(IECC Care) Independent Excel Care Consortium Limited

IECC CARE

Inspection report

2 Gladstone Road
Colchester
Essex
CO1 2EB

Tel: 01206793630
Website: www.iecc-care.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
IECC Care is a large domiciliary care agency which also operates 7 supported living services. The service provides support to adults and younger adults living in their own home. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection there were 147 people using the service.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support: The model of care and setting did not maximise people's choice, control and independence. The provider was not aware of right support, right care, right culture and was signposted to review this on the CQC website.

People were not 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.

Right Care: Care was not person-centred and did not promote people's dignity, privacy and human rights.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives.

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 good (published 22 April 2020). At this inspection we found there were breaches of regulation and the provider is now rated as inadequate.

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection started as a focused inspection but was opened out to a comprehensive inspection due to concerns identified.
You can see what action we have asked the provider to take at the end of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for IECC

Care Ltd on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding service users from abuse and improper treatment, safe care and treatment, fit and proper persons employed, staffing, person-centred care, receiving and acting on complaints, notification of events to CQC and good governance 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. The representations process regarding the warning notice served against a Regulation 17 breach is now concluded and the representations were not upheld.

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.

Special Measures:
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 their 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 always effective. Details are in our effective findings below.	**Requires Improvement**
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**

IECC CARE

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 1 lead inspector with the support of 2 team inspectors. 2 Experts by Experience also supported the inspection. 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.

Supported Living:
This service provides care and support to people living in 7 'supported living' settings, so that they can live as independently as possible. However, people's care and housing may not be sufficiently provided under separate contractual agreements in 6 of these services. CQC is reviewing this. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

This inspection was announced. 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.

Inspection activity started on 21 June 2023 and ended on 25 July 2023. We visited the location's office on 21 June 2023 and 19 July 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make.
We used information gathered as part of monitoring activity that took place on 2 March 2023 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 28 people who used the service or their relatives. We spoke with 15 members of staff including the registered manager.

We reviewed a range of records. This included 11 people's care records and medication records. We looked at 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. We looked at training data and quality assurance records. We asked the service to provide us with information electronically. We also spoke with stakeholders.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- Although the service had a system to manage safeguarding concerns and alerts, there was not sufficient oversight to make this effective. For example, we reviewed the safeguarding log for the service which detailed 1 unsubstantiated safeguarding concern across a 12 month period. However, other stakeholders provided evidence that at least 35 safeguarding concerns had been made regarding people who use the service in the time period, some of which were substantiated or partially substantiated. The service therefore did not have clear oversight of the safeguarding concerns or actions to take to help to mitigate the risk of harm to people who use the service.
- Staff spoken with stated they had received training in safeguarding adults. Training records reviewed showed a bar graph with percentages and this indicated the staff team had completed safeguarding training. However, incidents where people were placed at risk of harm were not routinely identified as safeguarding concerns or reported as such. For example, an incident was reported to the Care Quality Commission (CQC) by the police regarding a fight between 2 staff members in a person's home. Whilst the provider had taken action, this was not raised as a safeguarding concern by the service and CQC was not notified of this incident or the police involvement. Additionally, one person spoken with told us they had complained about rough care and treatment, which their relatives told us, resulted in bruises, and had asked for the carer to be removed from providing their care. Even though the person informed the office the carer was sent again the following day.
- The safeguarding policy at the service was not up to date and did not include the local authority contact details. Documents reviewed showed that the service had tried to make a safeguarding referral but had not used the standard form or sent the email to the correct email address. It was not clear whether this had been followed up or whether mitigating actions had been put in place to help protect the person from the alleged abuse.

Systems and processes had not been established to adequately protect service users from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks were not well managed or sufficiently mitigated to keep people safe. For example, one person was at risk of choking, however, the risk assessment regarding this stated carers were to feed the person at a pace they were comfortable with but did not make any reference to actions to take to help prevent the risk of choking. Additionally, the person was at risk of falls and injuries, however, there was no specific risk assessment regarding how falls and/or injuries were to be mitigated. Risks regarding health were also brief.

For example, "diabetes, insulin controlled" and regarding the management of this, "all concerns to be directed to district nurse and GP". There was no information regarding what the staff team should be aware of and what constituted a risk.

● The service did not have clear systems and processes to administer and record medicines safely. Medication administration records (MAR) had handwritten details that were not signed and counter signed. Some of these were not clear and did not give specific details. Where medicines had been altered, stopped or the time of administration changed, there were no notes to provide details of who had authorised this change. For example, one person was prescribed an asthma medication to be taken when needed. This was signed in the MAR as being given every day in the morning and at teatime. There were no notes recorded to explain why 'as required' medicine was being given twice a day every day.

● Folic acid 5mg tablets were prescribed and recorded as take one daily. The MAR description stated 'Medication should be stopped 26/04/2023' however, this was signed as being taken daily up to and including 31/05/2023. One person had a medicine prescribed to be taken at night. This was crossed out on the MAR and 'morning' was handwritten. This was not signed by the person who made the change and there was no record to identify on whose authority the change was made. One person spoken with told us they were given their medication by the carers. They told us "Most of my tablets are given to me in the morning. However, I used to take them at a different time and my GP has said 'it should be as it used to be'", indicating a change to a way of prescribing not made by a GP.

● We saw that one person had suffered a fall, which resulted in serious injury. Although action was taken the following day to seek treatment for the person, it was not clear what had been put in place to mitigate the risk of reoccurrence.

● The service training matrix indicated that 98% of the staff team had completed training in medication administration. We requested the medicines competencies for the staff team and reviewed a document which showed 21 people had completed this. Copies of the medicines competency assessments were requested and 4 were made available. 13 staff were spoken with and 6 of these told us they had a medicine competency assessment while 7 told us they had not.

Systems had not been established to ensure care and treatment was provided in a safe way for service users. This placed people at risk of harm. 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

● Staff recruitment did not promote safety. Recruitment was not well managed and 8 personnel files reviewed had information missing. For example, there were staff employed with an incomplete employment history where the gaps had not been identified or explained. One person born in 1990 had employment history from 2020 – 2022 recorded. No months were detailed and the gap in history prior to 2020 was not explained. Staff files did not consistently have references, or these were applied for after their start date. One person had a reference from a family member and one from an employer not listed in their employment history.

● Disclosure and Barring Service (DBS) checks were being completed after the date recorded for the person starting work. One member of staff spoken with told us they had been employed for approximately 6 months and had only been asked to do a DBS check in July 2023. 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.

Recruitment procedures were not established and operated effectively to ensure staff recruited were able to provide care and treatment appropriate to their role. This was a breach of Regulation 19 (Fit and Proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff used personal protective equipment (PPE) effectively and safely. Staff spoken with told us there was enough PPE and people told us this was used by their carers.

● The service training matrix showed 94% of the staff team had completed food hygiene training.

Learning lessons when things go wrong

● Incident reports were not adequately completed or reviewed to identify risks to people and measures were not adequately taken to adopt suitable control measures to make the risk for people as low as possible. For example, the incident log for the service was reviewed and this detailed 4 incidents across a 12 month period. There were additional incidents that we became aware of, such as a person suffering a fall, the police being called to a disturbance and concerns regarding financial abuse and none of these were recorded as incidents. The system therefore did not take account of all incidents and the service did not sufficiently monitor for mitigation and action.

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

- We reviewed the care and support plans for 10 people and saw some of these were personalised and reflected people's needs and some contained limited information. For people receiving care at home, guidance for the staff team on how to support people with their behaviours, choices and aspects of daily living was brief. For example, one person had a diagnosis of dementia and there was a lack of detail about how this affected them in terms of support required or decision making. The care plan stated in the cognition and mental health section, "Offer (person) reassurance when (person) is becoming upset or anxious, ensure (person) is given adequate time to process what is being requested of (them)".
- Other care plans reviewed contained brief information such as "greet (person) on arrival", "ensure dignity is maintained", "use a towel to cover", "assist with continence needs".
- There were behaviour support plans in place for some people. However, records reviewed did not reflect the support plans were being followed or understanding of positive behaviour strategies. For example, one document stated, "(Person) showed (their) bad behaviour pattern again, (They) were on her bed and started crying. Staff tried to comfort (them) at several times" and "(Person) started (their) bad behaviour pattern (crying) time to time, The staff always tried to comfort (them)".

- Staff ensured people had up-to-date daily care and support notes completed, however, records were not always legible and it was not possible to determine either what had happened during the care visit or who the staff member was who had written the record. The provider was in the process of moving to a digital system, where records would be typed into the system. This should help to mitigate the risk of unclear notes.

Systems and processes were not sufficient to ensure people received appropriate care and treatment that met their needs and reflected their preferences. 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

- The service told us people were supported by staff who had received or had access to relevant training. A training matrix was reviewed which was a bar chart with percentages of people who were trained. The matrix did not identify the staff who had completed the training. The service told us that certificates were kept in staff personnel files, 4 out of 8 staff files reviewed had some evidence of training being planned or completed.
- The service provides care and support to people with a learning disability and autistic people, however,

staff have not received the required training in this area or other associated training such as mental health awareness, communication tools and positive behaviour support.

● The service did not provide specialist training for the staff team such as catheter training. Care plans reviewed demonstrated that staff were emptying catheters and checking them for blockages or twists but had not received training in catheter care. However, we found no concerns with catheter care at the service.

● The service did not have a robust system for induction. We reviewed 7 staff personnel files and found that 4 of these had not completed their induction. For example, the induction process is signed off after 1 day, 1 month, 3 months and 6 months. 2 people who started working for the service in 2020 had completed only the first day of the induction process; another had completed the first day and month and nothing further, another had no induction information in their personnel file. This means the service did not sufficiently monitor new staff to ensure they were competent.

● The service used a spot check system to review the care being provided to people in their homes. Documents reviewed demonstrated spot checks on people receiving care were completed between June and July 2023. Prior to this none were recorded as having been completed since 17 November 2022. The forms reviewed were not fully completed or signed. Where a person made a comment this was not always carried over into an action. For example, one person stated they 'Would like consistency with carers due to anxiety/stress levels'. There was no information to indicate whether this had been actioned or how.

● The service used a spot check system for the staff team. We reviewed the log regarding staff spot checks and found no records of spot checks taking place between November 2022 and June 2023. However, after the inspection the provider sent documents to demonstrate some spot checks had been undertaken between November 2022 and June 2023. The log showed there had been spot checks for only 21 of the staff team. The system was therefore not effective at ensuring staff were reviewed and where necessary supported to develop.

● The service did not have an electronic monitoring system and used a freeform messaging platform to communicate with the staff team, including sending rotas and changes to care visit frequency. They did not have specific times for people to receive a care visit. Instead, people were seen within a window of time. This meant that some people had care visits close together. For example, on 28 February 2023 one person had a morning care visit at 10:30-11am, their lunch care visit between 11:10-11:35am and their bedtime visit between 15:05-15:35.

● People spoken with told us care visits could be spaced too far apart. One person told us, "The timings of the visits aren't great the morning visit is ok but the lunch call can be between 11.30am to 1.30pm and the tea call between 4.30pm - 6.30pm. The gaps too long. I have complained to the office, but they just say that's the way it is".

● It was not possible to determine whether the service had enough staff to support people at home as there was no system to determine when people arrived and left their visits. People spoken with told us that the care staff often arrived late. For example, people told us, "Sometimes they [carers] turn up a bit late" and "The carers are sometimes late but will let us know if they are going to be late".

● People told us staff were always rushing and did not always stay for the allocated time. For example, one person told us the carers stayed between 5 and 25 minutes and said, "They are 'in a rush to leave". Another person told us "The visits should be half an hour but are usually 15 - 20 minutes". This demonstrates a lack of consistency in call times which is impactful for people receiving a service.

● The service did not have a robust system to monitor care visits. There was no clear system to identify when care visits were late or missed. The manager told us that the staff member involved would call the office to let them know if they were running late. However, records reviewed demonstrated that this system was not effective. Relatives, adult social services, and people themselves were informing the service or the carers that a visit had been missed or was late, which meant people were left without care as the office were not promptly informed and remedial action was not taken. For example, records reviewed stated, "NOK called to complain that carers didn't come last night 06/03/2023 and also carers didn't attend this AM call today

07/03/2023". Another record stated that a person informed their carer the following day that their carers did not come to the evening visit. On 4 July 2023 a person complained that 'staff came late for all calls'. This was not recorded on the late calls documentation.

Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had commissioned a bespoke electronic system which was in the preliminary stage of being implemented. The registered manager told us this would address some of the call monitoring concerns identified.

Supporting people to eat and drink enough to maintain a balanced diet
● The service supported some people with their meals. The training matrix bar chart percentage for completed food safety training was 94%.
● Care plans reviewed for 2 people who lived in supported living style services showed that people were served their food and where appropriate involved in washing up their plate.

Staff working with other agencies to provide consistent, effective, timely care
● People were supported to attend hospital and primary care services where this was appropriate. Record keeping regarding this was not consistently up to date, for example the record of a recent appointment was only recorded in the persons daily notes.
● Additionally, we saw one person had not attended a device check appointment for their pacemaker. A new appointment had been scheduled.

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.

● The bar graph regarding MCA training on the service's matrix indicated 92% of the staff team and completed it. 13 staff were spoken with and of these, 2 people had a clear idea regarding what the principles of the MCA were.

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 did not always feel well-supported, cared for or treated with dignity and respect.

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

- Some people who use the service told us they received kind and compassionate care. However, our findings did not suggest a consistently caring service due to lack of clear oversight of the service provided and systems which did not effectively keep people safe.
- People spoken with told us most staff members showed warmth and respect when interacting with them. For example, one person told us, "We are very happy with the carers, they are wonderful, they're just like friends", another said, "I can't fault them, and I am happy from the bottom of my heart" and another person told us "To be totally honest, we are so happy they are brilliant, (relative) has regular carers, and we have good relationship with them".
- Some of the feedback we received was mixed. For example, "They (carers) are fine no problem they are respectful, just one I don't like her attitude", another person told us "They make me feel uncomfortable because some of them don't talk or chat to me, 2 of them are chatty".
- There was limited equality and diversity information available regarding the people who use the service. The care plans reviewed did not ask if there were gender preferences for carers and did not provide detailed information about religion or culture.

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

- People were able to make decisions about the service when appropriate and could provide feedback on their care and support. For example, some people were sent a questionnaire to complete regarding the care provision. These were reviewed for area where action was required and an action plan compiled. Initial concerns that required action included staff not showing their ID cards when they arrived at the service. Action to be taken included, contacting people to identify the care workers who did not wear ID badges while in their home. Consistency of care workers was also highlighted and the action plan noted that the new process of using 2 sets of 2 carers per person had been effective and would continue.

Respecting and promoting people's privacy, dignity and independence

- We received mixed feedback from people regarding being treated with dignity and respect. One person told us "'99% [of carers] are wonderful; they treat (relative) with respect. They have a laugh. They help (relative) all the way. I can't fault it", another person said, "They are nice people, they are polite, cheerful and respect the property". However other people told us they did not feel their dignity was considered, for example, one person told us their female relative would be more comfortable with 2 female carers. Another stated their female relative was "OK with one male carer". A third person told us that the care workers did not chat with their relative. They told us "The 'nice' carers tell (person) what they are doing, (person) loves

this couple, but the others just tell (person) to 'turn over' but (person) can't".

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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's care needs were not consistently met due to the service's lack of oversight and monitoring of care visits. This impacted on people's ability to have sufficient choice and control of their care. For example, one person told us their relative had been put to bed early to meet the needs of the service rather than to support their relatives choice. They told us "My (relative) was put to bed early to fit in with their schedule". A second relative told us they were struggling despite having carers. They told us they change their relatives continence aids themselves as they won't leave them soiled all night as "(relative) is put to bed at about 7.30pm and this is the last of 4 visits".
- One care plan reviewed showed a person was supported to attend music and movement classes in the community and had completed a pottery course. The person lived in a supported living style service.

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 (AIS) 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.

- There was limited information regarding AIS in the care plans reviewed. For example, 1 care plan stated, "Communication – (person) can express (themselves) when (they are) in good mood; has capacity to decide what to do but unable to hold (their) emotion", a DCA care plan stated under support needs for mental health and cognition, "none reported at present" and "please communicate changes and escalate as appropriate".

Improving care quality in response to complaints or concerns

- Although the service had a system to identify complaints there was not clear oversight. For example, the complaints log was reviewed and identified 2 complaints. Both of these were recorded as having occurred in July 2023. People spoken with referenced making complaints about the service, but these were not recorded on the log. For example, one person made a specific complaint and told us they had not had an outcome regarding this. This was not recorded on the complaints log reviewed.
- One complaint viewed had been investigated and a witness statement taken from the member of staff involved. The findings of the investigation advised the staff member to contact the office if they were running late and to be more compassionate.

End of life care and support

- Some care plans reviewed showed that end of life care had been discussed where appropriate and wishes recorded. The care plans reviewed for the care at home component of the service did not have any information regarding end of life care.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a sufficiently open and positive culture. For example, CQC sent a number of requests for information to the provider/registered manager regarding areas of concerns which had been raised by people about the service and received no reply. The most recent of these was on 15 July 2023. The service was asked for specific information and documentation by CQC for this inspection to be supported and conducted. The information was not received by the due by date, or the extension date. An official letter informing of CQC's legal powers to request information was sent to the provider. The documents in their entirety were still not received by the due date. A follow up letter was sent and further documents were gradually received, meaning it took 5 weeks for all the required information to be received and reviewed. The manager told us the delay in providing information regarding the inspection was due to an IT problem.
- Management were not sufficiently visible in the service and people stated that it was hard to make contact and get feedback from the office. Although there was an on-call service, staff and people who received care stated that this was not always easy to access. For example, one member of staff told us "In the mornings it is hard to get hold of anyone in the office you need to, we may start at 6am but there may not be anyone in the office until 10am and at weekends there is no one in the office. On call take a long time to get back to you". One person told us "There's poor communication between the office and the carers, for example, carers turned up to do a visit when they had cancelled the call and family were present in the house". Another person told us, "Communication with the office is bad they don't return calls".
- The service had not completed the requested Provider Information Return. This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make.
- There was not sufficient oversight of safeguarding concerns for the service to take action to address the issues raised or use the information to make improvements.
- The service did not have a sufficient system to identify and assess risks to people and where risks were identified did not introduce clear measures to reduce these risks.
- There was not sufficient management and oversight regarding reporting, recording and responding to concerns and identifying actions to make improvements. For example, information on complaints and missed or late care visits were not always appropriately recorded and did not always contain clear information about how risk of reoccurrence would be mitigated.
- Audits were insufficient. There was not a clear system of audit and these were not completed in the time frames identified by the services policies. Additionally, they did not identify the concerns found during this

inspection.
● It was not possible to gain clear oversight regarding the system for supervision. Of the 7 staff files reviewed, only one contained documentation regarding supervision and this was dated 14 July 2023. 12 staff members were spoken with and gave an unclear picture of supervision. Some staff told us it was 3 monthly, others 6 monthly or yearly. One staff member told us "I feel supported by (co-workers), [there are] no face to face supervisions", another told us there are "no regular supervisions", another said "supervision, not regular", another person told us "I feel supported, supervisions are as often as possible".
● Staff members spoken with told us there was a punitive culture within the organisation, with members of staff being suspended for periods up to 3 weeks without pay for being late to training or doing something wrong. One member of staff told us they were removed from the rota for 21 days unpaid as a punishment. The person told us this happened twice. A second member of staff told us "I can't understand all the suspension's people are getting, mistakes, these happen, not to hurt a client, many people finding it difficult, people are suspended and then can't pay their rent, this is scaring us, we aren't the military, people being punished, this has just started now, people have been late to the training hall, might have been hold up on the way, but they (management) don't care what the reason is, staff are just sent away and suspended for 2 week as a punishment, can't pay rent, this isn't fair".

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. 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.

● Some staff members spoken with told us they did feel valued and supported by the service. For example, one member of staff told us, "The company are really good, if you don't feel comfortable doing something and you talk to them about it they support and accommodate". A second said, " I feel supported, respected, and valued, they answer any time we call, call us to office if there is anything to discuss with you", and a third member of staff told us, "Very supportive, respected and valued, if you call send a message they reply immediately".

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
● The service had a duty of candour policy; however this was not up to date and referenced a previous registered manager throughout.
● There was a culture within the service of not recognising incidents as safeguarding concerns and therefore alerts were not appropriately made and the required statutory notifications were not consistently made to CQC. Notifications are required by law to ensure CQC has oversight of the service and can monitor it to ensure people receive safe care and treatment. Stakeholders provided evidence of 35 safeguarding events associated with the service. The service had 1 on its safeguarding log. None of these had been notified to CQC.
● Additionally, we saw that two people had fallen and been injured and the required statutory notifications regarding an injury to a person using a service were not made to CQC.
● There had been an event where the police had been called to a service. The required notification regarding an event reported to or investigated by the police was not made to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People spoke with told us they would speak to the office if they had cause to complain and there was evidence that some spot checks were taking place. However, there was no clear system to demonstrate how actions were taken and improvements made following feedback.

● The service sought feedback from some people by sending out questionnaires. They devised an action plan of the three main concerns identified to improve the service.

Continuous learning and improving care; Working in partnership with others

● The governance processes established by the provider were not used to effectively safeguard people and improve their care.

● Required statutory notifications regarding safeguarding incidents and accidents were not consistently made.

● The manager engaged in local and national quality improvement activities. For example, the service engaged with commissioning bodies and other health and social care organisations.

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 Systems and processes were not sufficient to ensure people received appropriate care and treatment that met their needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to ensure care and treatment was provided in a safe way for service users.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established to adequately protect service users from abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure staff recruited were able to provide care and treatment appropriate to their role.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

Warning notice served.