the providers induction process. Staff files reviewed for one staff member showed a discrepancy in the dates of their training sessions and shadowing.
- We found staff had been briefed by the management team with answers they should give to questions asked by the Care Quality Commission (CQC). This included the duration of their induction.
- People using the service and their relatives had mixed views about staff skills. One person using the service told us staff were not trained regarding their medical condition. They said, "They (staff) are not trained but some have someone in the family so they understand it but they are not trained." A relative told us, "The regular carers are very good. But the temps are very passive, do not interact very well with [person using the service]. These staff are probably not very well trained."
- We were not satisfied that newly recruited staff were being adequately trained and their knowledge

checked prior to providing care and support to people. This put people at risk of receiving care or treatment provided by staff who did not have the qualifications, competence, skills and experience to do so safely.

These findings were breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care files and staff records confirmed spot checks were carried out. A spot check is a member of the management team observing care staff when they support people to check their performance. Staff carrying out spot checks had identified training needs for staff and had been working closely with staff to improve their practice when delivering care. Staff were positive about the process and told us they felt supported.
● Supervision meetings were carried out to enable staff to discuss any issues they may have.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
●People's needs and choices were not always assessed to achieve effective outcomes for their care and support.
● Assessments were carried out by senior staff before people begun using the service. This enabled the service to identify people's daily living activities and the support that people required. Care plans were developed using this information.
● However, the care plans were completed by other office-based staff members who had not been involved in the pre-assessment process. This process was not robust and meant care plans were not always personalised and detailed to reflect people's needs and preferences.
● For one person living with three chronic health conditions, the information from their pre-assessment did not transfer to their care plan in sufficient detail to guide staff. This meant staff did not have the information regarding how these health conditions affected the person or impacted on the way care and support should be delivered. We found similar short comings in care plans for other people using the service. This meant there was potential risk of people receiving inappropriate care as staff worked unsupervised in people's homes.
● The service supported people with nutrition and hydration. However, people's preferences or nutritional requirements were not always detailed in their care plans.
● People who had a medical history of diabetes did not have information in their care plan about the foods to include or avoid when preparing meals to ensure a nutritious diet was provided to meet their dietary needs and maintain good health.
●Clear records were not always maintained when people required thickened drinks to minimise the risk of choking. One person's daily log indicated they had been supported to drink and detailed the type of fluid but did not record if the fluid was thickened. The persons care plan did not specify that staff needed to check if the drink was thickened before supporting the person to drink in order to minimise the risk of choking.

These findings put people at risk of receiving care which was not adequate, safe or person centred and were a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their meals when they required them. Relatives did not express concerns about support with meals or meal preparation.
● Staff supported people with their choices at meal times. One staff member said, "We ask what they would like and then encourage and support them to eat."

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

●The service worked with other agencies to ensure people received appropriate care.

●People told us care staff contacted and worked with other agencies on their behalf. One person said, "If the nurse comes to give advice, the carer sorts it all out."

●Care records included the contact details of people's next of kin, their GP and other health and social care professionals. This meant staff were able to contact them if the need arose. Staff were aware of what to do in a medical emergency. One person told us, "One day I was really ill and [staff member] called the agency and an ambulance was called and took me in. [Staff member] is very aware if I am not well." One relative said, "Carers always contact me if they are worried about something."

● Records showed staff worked with the district nursing teams and GPs to ensure people received the support they required. Concerns raised by staff, for example when people refused to give access to their homes, was recorded with actions taken. Staff involved social care professionals to resolve this.

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.

● Mental capacity assessments had been carried out to determine if people had capacity to make decisions.

● Staff had completed training on the MCA and were aware of the principles. People had signed a form to consent to the care set out in their care plans.

● People told us staff sought consent before carrying out care and support. One person told us, "They do seek my consent." One staff member confirmed, "I ask for their consent before I do anything."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People and their relatives were unsure about their involvement in care planning. Some people knew they had a care plan but others were unsure and did not know if they had been involved in making decisions about their care. One person said, "I think I have a care plan. One of the carers showed it to me, it's in the folder." Another person said, "The care plan is that they help me with what I enjoy doing and cannot do on my own."
- We saw people had made changes to the times they required their care. Staff told us they supported people to make decisions about their care. One staff member said, "It's usually in the care plan what they need but you still ask them anyway."

Ensuring people are well treated and supported; respecting equality and diversity

- Some people and their relatives were positive about staff. However, others were less positive about staff approach and said this was mainly linked to a lack of staff continuity and punctuality. They told us they did not always know the staff supporting them, as they hadn't been introduced. One person said, "They do not help me. I never know who is coming." Another person said, "One or two are a little bit off, they talk but do not communicate."
- Relatives of people using the service told us staff did not always speak to their family member in a respectful manner. One relative said, "Some don't talk to [person using the service] and some are rough." Another relative said, "Some carers do not say a word. They may think that they are being business-like, but it comes across as quite harsh."
- People were protected from discrimination within the service. People's care plans had guidance for staff regarding their preferences in line with their religious beliefs. Staff told us people were treated equally and people should not be discriminated against because of their religious beliefs, race, age, gender or sexual status.
- Staff gave examples of how they built relationships with people and their relatives. They told us they spoke with people and their relatives to build a rapport with them. One staff member said, "I do the same shifts so I have a good relationship with them (people using the service) and their family too." One person said, "They do chat to me. We talk about all sorts of things. They ask how I feel, how I am."

Respecting and promoting people's privacy, dignity and independence

- People using the service told us their privacy and dignity was respected by staff. One person said, "They definitely respect my dignity."
- Staff told us they respected people's dignity and privacy and gave examples of how they ensured this. One

staff member said, "During personal care make sure it is done in private. Even if they live with their partner keep them covered up and not exposed."

● Staff gave examples of how they promoted people's independence by encouraging people to do tasks for themselves within their capability. For example, during personal care or meal preparation.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans were not always personalised or detailed and we found inconsistencies with some care plans. Each person had a care plan which contained information about the support they needed from staff. Care plans were divided into sections and included information on people's mobility requirements, religion, continence, nutrition, health condition, religious practices and social support.

● We found, one person's care plan did not contain specific signs staff should be aware of that would indicate the person was becoming unwell with an existing health condition. This put them at risk of receiving inadequate care or support. Another person's care plan did not include their goals.

● People and their relatives had mixed views about care plans and reviews. People told us they had a care plan and reviews were completed. However, one person said, "They (staff) look at the programme (care plan) but they do what they want to do and do alright in the end. The office don't come often." Another person said, "They ask me what I need and what I want done. They don't consult the care plan."

●People and their relatives did not always feel staff knew them well and reported they did not always see the same staff which made them concerned about continuity of care.

●Care plans were not always reviewed in a timely manner when people's needs changed and staff were not given information regarding these changes. A relative said, "I started with this agency last January and care plan has not yet been looked at. Supervisor supposed to come and I have seen them once. New one said they would come more often to see if care plan followed." Staff told us they did not always get a thorough handover of the needs of the person they would be supporting and were not guided to the persons' needs through care planning. They told us care plans were in place but they were not always updated in a timely manner.

These findings meant people were at risk of receiving care that was not person centred to meet their assessed needs and reflect their personal preference whatever that might be. This was a breach of breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

●The service sought people's communication preferences. Initial assessments and care plans included

information about people's communication needs.
● Information including the service user handbook was provided in large print and easy read formats when people required this.

Improving care quality in response to complaints or concerns
● The service did not always respond to complaints in a timely manner.
● We looked at complaint records and saw the service had received three complaints since the last inspection. Of the three, two complaints were resolved within the timescales indicated in the providers policy. However, a third complaint had taken three months to be resolved. One staff member told us, "The handling of complaints needs to be more effective. We need to communicate with people and solve problems. Not consistent in the approach of dealing with complaints and some complaints are missed."
●The service had a complaints policy and procedure which was included in the handbook when people started using the service. People and their relatives told us they knew how to raise complaints.
● However, some people and their relatives told us the service did not always respond in a timely manner when they raised complaints. One person told us "I have made countless complaints about lateness. They always apologise and then it happens again." Another person said, "If you ask them something, then they say they will sort it out. But they do not sort it." Relatives of two people using the service told us they had raised complaints by telephone. However, the service had failed to respond appropriately and the quality of care had not improved.

This meant the service did not take appropriate action without delay to respond to and investigate any failures identified by people using the service. These findings were a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● At the time of the inspection, the registered manager told us the service was not providing end-of-life care. However, some staff disputed this and told us they had verbally been told one person was receiving end-of-life care when they started working with the person. This was not documented in the persons care plan. We saw records which confirmed another person had recently been identified as being at the end of their life however, their care plan had not been updated to reflect this.
● People's care plans did not contain evidence that the service explored people's preferences and choices in relation to end of life care and support.

We recommend the provider seeks best practice guidance on end-of-life care to ensure care plans are person centred and respectful of people's wishes.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People using the service were supported to maintain relationships and participate in social activities.
● Care plans showed details of people's hobbies and preferences relating to social activities. For example, one person's care plan detailed their preferences for going out twice a week with staff support.
● Staff told us they ensured people were supported to attend events in the community with their family members. For example, making sure people were dressed and fully prepared to attend events.

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 Requires improvement. 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.

Continuous learning and improving care

At our last inspection the provider had failed to have robust governance systems in place to ensure shortfalls in the quality of the service provided could be identified and action taken to ensure people always received safe care and effective care at all times. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. Robust quality assurance processes were not in place to identify and address areas for improvement.

● The provider did not have oversight of commissioned care packages and needs of people using the service. During the inspection they told us the service provided personal care to 95 people. However, the actual number confirmed by the local authority was 115.
● Complete and accurate records were not always maintained, including records of care provided and decisions taken in relation to people's care. Records were not completed in a timely manner and did not communicate information in a clear way when there were changes in people's care needs. There was a reliance on verbal communication which meant staff were not provided with detailed written information and this put people at risk of unsafe care.
● Records regarding personal information of people using the service were not always up to date. Staff records were not up to date as we were given the contact details of staff who no longer worked for the service.
● Medicine audits did not identify discrepancies in the required details on medicine administration records (MAR). Although there were no gaps in MAR charts, audits did not identify missing information regarding dates. This meant it was unclear which month the record related to.
●The service had not followed up on action plans they had put in place to improve the service. For example, an action plan had been put in place to improve the punctuality of care staff and minimise missed calls. This included tracking the arrival and departure time of staff and using monthly graphs to analyse this. However, staff were still arriving later than scheduled and some calls had been missed. We found the action plan was last reviewed for progress on 30 May 2019 and no further updates were available.
● We found shortfalls in relation to a number of areas such as with staff induction, risk assessments, care planning and handover of changes in people's needs. The service did not always include people's assessed needs and risks in their care and plans. There were shortfalls identified with deployment of staff and

complaints management.
● We found widespread shortfalls, some of which were continued breaches. The provider had failed to ensure that, appropriate systems were in place to address the previously identified shortfalls. They had failed to prevent additional breaches of the regulations from occurring.

We found no evidence that people had been harmed however, the above issues show the service failed to ensure robust audit systems were in place to identify shortfalls and act on them to ensure people were safe at all times and maintain accurate records to ensure people received safe care. These issues were a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● Some people told us when they contacted the service, they received a response to their query. However, others and their relatives told us co-ordination and communication from the service was weak. One relative said, "There is a lack of co-ordination. We spend a lot of time chasing up, rotas are not issued and then someone unknown turns up. Communication is not good." Another relative said, "Communications could be better if carer is late or not going to turn up."
● People using the service and their relatives had mixed views about the culture of the service. One person told us, "One carer who I got on well with was not well treated and left. I have heard the office call carers and be rude to them."
● Staff had mixed views about how the service was led. Some staff told us they felt supported in their role and the service was well led. One staff member said, "[Registered manager] is approachable and helpful." However, some staff had concerns about the service old us they did not always feel supported by the management team. One staff member told us, "[Registered manager] is not always approachable to raise concerns with."
●These findings meant the culture of the service was not always positive for people using the service their relatives and staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The service had a registered manager who was also the owner of the business. They were supported in the day to day running of the service by a project manager and two newly appointed care co-ordinators.
●The registered manager did not send statutory notifications to the Care Quality Commission (CQC) in a timely manner. A notification is information about important events that the service is required to send us by law. The service did not submit notifications of allegations of abuse or safeguarding investigations. This meant monitoring of the service and frequency of occurrence could not be monitored or followed up by the Care Quality Commission. The CQC is still considering what action it needs to take in relation to this matter.

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

At our last inspection we recommended the provider analysed the results of surveys regularly to ensure there is a culture of continuous improvement. The provider had made some improvements, however further improvements were necessary.

● The service carried out customer surveys. We looked at surveys completed in June 2019. This indicated

staff punctuality scored five out of ten. They indicated this was due to one or both care staff being late. In October 2019 most people indicated they were satisfied with the service and there had been some improvement in punctuality.

● The registered manager told us they corresponded with people and their relatives by telephone to ensure they were happy with the service provided. People using the service gave mixed responses regarding contact from the office. Some people said they received telephone calls regularly while others told us it was infrequent.

● Records showed the registered manager met with staff every three months to discuss the service and provide updates. Staff confirmed meetings took place and told us they also received updates by email.

Working in partnership with others

● The service had an action plan in place, which was monitored by a commissioning local authority. The action plan was in place to address concerns about the quality of service delivery.

● The service was affiliated with Skills for Care to develop and share staff knowledge regrading best practice.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure service users are protected from abuse and improper treatment in accordance with this regulation. Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure any complaint received was investigated unnecessary and proportionate action taken in response to any failure identified by the complaint or investigation. The provider did not establish and operate effectively and excess above system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (1)(2)