Compassion Home Care Limited

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Inspection report

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22 September 2023

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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: Compassion Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own homes, At the time of the inspection there were 42 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

We found that the provider failed to carry out comprehensive pre-assessments before people joined the service. Appropriate risk assessments were either not in place or not adequate. Risk management plans were not always in place to manage these risks, which included falls, mobility, mobility equipment, multiple sclerosis, dementia, epilepsy, asthma, diabetes, and skin integrity. Medicines were not always safely managed.

There was a system in place to log and investigate accidents and incidents, however, these were not analysed and learning from this was not disseminated to staff.
People's independence was not always promoted, and people's privacy and dignity was not always respected. Staff did not receive training in areas such as epilepsy and catheter bag care. People's communication needs were not always clearly documented.

Staff did not have a good understanding of the Mental Capacity Act (MCA). Staff were not supported with regular 1:1 supervision meetings and staff meetings. Complaints were not always managed effectively. Governance systems were not always effective at identifying and reducing risks to people's safety.

People or their relatives told us that they were involved in planning their care, although this was not always documented. People told us that they felt safe. People were protected from the risk of infection. Appropriate recruitment checks were carried out before staff joined the service. The service worked in partnership with key organisations and health and social care professionals when required.

Rating:
The last rating for this service was Good (published 17 November 2017). The service has deteriorated to inadequate.

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

Enforcement and Recommendations:
We have identified breaches in relation to safe care and treatment, staffing, person-centred care, dignity,

MCA 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.

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 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 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**

Compassion Home Care 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors over 2 days. 2 Experts by Experience also supported this 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

Compassion Home Care Limited is a domiciliary care agency, it provides personal care to people living in their own houses and flats

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. 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 as we needed to be sure that the registered manager would be in the office to support the inspection. This inspection site visit took place on 14 September 2023 and 22 September 2023 and was announced.

What we did before the inspection
We checked the information we had about the service including notifications they had sent us. A notification is information about incidents or events that providers are required to inform us about. We sought feedback from the local authority who work with the service. The provider completed a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 15 people and 6 relatives to seek their views about the service. We spoke with 17 members of care staff, including 2 team leaders, the director and the registered manager. We reviewed records, including the care records of 10 people using the service and recruitment files and training records of 5 staff members. We also looked at records related to the management of the service such as quality audits, accident and incident, and policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

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

Assessing risk, safety monitoring and management
• People were not always safe and protected from known risks of harm. Risks had either not been assessed or were not adequate in relation to falls, mobility, mobility equipment, dementia, multiple sclerosis, strokes, choking, asthma, diabetes and skin integrity.
• Risk management plans were either not in place and/or not detailed to ensure that there was up to date person-centred guidance for staff on what to do should people become ill. Some people's care records were not person-centred and contained minimal information about people's specific and individual health needs to ensure that staff were able to support people with their individual needs effectively.

• There was not always clearly documented information and guidance for staff about specific medical conditions people had, for example, epilepsy, strokes or multiple sclerosis and staff were not always aware of people's medical conditions. There was no epilepsy protocol or guidance in place for staff on what they should do if a person had a seizure. One staff member we spoke to said, "I think [one person] has epilepsy but haven't seen any information about this. [The person] tells me when they have had an epileptic turn, I give [the person] a biscuit." One person who had a number of medical conditions they lived with, however when we spoke to the staff member, they supported they said, "I don't know all of [person's] medical conditions, he has a lot. I read [person's] care plan when I first started work, 6/7 years ago. Not read since." Another person had a number of medical conditions including dementia, we spoke to a staff member who supported them, they said, "I am not aware of [person's] medical conditions. From my knowledge [person] get muddled up, so not sure if [person] has dementia - but [person] has doesn't have no other medical conditions."
• Some people used mobility aids, such as standing hoists, walking and standing frames to mobilise. However, their moving and handling and falls risk assessments did not always identify the potential risks of using these mobility aids. There was not always guidance in place for staff on how to safely mobilise the person and how to minimise potential risks.

• Some staff members we spoke with told us that at times a hoist was used by two staff members for people. Whereas, at other times a hoist was used by one staff member for the same people. This placed people at risk of falls and avoidable harm. One staff member said, "It can be difficult to turn [person] so all transfers should be double handed for safety. [Person] gets shaky and can be difficult to single handedly transfer. Lots of carers have told the manager this, but nothing has been done."

We found no evidence that people had been harmed however, we found the provider had failed to ensure systems or processes were in place or robust enough to demonstrate safety was effectively managed. This

placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection, the provider told us that people's risk assessments and risk management plans will be updated. We will check t these at our next inspection.

Using medicines safely

• Medicines were not always safely managed. The provider did not always maintain accurate medicine administration records.
• Medicines risk assessments were not always carried out. Where people were taking high-risk medicines there were no risk assessments in place or guidance for staff on what they should do if people became ill.

• People prescribed controlled medicines patches did not have appropriate risk assessment information in their care plans to ensure this medicine was administered as prescribed to keep people safe. For example, some people were administered medicine patches that required changing weekly on a different part of the body. However, body maps were not completed to demonstrate where on the body, the patch had been applied. Staff also failed to always record where on the body the patches were being applied. Therefore, we could not be assured that the patches were being administered as prescribed.
• One person's care plan showed there was contradictory information about when a controlled patches should be administered. Records, including Medicine Administration Records (MAR) showed that the patch needed to be changed on a Friday morning. However, contradictory information was documented, stating that the patch should be changed on a Tuesday morning. Therefore, we could not be assured that the patches were being administered as prescribed and safely.
• We found there were no fire risk assessments carried out for people using flammable prescribed topical creams. Staff we spoke to told us that they did not know that topical creams were flammable.

• Staff told us that application of topical creams on the body was recorded in the care plan under tasks, but not always. They told us that there were body maps were available on the electronic care plans but not always. This meant we could be assured that topical creams were being applied as prescribed.
• Staff we spoke with did not all understand when 'PRN 'as and when required' medicines should be administered. One staff member said, "I know if [people] need it. Or I ask the client. If they can't respond I'd give it like regular medicine - whatever dose is on the MAR." Another staff member said, "I know it's every 4 hours that PRN is to be given."

• There were no protocols in place to guide staff on when PRN medicines should be administered. One staff member said, "I've never had a protocol to tell me when clients should be given PRN." Another staff member said, "If [people] can't speak I would look to see if they were in pain, by expression or grunts or I would call office."
• We saw medicine competencies had not been carried out for all staff to ensure that staff were/remained competent to administer medicines safely
• We saw that medicine audits carried out were not effective as MARs were checked to highlight any medicines that had not been administered to people. The audits did not pick up the shortfalls we identified at the inspection.

We found no evidence that people had been harmed however, we found the provider had failed to ensure systems or processes were in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a further breach of Regulation 12 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse. Learning lessons when things go wrong
• Oversight of systems to safeguard people from the risk of abuse were not effective. The provider had not made any safeguarding referrals since the last inspection in 2017. Whilst accidents in relation to a pattern of unexplained bruising or a fracture were recorded, they were not investigated or followed up to ensure that it was not caused by potential abuse or improper handling. The registered manager and some staff did not demonstrate an understanding of why a pattern of unexplained bruising, or a fracture could indicate abuse.
• We found these incidents had not been referred to safeguarding authorities appropriately in line with best practice. Accidents and incidents were not analysed for trends/themes and learning was not always disseminated to staff so there could be a positive impact in improving people's experience of the care they received.

Failure to effectively implement systems and processes to ensure people were protected from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and/or their relatives told us that they felt safe. Staff had completed safeguarding training and people and relatives we spoke with told us that their family member felt safe.

Staffing and recruitment

• People and staff told us that overall, there were enough staff to meet people's needs. However, they said that calls were sometimes late due to bad traffic.
• The provider used an electronic system to calculate the time between care calls. Staff told us that they did not always have enough travel time between calls if they drove, walked or used public transport. They told us that the system calculated 5 minutes between calls that was not a realistic amount of travel time. They said that this meant they were late for the next call, and this continued to have an impact on later care calls. This provider needs to improve on this by ensuring staff have enough travel time between calls to ensure all care calls are delivered on time.
• Appropriate recruitment checks were carried out before staff joined the service to ensure. This included, appropriate checks with the Disclosure and Baring Service (DBS), completed application forms and references.
• People told us that they had the same regular carers for consistency and the majority of staff stayed for the duration of the care calls.

Preventing and controlling infection
• People were protected from the risk of infection. People and staff told us that they always wore Personal Protective Equipment (PPE) such as aprons, gloves, masks and shoe covers.

• Staff told us that they had access to PPE whenever they required it.

Requires Improvement

Is the service effective?

Our findings

Effective – this means 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 needs were not always fully assessed. The provider's processes for assessing people needs were not effective. The provider did not complete comprehensive assessments before they joined the service to ensure that they could meet people's needs effectively. This meant the provider could not be assured that they were able to meet people's care needs effectively before they offered to support them.

Staff support: induction, training, skills and experience
• The majority of online staff training was up to date. However, staff new to the caring profession did not always complete an induction in line with the Care Certificate. 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. One staff member said, "No new staff do the care certificate." Another staff member said, "I didn't do the care certificate."
• We reviewed the training matrix and saw that the majority of staff training was up to date. However, staff had not undertaken training that was relevant to the people they were supporting. This included epilepsy, diabetes, Parkinson's disease and catheter bag training. The majority of staff told us that they had not had training in these areas. One staff member said, "I think [person] has epilepsy, but haven't seen it on the [care plan]. The [person] tells me [they] had an epileptic turn, I give [them] a biscuit. I haven't had epilepsy training." Another staff member said, "[person] has had a mini stroke, [they]are shaky, [they] told me this, I have not read this on [the care plan]. I have only seen [person] a few times, so don't know [person] that well." A 3rd staff member said, "No, I haven't had catheter bag training." A 4th staff member said, "I had previous catheter bag experience and learnt from other carers, no training here."
• Staff files reviewed, and staff spoke to confirmed that staff were not supported with regular 1:1 supervisions. This meant there was no formal process between staff and managers where staff could review their workload, monitor and review performance, and identify any learning and development opportunities. One staff member said, "Last supervision I had was 2-3 years ago, we should have more." Another staff member said, "We don't have supervisions. Not unless you raise that you need it. Would be good to have them regularly."
• There was no process in place to assess staff competency to ensure they had the right skills and know to carry out their roles effectively.

There was a failure to ensure that staff were competent, skilled and had relevant up to date training in order to carry out their role and effectively. This was a breach of Regulation 18 of the Health and Social Care Act

2008 (Regulated Activities) 2019 Regulations 2014.

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.

We checked and saw the service was not working within the principles of the MCA

• The provider was not always working in line with the principles of the MCA. They were not able to demonstrate and evidence that people's rights under the MCA were being protected.

• The registered manager and some staff were not able to demonstrate a clear understanding of the principles of MCA and when it should be applied.
• Records did not always evidence how or when people's mental capacity had been assessed or best interests' decisions were made.
• The provider did not have a robust system in place for seeking consent from people. For example, we saw that one person's consent form had been signed by a relative, but there was no record to show this person had legal authority to provide consent on their behalf.

The failure to maintain complete and contemporaneous records of decisions was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• People were not always supported to live healthier lives as staff did not have detailed information about people's specific health and medical needs.
• People's care plans did not always clearly document the support they required. For example, people living with Parkinsons's disease, strokes, multiple sclerosis and epilepsy did not have person-centred detailed guidance in place for staff on how to safely support people living with these conditions.
• People's care records did not always document if the provider was working with other care agencies to support people's specific health conditions.

Supporting people to eat and drink enough with choice in a balanced diet
• Overall, people were supported safely with their nutritional needs, however, we found that one person was at risk of choking because they had trouble chewing food and were required to have mashed food. However, there was no choking risk assessment in place and there was not guidance in place for staff on how to safely support people to eat and drink and what to do should they choke.

• People were living with diabetes did not have person-centred diabetes risk assessments in place, which documented what a diabetic diet meant, if they were on diabetes medicines and what to do if people become unwell.
• Most people were supported with meals by relatives. However, people who were supported by staff, told us said that staff supported them to heat meals or make sandwiches. One person said, "[Staff] heat up

microwave meals, make an odd sandwich or hot drinks."

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.

Respecting and promoting people's privacy, dignity and independence.
• Peoples' dignity and privacy was not always respected. Incident records we viewed showed that some people had raised concerns that staff had not carried out the tasks required of them during care calls, such as oral care, changing bedding, dirty clothes and mouldy food left in a fridge. One concern was about a staff member on their phone or sitting in a chair for the duration of a care call. This same staff member had also not stayed for the full duration of a call. We saw that spot checks had picked up that two people had been left naked on a commode and another person had not had their hair washed for two weeks. One staff member spoken to confirmed that they did wash people whilst they were on a commode.
• Records showed that the provider had not adequately addressed these issues with staff to ensure that improvements were made, and people's privacy and dignity was respected, and their needs were being met safely, adequately and in a timely manner.
• We saw care records did not detail what people could and could not do for themselves or give staff specific guidance to staff on how to support people to encourage or maintain their independence. One staff member said, "I promote client's independence 100% by seeing what they can do for themself." Another staff member said, "I encourage them, I learn as I go along, and not from [care record]."

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other people's feedback was positive, where they were treated with kindness and care and their independence was promoted. For example, "[Staff] are very caring and helpful." and "[Staff] do encourage me to stay independent." However, the lack of appropriate escalation of concerns to ensure people's care and support needs were met was not always demonstrative of a caring approach.

Ensuring people are well treated and supported, respecting equality and diversity. Supporting people to express their views and be involved in making decisions about their care.
• People's communication care plans were either not completed or not adequately detailed to ensure staff could communicate effectively in line with people's needs and preferences.

• The registered manager told us that they were not supporting anyone currently that required support with cultural needs. However, we were not confident people's needs had been fully assessed because the

provider said no one needed cultural support.

• People's preferences were not always documented, but their feedback was positive. They told us that they were given a choice of what to wear or eat on a daily basis.

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. End of life care and support
• People's care plans were not always person-centred and contained minimal information about people and their health and care needs.
• Although people were positive about being involved in planning their care, from the feedback received we saw that people did not always understand what a care plan was. One person said, "I can ask for a care plan anytime." and "The care plan started once a week." This meant people were not necessarily always involved in developing their care plans.

• As the provider did not carry out pre-assessments, records showed that care plans were drawn up over a period of time. Hence, the care plans we reviewed did not have all necessary risk assessments, people's likes, dislikes and preferences recorded. We asked staff if they referred to people's care plans, one staff member said, "I call the client and make sure they have a DNAR in place. I read all the information on the app there. Not always there." Another staff member said, "I don't know about [person's] background, [they] never told me, and it's not recorded." A 3rd staff member said, "Sometimes information is on the [care records], sometimes I just sit down and talk to [people] to find out information."

• When there was a change in people's needs, care plans were not updated. For example, one person had started to hide their medicines. The care plan had not been updated to support staff in ensuring that the person was taking their medicines as prescribed.
• There were no records to show that care reviews took place or that we saw could not evidence that people and/or their relatives were involved in care reviews.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The provider did not have a robust complaint process in place. The service had a complaints policy, which provided guidance on how to raise a concern or complaint and the timescales for responding. However, the complaints policy was not being followed.
• The registered manager told us that they had not received any complaints to date. However, we saw a number of incidents that should have been classified and investigated as complaints.

• We saw that where the complaints were about staff, these had not always been followed up and recorded to drive improvements.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 (AIS). 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.
• The provider did not have an AIS policy in place. People's care records showed that their communication needs had not been clearly recorded in their care plan to guide staff on how to communicate with people effectively.
• There was no information available in different formats should people need them to meet their personal needs.

This was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

• People did not receive a service that was well-led. The provider lacked leadership and oversight of the service. The provider had not effectively addressed issues that we found at the inspection and people were exposed to unsafe care and treatment
• Monitoring systems in place were not effective. This meant the provider had failed to ensure they always operated effective systems to assess and improve the care provided.

• Risks relating to falls, mobility, mobility equipment, dementia, multiple sclerosis, choking, strokes, asthma, diabetes and skin integrity were not always addressed safely and effectively by the provider.
• Accidents and incidents were logged, however the provider failed to carry out any analysis and did not always disseminate any learning to staff on how to minimise these in the future.

• Robust records, which included risk assessments and care plans were not always accurate or complete.

• There was no specific information about people's individual medical needs in care plans including guidance for staff on how to support these needs and what to do if people became ill.

• Staff's medicine competency had not been assessed to ensure they were competent to administer medicines safely There was no process in place to assess staff competency to ensure they had the right skills and knowledge to carry out their roles effectively. This meant that the provider could not be assured that they had adequate systems in place to keep people safe.

• The provider failed to maintain complete and contemporaneous records of decisions in relation to MCA.

• Quality assurance processes had failed to effectively identify and address the issues identified during this inspection.
• Although the provider had carried out audits which included diary entries, medicines, punctuality and duration they had not identified the issues we found at this inspection. Staff told us that care plan audits had ceased when the provider moved to an electronic system in November 2021.

The provider had failed to ensure systems for governance and management oversight were robust, safe, and

effective. 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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider told us that they did not hold staff meetings and staff were not supported through regular supervisions, which meant that they were not given the opportunity to feedback individually or as a group to drive improvements or share best practice. This was also a missed opportunity for the provider to demonstrate that learning from accidents and incidents was being shared with staff individually or as a group to and to minimise such incidents and accidents in the future.
• Records showed that there was a lack of engaging and involving people in decisions about their care.

• We saw that a survey had been carried out in 2022, overall, the feedback was very positive. However, where survey results suggested development areas, there were no records to show how this was followed up and actioned.
• People told us that they had good communication with the registered manager and office staff. However, some staff told us they were hesitant to contact the registered manager for advice and guidance as communication with the registered manager needed improving.

This was a breach of Regulation 17 (Good governance) 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 and understands and acts on duty of candour responsibility when things go wrong
• People did not always receive good outcomes. This was because there were not always clear and accurate records maintained to provide staff with robust guidance to ensure positive outcomes.

• Care plans were not comprehensive and did not clearly detail people's individual needs and preferences to ensure person-centred care and support was provided.
• People were not supported by a service that had adequate understanding of the duty of candour as accidents, incidents and complaints were not always followed up and shortfalls rectified.

Working in partnership with others.
• The team leaders told us that relatives mainly supported people to access healthcare professionals. However, when required the provider liaised with relevant agencies such as, district nurses and GPs to help ensure people's needs were met.

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 People's needs were not always assessed and care plans were not person-centred There was no evidence that people or their relatives were involved in planning their care needs

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was no robust system in place to safeguard people

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not a robust system to log and manage complaints

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure that staff were suitably skilled, competent and had the relevant knowledge to meet people's needs effectively

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 People's needs were not always assessed and risk management plans were not always in place Medicines were not always safely managed Systems to safeguard people were not robust

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems for governance and management oversight were robust, safe and effective

The enforcement action we took:

Warning Notice