Solitaire Homecare Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Solitaire Homecare Services Limited is a domiciliary care agency providing the regulated activity of personal care to people. The service provides support to older adults with a range of needs including people living with dementia, people with mental health needs and physical disabilities. At the time of our inspection there were 80 people using the service.

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.

People's experience of using this service and what we found
People often did not receive their calls at the agreed times and calls could take place hours later than planned. People's risks and medicines were not always effectively managed. People were not protected by clear safeguarding policy and process and the service did not always identify safeguarding concerns and shortfalls in the service. People told us they felt safe and raised no concerns around staff practice.

People's needs were not always fully assessed, and staff were not always provided with the training and guidance about their individual needs. People were supported to eat and drink by staff and to access healthcare support. 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; although the policies and systems in the service did not always support this practice as far as possible.

People and relatives described positive relationships with staff and told us they were caring and friendly. People told us they were involved in decisions and choices about their care, and felt well supported. We found however the service was not consistently caring based on the impact of late calls and where concerns had been raised about some people's care, these were not addressed to drive out poor care experiences.

People's feedback showed that they did not feel the need to complain, but if they did, concerns were addressed quickly. Managers could not demonstrate the learning and analysis taken from complaints, and how this had been used to improve the service.

We identified a breach in relation to good governance at the service. This was because the systems and processes built around meeting people's needs were not effective, including around training oversight, risk management and learning from information of concern. People and relatives spoke positively about the service overall and managers recognised improvements were required and attributed this to staffing issues at the service and within the sector.

Rating at last inspection
The last rating for this service was Good (published in September 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Response and Well-Led key questions sections of this full report. The provider has taken some action to mitigate risks, and further improvements will need to be made and embedded in practice. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified 5 breaches in relation to safe care and treatment, good governance, staffing, complaints and safeguarding processes 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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Solitaire Homecare Services Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by an inspector, an assistant 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 is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 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 and to give people time to consent to speaking with us.

Inspection activity started on 10 January 2023 and ended on 3 February 2023. We visited the location's office on 11 January 2023 and 12 January 2023. We carried out phone calls on 10, 11 and 19 January 2023 and continued to request and review evidence from the provider throughout this period.

What we did before the inspection
We used information gathered as part of monitoring activity that took place on 23 November 2022 to help plan the inspection and inform our judgements. We also reviewed information we had received about the service since the last inspection.

We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people using the service and 7 relatives of people using the service. We spoke with 5 staff members and the management team: the registered manager, the deputy care manager, 2 care managers, a director and a compliance manager. The registered manager was also the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at 2 staff recruitment records and 7 people's care records.

After the inspection visit, we used remote technology such as video calls to enable us to engage more with managers of the service, and electronic file sharing to enable us to review documentation as part of this performance review and assessment. We also spoke with a professional involved in the care of some people using the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Staff were not deployed effectively. Records showed some people's calls were routinely late by a number of hours, including for people who required 'time critical' support, for example due to medicines support and to help safely manage a healthcare condition.

● The provider did not have their own effective system to ensure people's calls took place at the agreed times. Staff were responsible for deciding when to attend people's calls, based on their own knowledge of people's needs and the local area. There were not enough staff, or enough guidance in place to help staff make these decisions safely.

● People and relatives told us their call times varied. One person told us, "This is a bit of a problem, they don't always come at the time expected which can prove to be quite awkward sometimes… Call times are different every day." A relative told us, "The timings are not great! It is understandable with [staff] going off sick and being short staffed because people are leaving… Also, calls can be very close so I will ring and ask them to try and spread them out". Managers told us staff could check the last time people had a call, to inform when they should carry out their next care call, but this was not a consistent approach.

● The provider had advertised care staff roles over several months and managers told us they still had staff vacancies. Managers had to step away from their own roles to provide emergency cover. Although managers knew staff were stretched and calls were not always planned around people's risks and preferences, not enough had been done to improve staffing and service arrangements in the interim.

The provider had failed to ensure there were sufficient levels of staff, and that staff are effectively deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We sampled recruitment records for two staff members. We saw suitable checks had been carried out before started in their roles.

● People were often supported by a familiar group of staff, and any staff they were less familiar with, always shadowed a more experienced staff member before supporting them.

Assessing risk, safety monitoring and management

● People's risks were not fully assessed to inform consistently safe support. For example, one person's mobility had deteriorated so staff provided hoist support, but there was no risk assessment to ensure this support was provided safely.

● Staff told us how they helped support another person with known mental health needs, however there was no guidance, or risk assessments to ensure all staff supported this person appropriately. We raised these findings with managers during our inspection and they started to take remedial action to address this.
● Managers had risk assessment templates for individual needs such as diabetes, but had not used these for people they supported who had diabetes.

Using medicines safely
● People's medicines records were not all accurately maintained about their individual needs or in line with current good practice. For example, records referred to people's 'blister packs' and did not detail what medicines they were supported with. We signposted the provider to best practice guidelines and a manager began to update people's records to reflect this.
● The provider's system did not alert managers when people had not taken their medicines. Managers relied on staff to identify and report any concerns. However, managers could not demonstrate staff had all received up-to-date medicines training and they told us medicines competency checks had lapsed over recent months. This did not ensure safe systems for people's medicines support and oversight to ensure safe practice at all times.

The provider had failed to assess and take reasonable action to manage risks to people's safety. The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff gave examples of how they had contacted emergency services when they suspected people were unwell. One staff member told us, "I phoned the ambulance straight away, called the office… we're trained what to do, I suspected a stroke." Staff we spoke with showed awareness of people's individual support needs, but record keeping around people's risks and poor staffing arrangements did not allow for consistently good practice.
● People and relatives spoke positively about their medicines support. Comments included: "Medication has been really good with them," and "They are very good at providing her medication".

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider failed to identify and respond appropriately to the risk of abuse and to ensure people were always protected from risk of harm. Staff did not demonstrate sound knowledge of the types of abuse people could experience and not all staff had completed safeguarding training.
● We prompted the provider to update their safeguarding policy because it did not refer to all types of abuse that people could experience and how to notify CQC about safeguarding concerns. There was also no robust system in place to ensure staff always handled people's monies appropriately.
● The provider did not always identify and address potential safeguarding matters within complaints they had received about the service, or within their own recorded incidents. Information of concern had not been effectively learned from or shared with relevant partners to continuously improve the safety of the service.
● The provider had failed to recognise that late calls for a person who required time specific support was neglectful of their needs. We asked managers to refer this to the local safeguarding team however, three weeks later, managers confirmed they had failed to do so. The managers made a safeguarding alert on this later date after our further prompt. We had already shared our concerns with the local safeguarding authorities to help protect this person.

The provider had failed to establish effective systems to prevent abuse, and to effectively respond to any allegation or evidence of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had raised other safeguarding alerts to help protect people. People told us they felt safe. One person told us, "Definitely safe, I have no problems whatsoever". A relative told us, "They have always been fine. They advise us on safety".

Preventing and controlling infection

● People told us that staff used personal protective equipment (PPE) such as face masks and gloves appropriately. One relative told us, "Gloves, masks, aprons, uniforms – they wear them all". The provider told us they had ample PPE available for staff use.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care records lacked enough guidance and information about their individual support needs, for example, diabetes and dementia care. This meant managers had not thoroughly assessed people's needs and ensured staff had the right guidance to always provide effective support. Managers started to address this during our inspection.
- People and relatives gave positive feedback about the care and support. Comments included: "I have seen them and they are very good. My mum is happy with them," "They are quite good," and, "They seem to be very well trained. I have never had any doubts about them".

Staff support: induction, training, skills and experience

- Managers said they did not have a clear overview of training completion due to system issues. The current available training matrix showed gaps in core areas such as the Mental Capacity Act, moving and handling and medicines support. We saw there were also gaps in staff guidance in people's care plans about people's individual care needs.
- The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Staff and managers told us that staff who were new to care completed the Care Certificate, however this information was not recorded. Similarly, staff told us they had received First Aid training however this was not recorded to help monitor staff training needs and when this training expired.
- Managers told us that planned regular supervisions and spot checks had lapsed in recent months. A more structured schedule had been set from January 2023 to address this.
- People told us new staff members shadowed more familiar, experienced staff before providing support. One person told us, "We have the same two [staff members] but one of them regularly. Continuity of care is important. If they have someone new, they will shadow my regular [staff member] first". Staff told us they felt supported.

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 MCA 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.

● Staff did not demonstrate good understanding of the requirements of the MCA, though most staff could describe how they promoted people's choices when supporting them. People told us their choices were respected. One person told us, "I know what I want, and they do what I need them to do."
● At the time of our inspection, a manager was involved in a best interests meeting for one person using the service and had gathered information to contribute effectively.

Supporting people to eat and drink enough to maintain a balanced diet
● This support was not consistently effective. One person had been prescribed supplements, was refusing meals and losing weight. This person's calls did not take place on time or for the agreed duration, which reduced the opportunity to encourage the person to eat and drink as far as possible.
● People and relatives we spoke with told us they were supported by staff to prepare and eat meals of their choice. One relative told us, "They make [person] a good proper breakfast and prepare lunch and wrap it up for [later]." Another relative told us, "If [person doesn't] eat a lot, the [staff] will let us know and we will go in at teatime to make sure they have eaten enough".
● A staff member told us they worked well with a relative and offered alternative foods to encourage the person to eat. The staff member commented, "We make a bit of a game of it; 'Come on you can eat this.'"

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff and managers worked with health professionals and supported people to access healthcare services when they were unwell. People and relatives confirmed this. One relative commented, "They have had to call an ambulance and they waited until the paramedics arrived".
● One person described how staff identified their symptoms and helped the person to book a doctor's appointment. The person commented, "The GP has been out to see me and the carers were here when he came. Everything is alright… The [staff member] whilst here rang the office to make the office aware of what happened. They are very good."

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

- Late calls meant people were left waiting for their calls and people's dignity was compromised as a result.
- Managers told us they covered people's care calls when needed because they did not want anybody to miss their care calls. One person told us, "They never let you down. They have always come, no matter what time it is. If they are going to be late… they will let me know."
- Managers showed personal commitment and care for people they supported, however systems did not effectively address late calls and ensure care rotas were appropriately designed. This failed to consider the potential impact of routinely late calls for the quality of people's experiences, and promoting people's dignity, choice, and wellbeing as far as possible.
- Some, not all, staff had received training in relation to equality and diversity. Staff were able to give some examples of when they had acknowledged and met people's religious and cultural preferences when caring for them. One staff member told us, "We haven't had any people screaming out needs wise... We just treat as we find. It's all on the [person's care record], anything specific on that… so we just follow that."
- People and relatives described a valued and positive relationship with staff. One person told us, "Hand on heart I have a brilliant rapport with them. We have a laugh and a joke and that makes a big difference to someone who is housebound. They really make my day". A relative told us, "Some days I can hear them having a ten-minute conversation and giggling. They always make time for a chat".
- People and relatives spoke positively about staff and commented they were very caring and respectful. One relative told us, "All the staff are friendly, polite and caring. Mum enjoys them being here, they put a smile on her face". Another relative told us, "They are proper carers and they are thoughtful, which is great. They are a great bunch".

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us their privacy and dignity was respected, however the service had received information of concern which showed this was not consistent practice, and people's dignity had been compromised. These poor experiences were not effectively addressed to prevent similar concerns in future.
- For example, staff had left one person's calls early, and had not provided personal care as required over two days. Relatives had to ring the staff and ask them to come back to support the person. Records did not show any action taken against staff in relation to this poor care. This did not reflect a consistently caring service. The compliance manager told us they would revisit these concerns in light of our findings.
- All people and relatives we spoke with told us staff encouraged people to do as much as they could independently. A relative told us, "[Person] can't do much for himself but the [staff] are really good at trying to get him to do exercises".

● Staff we spoke with understood their role in promoting people's independence. A staff member told us, 'It very much depends on that person, asking them what they want to wear, just encouraging them to do anything can for themselves, a choice of a meal. If they can't tell you, show them choices."

Supporting people to express their views and be involved in making decisions about their care
● People told us they were involved in decisions about their care. One person told us, "They always explain things to me in a way I can understand". A staff member told us, "[Person] takes the lead, tells me what she wants, I ask her what she wants me to do. I follow her lead and we know each other really well."
● People told us that a care plan was put together when their support first started and that this was reviewed annually. The compliance manager told us they had introduced a new rota so that people's care plan reviews took place quarterly moving forward, as they recognised improvements were required.
● Some people confirmed they had received surveys to share their views about the service.
● Whilst people's feedback showed good practice in this area, the provider had not ensured people received calls at the times they had decided together, and which met people's individual needs and preferences.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
● Complaint records did not demonstrate that complaints had been fully addressed to identify learning and improvements for the service. Managers confirmed they were not always able to demonstrate the learning and analysis taken from complaints and how this had been shared with the complainant and staff where appropriate.
● For example, we saw one complaint failed to address poor practice from staff and a potential safeguarding matter. This failed to ensure good quality care standards were made clear to all staff. Managers told us they would revisit this complaint in light of our feedback.
● Where complaints referred to late calls and the impact of this for people using the service, these concerns were not effectively addressed and used to drive wider improvements.

The provider did not have effective systems to make sure all complaints were investigated without delay, including referral to appropriate authorities and identifying the actions required to prevent similar complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Everyone we spoke with told us they would feel comfortable raising a complaint. Most people told us they did not have any concerns that needed to be raised. One relative told us, "I always talk to the care manager directly and every issue has been resolved straight away".
● The people who told us they had raised concerns or grumbles were satisfied with how these had been dealt with. A person said, "They sorted it out straight away." One relative commented, "One [staff member] was a bit brusque so I had a word with management, and they took her off [person's] schedule". We saw this feedback and action taken was not always recorded and used as an opportunity to drive wider improvements across the service.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
● People's care records were not always accurately maintained when their needs changed. For example, managers told us two people were at end of life. Their records had not been updated to provide detail about any changes to the level of care required of staff as a result. The provider had a care planning template available but had not used this or current good practice to help plan people's care needs.
● People's care plans stated their preferred and agreed times for care calls to take place.
● The service did not fully consider people's preferences in relation to the gender of staff providing their personal care. The managers told us, "Unfortunately we are not in a position where we can say never – wherever, we will try not to as they may have to be a second [staff member]." People and relatives we spoke

with echoed this and most people accepted this arrangement.
● One person told us, "We are very pleased with the continuity of [staff]". Records indicated people were often supported by regular staff members.
● People and relatives told us they were happy with the support provided. One person told us they felt their care was, "First class", and commented, "The service I have had is brilliant, I cannot fault it. They are lovely people."
● People and relatives were involved in planning care. A relative told us, "We helped to put the care package together". Another relative commented, "It was reviewed three or four months ago and we are happy with it".

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Staff and managers were aware of a person's communication needs but these had not been fully assessed and acted on. The person's care plan but did not go into detail about how to support this person and ensure that information was made accessible to them.
● One staff member gave a good example of how they supported a person to communicate, recognising that talking at a slower pace and using simple sign language worked well for this person.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- Risk and issues were not dealt with robustly. Systems did not ensure people's risks were properly assessed and known to all staff, and that people's care plans were accurately maintained to provide staff with the right guidance.
- Managers were aware one person had refused their medicines over a number of days and the person's doctor was involved. However, managers relied on people and/or staff to raise these issues with them, as the provider's systems did not proactively and promptly flag people's medicines refusals or errors. This did not allow for effective oversight to ensure people always received safe medicines support.
- The provider failed to ensure records were accurately maintained. In October 2022, a person was prescribed thickener for their drinks. Staff we spoke with knew this, however none of the relevant records including the person's risk assessments, medication records or daily care entries reflected this change to the person's care.
- The director told us there were training facilities on site, however, they could not demonstrate all staff training was up to date and effectively monitored, to ensure staff training gaps were addressed promptly. Guidance in people's care plans was not always complete. This exacerbated the risks posed by staff being responsible for prioritising the order in which they carried out people's care calls.

Continuous learning and improving care; 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

- Managers were aware of staffing concerns which had gone on over several months but did not adequately resolve risks and issues that arose as a result, such as complaints and routinely late calls. Systems were not improved to ensure people's calls took place at the right times.
- The compliance manager had recognised audits of people's medicines support, care records and staff support, were not detailed enough to drive and demonstrate improvements to the service. New audits were being introduced from January 2023. Staff development had also not always been given sufficient priority and so structured support for staff was being re-introduced.
- The registered manager had not always formally notified CQC of specific incidents and events as required, for example for a safeguarding referral and for a person's serious injury. We asked for these notifications to be submitted retrospectively, however this was not done.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● Managers recognised that records were not accurately maintained and addressed oversights during our inspection. Audits were being introduced to ensure people's care plans were reviewed more regularly.
● Managers identified their current medicines audit was not effective. A new audit had been introduced but this did not fully reflect current good guidelines around medicines support.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Managers were trying to address concerns whereby the service had adapted to staff need and preference, rather than that of people using the service. For example, they told us some staff would not travel to geographical areas that were too far away, and some staff spent less time at people's calls as it affected their pay.
● People and relatives told us they would recommend this service to others. A relative told us, "I genuinely cannot fault them. I have no reason not to recommend them but I have nothing to compare them against". Another relative told us, "I have recommended them".
● A relative told us, "We have regular phone calls with the office, we have such a good relationship with them. They are always there for us… [Person] always has a laugh and joke with them, the [staff] treat my parents like family."
● People's feedback had been gathered to help identify future priorities and areas of improvement for the service, although there was no action plan in place as yet.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There was not effective oversight of the safety and quality of the service. Managers told us this was because they needed to cover care calls due to staffing issues.
● Managers felt it was important to help staff to provide emergency cover of people's care calls, but managers did not do enough to address ongoing staffing concerns that were causing these issues and which impacted on the quality and safety of the service.
● Some people told us they had been asked for their feedback about their service, for example through questionnaires. We saw feedback had been analysed and used to identify how the service could improve.
● Staff told us they were given the opportunity to share their feedback about the service, and that they felt supported especially with personal issues. A staff member commented, "The job itself is good, rewarding, it's a national thing at the moment, the shortage of staff, it's a bit hectic, a lot sometimes. But that's not the fault of the company itself… they are extremely supportive."
● The provider worked in partnership with relevant healthcare professionals. Commissioners had recently visited the service to carry out a quality check. The provider intended to use this feedback to add to their ongoing improvement plans.
● The provider was exploring a wide range of methods to recruit more staff.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have effective systems to make sure all complaints were investigated without delay, including referral to appropriate authorities and identifying the actions required to prevent similar complaints. This was a breach of Regulation 16 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and take reasonable action to manage risks to people's safety. The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to establish effective systems to prevent abuse, and to effectively respond to any allegation or evidence of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient levels of staff, and that staff are effectively deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to impose conditions on the provider's registration.