Living Glory Social Care Ltd

Living Glory Social Care

Inspection report

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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
Living Glory Social Care is a domiciliary care agency providing personal care to people living in their own homes, including children, younger adults, older people, and people with learning disabilities. At the time of our inspection 228 people were in receipt of personal care, 44 of these were children. The provider told us at the time of inspection they were not supporting any people in supported living settings.

People's experience of the service and what we found:
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Culture
People were not consistently supported to have maximum choice and control of their lives and staff did not always 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.

The provider did not have robust systems in place to monitor the quality and safety within the service. This meant the provider had failed to identify some of the issues we found. This included concerns about the lack of care plans and risk assessments for people's known health conditions, lack of guidance for staff to follow in relation to prescribed medicines and lack of monitoring for people for whom methods of restraint had been approved. Where the provider's systems had highlighted concerns, the systems in place to action and follow up on these were not robust and did not evidence appropriate actions had been taken.

The registered manager told us how they had communicated with staff and people using the service to ensure the culture within the service was open and inclusive.

Right Support
Risks to people were not always well managed which meant risk of harm to people had not always been considered. There was no evidence that people had been harmed. There was little evidence to demonstrate people had been supported with things which were important to them such as their interests. However, staff knew people well. Medicines were not always well managed, including a lack of robust guidance for staff to follow in relation to 'as required' medicines.

People were supported to live in their own homes. Although there were adequate numbers of staff to support people, calls did not always take place at the time people wanted and for some, they were often shorter than commissioned.

Right Care
People's care plans and risk assessments did not always provide robust guidance for staff to follow in relation to people's known health needs. This included how to support people who expressed emotional distress to minimise the risks to themselves and staff. This meant people could be placed at risk as staff may not have information in relation to how known health conditions impact on people's needs, wishes and abilities. However, there was no evidence to demonstrate people had been harmed. People were not always supported and encouraged, to promote their independence.

We found overall there was a stable team of staff who knew people's needs.

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

Rating at last inspection
The last rating for this service was Good (published 02 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, poor care practices, missed, short or late call times, and poor medicines management. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified new breaches in relation to Person centred care, Need for consent, Safe care and treatment, Safeguarding service users from abuse and improper treatment, Receiving and acting on complaints, Good governance, Staffing and Fit and proper persons employed.

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. Once the report has been published, we will arrange a meeting with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 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**

Living Glory Social 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 team consisted of 4 inspectors and 3 Experts 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
Domiciliary care and Supported Living;
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. Although this service is registered to provide care and support to people living in 'supported living' settings, so that they can live as independently as possible. The provider told us they were not supporting anyone via the supported living service at the time of the inspection.

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
The inspection was announced. We gave the service 24 hours' notice of the inspection. This was to ensure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We sought feedback from commissioners who work to find appropriate care and support services for people and fund the care provided. 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.

During the inspection
We spoke with 2 directors and the registered manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the operations manager who is also a director, 2 care coordinators, office administrator and care staff who also worked as office staff. We reviewed records relating to the management of the service including quality audits, training data and people's feedback. We also reviewed 8 staff files to check staff had been recruited safely.

After the inspection
We spoke with 20 care staff, 12 people who use the service and 25 relatives/representatives via the telephone to gather further feedback on the service. We also reviewed care records for 16 people including care plans, risk assessments, daily notes and medication administration records, policies and procedures and other supporting records.

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 and avoidable harm

- People were at risk of abuse and were not consistently protected from harm.
- Lessons had not been learned. At this inspection we found multiple safeguarding concerns had not been identified, reported, or actioned robustly. This included people at risk of inappropriate restraint, going missing and police incidents. For those at risk of short and late care calls, these resulted in people not receiving the correct level of support, such as taking their medication and being supported to have something to eat and drink which was unsafe.
- The provider did not have oversight of all staff logging into their calls. This meant the provider could not demonstrate the calls had taken place for the length of time recorded or if they had taken place at all. This placed people at risk of harm.
- Incidents were not consistently recorded or acted on. This included when methods of restraint had been used. This meant people were at risk from potential further incidents happening, as concerns were not always identified, and appropriate actions had not always been taken. A relative told us and staff confirmed a staff member had restrained a person whilst they sat on their lap for a car journey. This had not been identified by the provider to ensure appropriate measures were in place to mitigate the risks associated with the staff member's actions.
- Poor safeguarding systems meant the registered manager had not taken action to safeguard people. For example, where a person had attempted to cause themselves harm, robust actions had not been taken to prevent recurrence to keep people safe.

The provider's systems and processes to protect people from abuse and improper treatment were not operated effectively and consistently. 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

- The provider did not assess risks to ensure people were safe. Staff did not take action to mitigate any identified risks.
- Risks associated with people's care and support were not consistently and effectively managed. This was unsafe.
- Risk assessments were either not in place or were not sufficiently detailed to help staff provide safe care. For example, risks associated with health conditions were not consistently in place or contained limited information. We also found risk assessment had not always been reviewed and updated as per the provider's policies which meant opportunities to keep people safe had been missed.
- One staff member attended a call and found the person had fallen, resulting in an injury which required

the ambulance service to attend. The staff member carried out personal care and provided meals whilst the person remained on the floor. The staff member left and returned later that day and carried out the same support before leaving the service user on the floor again, awaiting the ambulance service. The staff member failed to recognise the risks and report this to the office.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded, and managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider's recruitment systems were inadequate. Safe recruitment practices were not always followed.

● People were at risk of harm from receiving care and support from unsuitable staff. Suitable references had not been obtained for some staff members. For example, references had not always been obtained from prospective staff's most recent employer and there was not always evidence of personal identification held in staff members' files.

● The provider had failed to evidence that they had seen the original documents which they had relied upon for their recruitment processes.

The provider failed to ensure they had obtained all the information required ensuring the suitability of all staff employed. This meant people were placed at risk as the provider did not know if staff were suitable to support vulnerable people. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All of the staff files which we looked at had a Disclosure and Barring Service (DBS) check completed prior to staff commencing employment. The DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Some people told us they often did not receive their care calls on time and they regularly experienced short calls. We looked at a range of call records which confirmed this had happened. One person told us late calls had made them feel very anxious and upset. A relative told us how 1 person had missed the school transport due to staff attending calls late.

● Records showed some people's care calls lasted for less than half of the required time.

● Some people told us and records confirmed that a single staff member sometimes attended calls for people who required 2 staff to support them safely. One relative told us when this occurred, they supported the care staff member, which impacted on their own morning routine. This meant people were exposed to the risk of harm as the provider had not identified this was occurring.

● Rotas did not always include details of which people's calls staff were to attend, the time they were to attend or for how long. This meant we were not able to assess if travel time between calls had been factored in, or more than 1 care call was scheduled at the same time, contributing to late or shortened calls.

The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People were not supported to receive their medicines in a safe way.

● It was unclear from people's care records the level of support they needed from staff with their medicines.

Care plans and risk assessments contained conflicting, inconsistent or no information, to guide staff on the level of medication support people needed. This was unsafe and placed people at risk of not receiving their medicines, as prescribed.

● The provider had failed to ensure people received their medication as prescribed. This was due to care calls not taking place as commissioned. Calls had taken place too close together or medicines were simply not documented on Medication Administration Records (MARs). A relative and staff told us staff were administering medicines to 1 person, which was confirmed by their daily care notes. However, the registered manager stated this person did not receive support with medicines and there was no MAR chart in place. This meant staff did not have records to refer to, ensuring they were giving the correct medicines, at the correct time.

● We found some people were prescribed medicines to reduce the risk of blood clots, which increased the risk of excessive bleeding. The provider had not completed a risk assessment or care plan to guide staff on how to manage this risk. This placed people at increased risk of harm.

● The information for staff members to follow for 'as required' medicines, to ensure a consistent approach, was either not in place or not clear as to when or why to use such medicines. Without clear protocols in place this could lead to staff not knowing when to give these medicines, leading to the potential for too much or too little medication to be given.

● For people who were prescribed creams to treat skin conditions, we saw these medicines were not consistently included on the Medication Administration Records (MAR) or body maps. This meant people were at risk of their skin condition deteriorating and staff did not have the information they needed to provide safe application of prescribed creams. They did not have clear instructions on when, where, or how the creams should be applied. This was of particular concern for people who had skin conditions or were at risk of developing pressure sores. Their prescribed creams needed to be applied to prevent further deterioration of their skin.

Medicines management was not robust enough to demonstrate that medicines were always managed safely. 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.

Learning lessons when things go wrong

● Due to the lack of analysis of feedback, complaints, compliments, daily records and incidents and accidents, the provider failed to robustly identify, and cascade lessons learnt.

●This meant we could not be assured when things did not go well, actions had been taken to reduce the risk of such incidents occurring again.

Preventing and controlling infection

● We found people and staff were at risk as the provider could not be assured all staff were following safe practices and were adhering to the correct use and safe disposal of personal protective equipment (PPE). This included the use of gloves, aprons and masks. The provider failed to operate an effective system to ensure all staff were subject to spot checks to monitor the safe and correct use of PPE.

● Some people and their relatives told us staff attended calls without wearing uniforms, instead wearing their own clothes, including tops with long sleeves.

● Staff told us the PPE they needed to prevent and control the spread of infection was available to them.

● Most people and relatives we spoke with confirmed staff wore appropriate personal protective equipment (PPE).

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 needs were not always assessed, and care and support was not always delivered in line with current standards. People's care and support did not always achieve effective outcomes.
- Some people and relatives told us they were not involved in their initial assessments completed by the provider before starting to use the service nor on-going care reviews.
- Some people told us they did not receive their care calls at the times that they wanted or needed.
- People and relatives told us they experienced shortened calls and inconsistent call times. This left people at risk of neglect as they were unable to access the support they needed, when they needed it. When we asked 1 relative if staff turned up at the right time they said, "Some calls do not happen at all and we [family] have to carry out the care. This lacks dignity." A person told us, "When they [care staff] come early for the lunch call, I might not be ready for my food but if I don't have it, I won't eat again until the evening."
- The provider had failed to robustly review people's care plans to ensure these continued to reflect people's needs. For example, 1 person's daily care records indicated staff were supporting them with medicines; however, this information was not recorded in their care plan or risk assessments.

The provider failed to ensure people's needs and wishes were always considered when planning their care and support. This meant people were at risk of not receiving effective care and was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings some people and relatives told us they had been recently asked recently for their feedback on care plans and risk assessments.
- Staff told us they had the opportunity to read people's care plans.

Staff support: induction, training, skills and experience
- The provider did not always make sure staff had the skills, knowledge and experience to deliver effective care and support.
- We receive mixed feedback from people and relatives about the level of skill demonstrated by the staff, and some felt there was a lack of training. A relative told us they did not feel staff had appropriate experience or skills to support their loved one's support needs and had witnessed staff pulling the person by their arm, to prevent them going upstairs.
- Some people told us they felt rushed by staff at times. When asked if they felt the carers had adequate training and knowledge to meet their needs, 1 relative told us, "Yes, they know what they are doing, only because I make sure I train them up." Another person told us staff members' poor support when transferring

them from the bed to their wheelchair had resulted in them falling and injuring themselves. Another relative told us staff did not know how to use the hoist resulting in the person being cared for in bed instead of sitting out in the chair.
● The provider had failed to assess the effectiveness of their staff training. For example, competency checks of staff skills were not completed. This meant the provider could not be assured staff were safely and effectively applying their learning when supporting people.
● Feedback from staff was mixed regarding their training which included on-line training and face to face training in the office. Some staff told us they had not received specific training for people's known health conditions or how to respond when people exhibited distress.

The provider did not ensure all staff were competent, skilled and had up to date training in order to carry out their role and effectively support people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

●Staff told us they had received an induction and had the opportunity to shadow other staff members prior to supporting people on their own.

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.
● The provider was not compliant with the MCA. For people who were unable to make their own choices and decisions, the provider had not obtained evidence that those making decisions on their behalf had the necessary legal authority to do so. This meant the provider could not assure themselves people were being supported in the least restrictive way and decisions were not being made on their behalf inappropriately.
● We had concerns in relation to the registered manager's understanding and application of the MCA. We found the required principles of the MCA were not consistently applied and where mental capacity assessment had been completed these were not decision specific.
● Some people and relatives told us they had not been consulted or involved in developing their care plans. Some also told us they had not been given the opportunity to read and consent to the information made available to staff members.
● When we asked people if staff gained consent before supporting them some told us they did not. One person told us staff did not greet them when they came into their home. Most staff we spoke with were gave examples of how they gained consent before supporting people with their care. However, their knowledge about MCA was limited and they were not aware that a person's capacity was decision specific.

The provider did not ensure people's consent was gained prior to support being provided. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Many people and relatives who had regular staff gave positive feedback as to staff always seeking consent before providing care and support and had good interactions with staff.

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

● People were not always supported to eat and drink enough to maintain a balanced diet.

● Not all people we spoke with required support with meal preparation or assistance to eat. Where this support was offered feedback was mixed. Due to late care calls, people's hydration and nutritional needs were at risk of not being met. For example, where people could not access their own food and drinks there were times records demonstrated very short gaps between calls, resulting in them not wanting the food at that time. At times there were very long gaps between calls due to calls being short, very early or late.

● People's dietary needs were considered and assessed by the local authority. We found information to guide staff members for a person who required specialised support to maintain nutrition and hydration was unclear. However, staff we spoke with knew how to support people's specific nutritional needs and their relative confirmed they had trained staff.

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

● The provider's systems and processes did not always ensure the service worked effectively within and across organisations to deliver effective care, support, and treatment. This meant people were not always supported to live healthier lives, access healthcare services and support in a timely way. For example, for one person who tried to harm themselves, this had not been referred to the local authority or mental health services to provide additional support.

● Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency. However, we found this was not always put into practice or reported to the management to be escalated. This resulted in safeguarding incidents not being actioned and reported appropriately.

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; Respecting and promoting people's privacy, dignity and independence

- The provider did not demonstrate a caring approach towards people. We found some people were experiencing late, short, and missed care calls. This meant people were often uncertain or anxious about when they would get their care.
- Staff did not always demonstrate a caring approach. One relative told us a staff member had not respected their cultural beliefs, which had resulted in the family raising safeguarding concerns. They told us that the provider had not acknowledged the impact this had had on the person and the family.
- Other people and relatives told us that at times they felt rushed by staff which meant they did not get their support in a dignified and respectful way. One relative told us when asked if the staff stayed the full time, "One staff member comes but the second one does not come until at least 15 minutes later then they both leave together. We are not getting the correct staff or time we are paying for."
- Some people told us staff did not always respect their privacy and their dignity were not always promoted. Staff did not always ensure people and their personal living spaces were respected whilst supporting with their personal care. A person and another relative told us staff had plugged in their mobile devices, using people's electricity, without gaining permission first.
- Feedback from people and their relatives confirmed not all staff promoted people's independence. One relative told us, "Staff do not help to promote [relative's] independence and help them to achieve goals and aspirations and they get bored. We have to remind staff [Name] can do things for themselves."
- The provider employed staff from different cultural and religious backgrounds, but this did not always lead to positive outcomes for people or their relatives. For example, whilst it was the provider's intention to allocate staff members from the either the same culture or who had the ability to speak the same language as the person this did not always happen. Some people and their relatives told us they could not always effectively communicate with staff due to language barriers. Some people also told us that at times staff spoke in their native language in front of them. This meant they could not understand what was being discussed and made them feel uncomfortable.
- For many people we found information about their preferences and personal histories in their care plans lacked detail and needed to be improved, to help staff get to know them and how they liked to be supported.
- Some people provided positive feedback about the staff. One relative told us, "The care is second to none. Carer [Name] comes all the time and treats [relative] like she is her own [relative]. They are exceptional." Another relative told us, "The new carer is great. They have a good friendship and [Name] waits for them to come."

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

● People were not always supported to express their views and make decisions about their care.

● Some people told us their care plans and care records were not easily accessible to them and they had not seen these. The provider told us that there were paper copies in people's homes, and they would make sure people were aware of these.

● Other people and their relatives confirmed they had recently been consulted about their care needs and wishes. Whist some people said they had been asked to complete feedback on the service, others said they had never been asked. One person told us that after a meeting with a staff member about their care, they did not receive their care plan.

● Records demonstrated the provider had gained feedback from some people and their relatives. This feedback contained both positive and negative feedback which the provider told us they had actioned. The most recent feedback had yet to be analysed and actioned.

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
● People's concerns and complaints were not always listened to, responded to and used to improve the quality of care.
● Whilst a complaints policy was in place, complaints were not consistently recorded and the actions that had been taken to prevent similar occurrences were not recorded. There had been no complaints recorded since 2015 although we are aware complaints had been raised with the provider.
● Most people told us they knew how to raise complaints, but they were not confident their concerns and complaints were listened to, acted on or led to any positive change in their care and support. This included short, missed and late care calls. One person told us, "I requested better qualified staff who can use the hoist. The manager assured me 3 or 4 weeks ago they would send better quality staff. They didn't turn up, so I messaged him [Director] and asked him to ring me. He never got back to me."
● Other people and their relatives told us they had never received a call back from the registered manager when raising complaints.

The provider failed to ensure people's complaints were listened to, acted on and responses provided. This was a breach of Regulation 16 (Receiving and acting on complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Many people told us they were able to speak to someone out of hours if they needed to contact them and action was taken to address their concerns.
● Other people and their relatives told us they had experienced positive outcomes when raising complaints and felt the issues raised had been resolved.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People were not always supported as individuals, or in line with their needs and preferences.
● The provider had failed to ensure all people's plans of care were personalised as per their current level of support or health needs.
● Some people felt their care was not responsive to their needs and the inconsistency of their call times made them feel anxious not knowing when care staff were coming.
● Whilst staff could tell us about people's needs and how they supported them, this was not always reflected in care plans. This posed risks people could receive inconsistent care as they were supported by different staff.
● During calls to people and their relatives we found evidence that concerns raised by people had not been actioned. These included concerns about the failure to inform people staff were running late. All these issues

impacted negatively on people.
● Care records and conversations with staff demonstrated staff recognised when a person was unwell and required additional support such as a GP or ambulance. However, this was not always reported to the management team resulting in people being placed at risk whilst awaiting support from other health professionals.

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.
● The provider was not always meeting the Accessible Information Standard.
● People's communication needs were not always understood and supported.
● Staff did not always have clear information about people's communication needs to ensure they were able to involve them in making decisions. Records lacked detail.
● For example, 1 person was unable to communicate verbally to indicate their needs, wishes and feelings. We found they did not have a communication care plan which informed staff how to recognise if the person was happy, sad or in pain. Their relative told us, "Staff simply do not speak to them and do not appear to understand that the person is able to understand them although they can't communicate with them. As their [relative], it is crippling for me to see this."
● People and relatives told us they had not been offered their care plans in an alternative format. For example, for a person receiving support who was unable to read English, relatives told us alternative formats had not been offered or provided.

End of life care and support
● At the time of the inspection, the provider told us no one was supported by the service who required end of life care.
● The provider told us they had yet to commence work developing people's care plans to ensure people's preferences and choices for their end of life care were acted on and they had the support they needed. This meant what was important to people when approaching the end of their lives, had not been explored to ensure their needs and wishes were met.

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 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

- The provider did not have an effective management structure. The provider did not monitor the quality of care provided in order to drive improvements.
- The provider's quality assurances systems and processes were either were ineffective as they failed to support the registered manager in identifying the on-going concerns we found. For example, we found inaccurate and unclear information in people's care plans and risk management plans; poor management of medicines; people experiencing short, late and missed calls; and a lack of monitoring of incidents and accidents. There was missing information in staff flies and the Working Time Regulations 1998 had not been applied by the provider to ensure all staff had suitable and adequate rest time. That meant opportunities to drive forward improvement to benefit people had been missed.
- The provider's auditing and monitoring of people's care calls was ineffective. People experienced late, short or missed calls through the lack of provider oversight of the service. Only 90 of the people using the service had been added to the provider's electronic care panning system which meant the outstanding people were not having their call times monitored to ensure they were taking place, as required.
- The provider failed to carry out staff recruitment checks to identify discrepancies in staff records which was unsafe. In addition, systems to assess the effectiveness of staff training were not robust as some staff were unable to tell us what they had learnt from certain training. This lack of oversight meant the provider could not assure themselves their staff were skilled and had the necessary knowledge to undertake their job roles.
- The provider had failed to ensure their safeguarding processes to identify when people were at risks of abuse were robust. Where incidents happened, the correct actions were not always taken or reported to the appropriate authorities. During this inspection we raised several safeguarding alerts to the local safeguarding team as we found people were at risk from abuse.
- Audits of care plans and risk assessments had not been carried out to identify the discrepancies and missing information we found. This meant people were placed at risk as the provider's systems failed to provide staff members with robust information to keep people safe.
- We found the provider had failed to update their own policies and procedures since 2016. This meant guidance was not always reflective of the current legislation. In addition, they had failed to carry out robust environmental risk assessments to ensure the safety of office staff. This included fire risk assessments. We made a referral to the West Midlands Fire Service due to our concerns.

The provider had not operated an effective system to enable them to assess, monitor and improve the

quality and safety of the service provided. 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
● The provider did not have a system to provide person-centred care that achieved good outcomes for people.
● The evidence we gathered demonstrated the service did not always promote a person-centred approach. People's individual needs were not always considered or met. This included specialised training needs, communication needs and the negative impact late and short care calls had on people's safety and overall well-being.
● Although some people and relatives told us they had been involved in care reviews, others told us they had not been invited to attend care reviews to discuss the continuing care and support required.
● The provider's records demonstrated staff competency checks, to confirm staff were working in line with their expectations. had not routinely been completed for all staff. We saw some evidence of feedback on how well staff were meeting their needs. However, such feedback had not been obtained from everyone.
● The provider was displaying their most recent inspection rating as they were required to by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were not involved in the running of the service and their protected characteristics were not well understood.
● We saw evidence that feedback from people had been sought via questionnaires. Some people were positive about the service they received; however, there was no evidence that negative feedback had been consistently acted on and issues rectified to ensure they were supported in a person-centred way.
● People and relatives told us they understood how to contact the office to discuss concerns which they could use out of office hours. However, they did not feel confident their concerns would always be acted on.
● The culture of the service was not always inclusive or supportive. Some staff spoken with told us they did not always feel supported or that information was shared with them clearly. One staff member told us, "I must confess, from the beginning, it [support] was not good. We can't get an answer from the care managers. We had a meeting with the director about 3 months ago, but nothing has changed." However, other staff told us they felt supported.
● People's equality characteristics were not always taken into account to ensure their needs could be met.

Continuous learning and improving care
● The provider had not created a learning culture at the service, so people's care was not improved.
● The provider told us they could now see, following our inspection, that they had grown too quickly without the correct systems and processes imbedded. This meant they had failed to identify shortfalls within their service and implement systems to drive and sustain improvements.
● The provider was receptive to our inspection feedback and told us they would take on board our findings to improve their documentation, systems and processes.
● Systems in place to ensure staff received regular and supportive supervisions, were not robust. We nor the provider could be assured these had been regularly completed for all staff. This meant they were not ensuring staff were given the opportunity to learn and develop within their roles.

Working in partnership with others
● The provider did not always work in partnership with others.
● The provider told us they understood they needed to work in partnership with and share information with

other agencies, including the local authority and community health and social care professionals, to ensure people received joined-up care.
● However, we found failure by the provider to apply this practice in the best interests of people when making decisions about the support they required and to protect them from potential or on-going harm.

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 provider told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care. However, the failings we found during this inspection were not reflective of such responsibilities.
● The provider had failed to provide us with the full and correct details of all people supported by them as their systems and processes to track people using the service were not robust.
● The provider failed to fulfil this obligation with people using the service as they have not acted consistently on complaints and concerns raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's needs and wishes were always considered when planning their care and support. This meant people were at risk of not receiving effective care and was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure people's consent was gained prior to support being provided. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure people's complaints were listened to, acted on and responses provided. This was a breach of Regulation 16 (Receiving and acting on complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

proper persons employed

The provider failed to ensure they had obtained all the information required ensuring the suitability of all staff employed. This meant people were placed at risk as the provider did not know if staff were suitable to support vulnerable people. This was a breach of Regulation 19 (Fit and proper person employed) 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 failed to ensure care and treatment was provided in a safe way. 1. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded, and managed. 2. Medicines management was not robust enough to demonstrate that medicines were always managed safely. 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.

The enforcement action we took:

We issued the provider with a warning notice. This meant the provider was required to demonstrate they were compliant with the breach of regulations, ensuring peoples safety.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. 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.

The enforcement action we took:

We issued the provider with a warning notice. This meant the provider was required to demonstrate they were compliant with the breach of regulations, ensuring peoples safety.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the provider with a warning notice. This meant the provider was required to demonstrate they were compliant with the breach of regulations, ensuring peoples safety.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 1. The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. 2. The registered person did not ensure all staff were competent, skilled and had up to date training in order to carry out their role and effectively support people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the provider with a warning notice. This meant the provider was required to demonstrate they were compliant with the breach of regulations, ensuring peoples safety.