Sentricare Limited

Sentricare Birmingham

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sentricare is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection there were 282 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks.

There were systems in place for managing complaints, safeguarding concerns, accidents and incidents. However, we found these were not robust and feedback from people and relatives on how the provider dealt with complaints and concerns was very poor. The main complaint raised by people and their family members was the lateness, shortness of calls and missed care calls. We found from call records and rota's that short, late and missed calls were the occurring. Staff attending people's homes at times were inconsistent and their ability to communicate effectively was poor, this was due to language barriers. People felt the communication with the office staff and their responses were unsatisfactory.

People were not protected from abuse because the systems and processes in place were not robust to keep people safe. Staff we spoke with were aware of their responsibilities to keep people safe.

Based on our findings around the continual short, late and missed care calls, there were not enough staff members deployed by the provider to support people. People were supported by staff to take their medicines, however, guidance in place was not clear for staff to follow. Records demonstrated that medicines were not always given as prescribed.

We found the provider was not adhering to current Infection Prevention and Control guidance. They had no oversight of the staff to ensure they were carrying out COVID-19 tests or following guidance for the correct safe use of Personal Protective Equipment (PPE).

There were not always appropriate pre-employment checks in place to make sure newly recruited staff were suitable to carry out their role. Many people felt staff members did not have appropriate skills and knowledge to support them how they wished.

Care plans were not fully personalised, and information contained within them had not been reviewed and updated to reflect people's current support needs. Risks to people had not been thoroughly assessed. The assessments themselves did not always clearly reflect what action staff should take in the event of that

person becoming unwell or experiencing symptoms of known health conditions.

People's care and support was not always planned in partnership with them and persons close to them. Staff received induction training. People told us they did not always feel supported by the staff, they felt rushed and anxious at times. People told us, staff did not always seek consent prior to supporting them and encourage people to make their own decisions. Where appropriate, staff supported people with nutritional and hydration needs, however care plans contained conflicting information for staff to follow.

People were not always supported to have maximum choice and control of their lives as they told us they were not involved in care reviews and when they had raised concerns these had not been addressed. Staff did not always support them in the least restrictive way possible and in their best interests; the provider had policies in place.

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 requires improvement (published 01 March 2022).

Why we inspected
The inspection was prompted in part due to concerns received about missed and late calls, staff not staying the correct length of time, poor standards of care, not responding to complaints and infection control practices. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that the provider needs to make improvements to ensure the risk of harm to people is identified, and action taken to reduce these risks. Please see the safe, effective, caring, responsive and well-led key questions of this full report.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sentricare Birmingham on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to; Regulation 9 - Person centred care, Regulation 10 – Dignity and respect, Regulation 11 - Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 – Safeguarding service users from abuse and improper treatment, Regulation 16 – Receiving and acting on complaints, Regulation 17 – Good governance, Regulation 18 – Staffing and Regulation 19 – Fit and proper persons employed, at this inspection.

Please see the action we have told the provider to take at the end of this report.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sentricare Birmingham

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 comprised of three inspectors, two of these inspectors made calls to staff members and four Experts by Experience making telephone calls to people who used the service and their family members. 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.

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
This inspection was unannounced on the first day, but the second day of the inspection was announced. Inspection activity started on 05 July 2022 and ended on 26 July 2022. We visited the location's office on 05 and 06 July 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also contacted commissioners of care services for their feedback. We used all this information to plan our inspection.

During the inspection
We spoke with 33 people who used the service and 48 relatives. We also spoke with 23 care staff, two office staff members, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We reviewed 19 care plans and a selection of medication records and risk assessments. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider, following the site visits.

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 requires improvement. At this inspection 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

- We found that people's risks were not always effectively managed. Risk assessments were either not in place or were not effective. For example, where risks to people was known due to their diagnosed health conditions, risk assessments and care plans were not in place to guide staff on how to support people safely. We also found that when these should have been reviewed and updated following changes to people's needs or following incidents, this had not always happened and meant that people were not safe from the risk of harm.
- People who had been assessed by Speech and Language Therapy (SaLT) because they were at risk of choking, did not have the necessary information accurately recorded in their care records for staff to follow. For example, two people who were assessed as needing a specific diet because of their risk of choking, had conflicting information. We brought this to the immediate attention of the nominated individual who gave assurances that family members provided meals and support, however this was not clear for staff to follow.
- We also found people who took blood thinning medication had no care plans in place to guide staff with the associated risk from increased bleeding following any accidents or incidents and actions they should take.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Systems were either not in place or not robust enough to demonstrate recruitment was effectively managed. Safe recruitment practices were not always followed. Records demonstrated staff had a Disclosure and Barring Service (DBS) check prior to commencing employment. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Suitable references had not always been obtained for multiple staff members, full employment history had not been sought and gaps in employment had not been explored. This placed people at risk of harm from poorly managed recruitment systems and processes. The provider failed to ensure they had obtained all the information required ensuring the suitability of all staff employed.

There was not enough staff employed and effectively deployed to meet people's needs. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People consistently told us that often they did not receive their calls on time and regularly experienced short calls. We looked at a range of care records and staff rotas which confirmed this. Records showed that some calls were recorded as lasting one minute and records showed that some staff were attending two calls at the same time. For one person during a month, 75 of the 264 scheduled calls which took place were 50% or below the commissioned 30 minutes length of call. People told us that this caused them anxiety and frustration.
● People who required two staff to support them told us that often only one member of staff attended their call, relatives and records confirmed that there were multiple occasions where only one carer attended a two person call. This meant that people were exposed to the risk of harm.
● Staff told us their rotas did not always allow them travel time between calls or more than one call was scheduled at the same time. Rota's, we looked at confirmed this. This meant calls would either be shortened or late, impacting on the standard of support people received.
● Some staff told us they felt they could not raise concerns about not managing to attend the calls as scheduled, due to the fear of having their rota's cut back. This meant calls would either be shortened or late, impacting on the standard of support, which people consistently had concerns about. People and staff rota's confirmed calls were not attended as scheduled.
● One relative told us, "There have been times when they [care staff] have missed the call completely for [Name]. This meant they had no food or drinks, no medication and were left soiled from noon until the following morning."

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 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● At the last inspection some improvement was required to ensure people's care records identify the level of support they needed from staff with their medicines. At this inspection we found care plans and risk assessments to guide staff on the level of support people needed with their medication were still not consistent and contained conflicting information. This placed people at risk of not receiving their prescribed medicines.
● Some people were not given their medicines at the time they had been prescribed. This was due to calls taking place at much later times than scheduled. This included medicine for the control of diabetes, heart conditions and pain relief which should be administered at specific times. Although we found no evidence people had suffered harm, continued poor administration of medicines could have long term effects on people's health conditions.
● The information for staff members to follow, for 'as required' medicines was not always clear. 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, we saw these were not included on the Medication Administration Records (MAR). This meant people were at risk of their skin condition deteriorating. We also found that there were no body maps in place to provide staff with clear instructions on when, where or how the creams should be applied.
● Some people who staff supported with their prescribed medicines were happy with how this was managed. However, some relatives told us they had to give the medication to the person because calls were either late or not attended. Due to staff being able to log into calls when they were not in attendance, it was not possible to corroborate if medication had been given by staff members from MAR records. However, call attendance records demonstrated calls had taken place very late on occasions.

Medicines management was not robust enough to demonstrate that medicines were managed safely at all times. 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.

Preventing and controlling infection
● Staff were not adhering to current guidance on the practise of lateral flow testing.
● This meant people and staff were placed at risk as the provider could not be assured staff were not attending calls when they were COVID-19 positive.
● Many people and relatives we spoke with confirmed staff wore appropriate personal protective equipment (PPE). However, others told us staff did not always wear masks when providing their support.
● The provider could not be assured staff were adhering to the correct use and disposal of PPE as they had not been carrying out any recent spot checks to monitor staff adherence to infection prevention and control practices.

The provider did not have processes and systems in place to ensure that all staff met their responsibilities in relation to preventing and controlling infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us the PPE they needed was available to them. A staff member told us, "We [staff] have the PPE we need and can get more from the office." We saw stocks of PPE were available in the office for staff to collect when needed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were at risk of abuse and neglect and were not consistently protected.
● We were made aware that three people had reported to the provider thefts of their personal items, which included money. Although the provider had notified us of these allegations they had failed to put into place or consider any steps to mitigate the risk of this happening again.
● We found multiple examples of safeguarding concerns which had not been either identified, reported or actioned robustly. This included the impact of people being exposed to missed calls resulting in not receiving support for long periods of time, missed medication and meals and poor manual handling practices.
● We saw that one person had been left in the bath and had to get out by themselves. Their care plan stated they needed support to complete this task as they were at risk of falls and this had occurred in the past. The investigation into this incident was not robust and deemed the person to have capacity. There were no additional considerations or actions to prevent similar incidents.
● Another person had allegedly been assaulted and while the provider had notified the police, they had failed to put in place any steps to mitigate the risk of this happening again such as updating care plans and risk assessments. This person was known to be vulnerable and measures to safeguard them and staff had not been put in place to prevent such incidents and allegations.
● Incidents had not been consistently recorded or acted on. This meant people using the service were placed at risk from potential further incidents, as concerns were not always identified and appropriate actions had not always been taken. For example; There was no record that staff discussions had taken place to consider the management of incidents and to discuss more appropriate support and actions.
● Staff had not always recognised abusive practice. This and poor systems meant staff and the registered manager had not taken action to safeguard people. For example; where calls were significantly late, close together or missed or when medicines had been given at incorrect times, no actions had been taken to ensure this did not occur again and reduce the potential harm to people. We spoke with the nominated individual about such incidents and he advised he was not aware this had taken place as staff had not

reported this to him.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At 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 people's care, support and outcomes.

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

- People did not consistently receive care that met their needs and preferences.
- People and relatives told us they were not involved in the initial assessments completed by the provider before starting to use the service nor on-going care reviews. All 81 people and relatives we spoke with us told us they had not involved in care reviews or care planning meetings. This meant that we were not assured that peoples care was delivered in a person centred way and in line with their preferences. One relative told us, "We have never had a meeting to discuss my relatives care needs and we have never seen a care plan." Records we saw evidenced people, or their relatives had not been consulted about their care plans or had the opportunity to see and review the ones which had been put in place.
- Most people told us that they did not receive their care at the times that they wanted or needed.
- People and relative's main concerns were the missed calls, short length of calls, inconsistent call times and inconsistency of staff. This meant that people received care from people who didn't know their needs. One person told us, "I feel like an attraction, I have that many different carers." Another person told us, "Not knowing when they [care staff] are coming has made me feel suicidal." The providers PIR (Providers Information Return), sent to us before the inspection stated; 'We ensure that we send carers to the same person to ensure continuity'. We found this was not applied consistently and discussed this with the nominated individual, multiple times during the inspection, about these concerns around calls. We were told they tried hard but due to the amount of calls they had scheduled and staffing issues in some localities, this was difficult. This left people at risk of neglect as they were unable to access food or medication, and one person reported being left soiled overnight.
- Care plans and risk assessments were not kept under review to ensure they still meet people's needs. For example; one person's care plan indicated they required use of the hoist for their mobility and breathing equipment. We found there had been a significant change in their support needs which had not been reflected in their care plan. This meant people were at risk of not receiving care in the way they needed it.
- Another person who was unable to communicate verbally or move to indicate their needs, wishes and feelings, we found they did not have a care plan in place to guide staff on what they should look for to identify if the person was happy, sad or in pain. This meant we could not be assured staff had enough information to support people in a person centred way.
- People told us they were not consistently communicated with in their preferred language. Some people told us that some staff members often spoke over them in their own language and did not communicate with them. People told us they found this difficult as they could not have a conversation with the staff member about their care, support needs or wishes.
- Several people and relatives told us they were not being supported with their personal hygiene as they

preferred and were not supported with baths or showers. Some female staff members we spoke with told us they did not feel comfortable showering males and confirmed showers did not always take place.
● Another relative told us how their relative only wanted the same sex care staff members to attend their calls, but at times this was not the case, making the person feel uncomfortable. Records confirmed people were not always supported by the same sex carers, as requested.
● People were not always provided with meals of their choice particularly the provision of freshly cooked meals were not supported. People who had gas cookers for meal preparation, had been informed by the provider that staff will not use these due to the risk of fire. Instead, all meals are ready meals cooked in the microwave.

The provider did not ensure people's care was appropriate and met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us the care plans were accessible on the provider's computerised system. We found staff we spoke with understood people's support needs and how to provide their care.

Staff support: induction, training, skills and experience
● We received mixed feedback from people and relatives we spoke with, whilst some were satisfied with the level of skill demonstrated by the staff, others felt there was a lack of training. We found that not all staff had received appropriate training to meet people's needs.
● People told us there were some issues with staff having to be shown by people and relatives how to use equipment or provide support. Other people told us at times they felt staff were rough when supporting with repositioning and transfers. Staff had not received practical moving and handling training or had their competencies assessed, to ensure safe practices were adhered to. This was confirmed by the nominated individual.
● Spot checks and competency assessments were not carried out to ensure staff were applying their skills and knowledge in the right way or if there were any areas for development needed. This was confirmed by the nominated individual. This meant the provider could not be certain staff supported people correctly.
● Feedback from staff was mixed in regard to their training. Some staff told us when they first started working at the service, they received an induction. This included shadowing other staff members, on-line training and face to face training in the office. However, other staff members told us they had not received training only that which they had from previous employers.
● Some staff told us they received supervision and attended meetings, but others told us they did not, records also demonstrated this. Whilst some staff told us they felt supported, others told us they did not and felt the office staff were rude and unhelpful. This meant that not all staff were supported in the role.
● Although some staff members understanding and communication in English was limited the training provided on-line was presented in English and alternative formats had not been provided. This was confirmed by the nominated individual.

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 of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

● Staff told us they had received an induction when starting work and had the opportunity to shadow other staff.

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 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.

● For people who were unable to make their own choices and decisions for themselves, the provider had not explored or obtained evidence people making decisions on their behalf had the necessary authority to do so. This meant we could not be assured people were being supported in the least restrictive way and decisions were not being made on their behalf inappropriately.

● People and relatives consistently told us they had not been consulted or involved in developing their care plans. They also told us they had not been given the opportunity to read and consent to the information made available to staff members.

● People and relatives gave mixed feedback as to staff always seeking consent before providing care and support. Some people and relatives told us that at times, staff did not engage in communication with them at all. People told us this was either because of language barriers or due to a lack of respect and manners. People told us at times, this made them feel uncomfortable in their own homes. Other people who had regular staff members gave more positive feedback and had good interactions with staff.

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

● Staff we spoke with gave us examples of how they gained consent before supporting people with their care.

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

● The provider and staff were not consistent in their approach in working in partnership with people, their relatives and health and social care professionals.

● Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency.

Supporting people 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. Some people told us some staff needed further training to be able to prepare meals. For example, not all the staff used the cooker and only prepared microwave meals. One person told us, "The food they gave me was still partially frozen, I could not eat it." Another person told us how they had to wait for their meals and were hungry as staff were so late attending the calls.

● People's dietary needs were considered and assessed by the local authority however, information shared with staff members via care plans was not always clear for staff to follow. However, staff we spoke with knew how to support people with specific nutritional needs.

● Staff records indicated people had access to drinks and snacks before they left. However, we received mixed responses from people and relatives.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls. Many people using the service did not feel cared for.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The significant issues some people and relatives experienced around late, short and missed care calls did not reflect a caring approach. It meant people were often anxious about when they would get their care.
- Many people and their relatives told us that staff were not always kind and friendly. One relative said, "The carers are rude, condescending and some don't or won't speak English. One [carer] pushed past me the other day and refused to change [Name] continence pad, saying they had to leave." Another relative told us, "Staff speak in their own language in front of Mom. They have shouted at her, were rude to me and had a none caring attitude."
- Other people and relatives told us about staff members poor attitudes and how they felt rushed by staff which made them feel vulnerable. One person told us, "They [care staff] have left me feeling frightened and vulnerable because I am bedridden and was treated at times, like an object." Another person said, "I'm not very happy, they [care staff] don't do anything. They give me my tablets; they shove them in my mouth. I should get four calls a day for three quarters of an hour, but they are only here five minutes." This was bought to the attention of the nominated individual, who assured us they would remind all staff and re-visit dignity and respect training with staff members.
- People's care plans included some information about their preferences and personal histories to help staff get to know them and how they liked to be supported. However, we found these required improvements to give staff more detailed information, particularly for those people who have dementia and limited communication abilities.
- The service supported and employed staff from multi-cultural and religious backgrounds. We were told, where possible they allocated staff members from the same culture or who were able to speak the same chosen language of the person. This was not always the case as people told us and records demonstrated, some people were regularly supported by staff members who were not able to communicate effectively due to their ability to speak and understand English. The nominated individual told us they would review the allocation of staff although, they felt staff could speak adequate English to communicate with people on a basic level.
- People told us staff members approach in relation to dignity and respect, manners and supporting with mobility needs was often poor. One relative told us, "They don't know how to use equipment properly, they are dangerous. They [care staff] hoisted my mum on to the shower chair and her bottom was half on and half off. I pointed this out and they pulled the sling which could have broken her skin and hurt their backs. I called the manager and they told the care staff to leave and told me if I wasn't happy with the care, I should find somewhere else." Some of these concerns were identified at the last inspection and remained an issue

at this inspection. However, those who received a consistent staff team with more regular call times were complimentary about staff and the service.
● People and their relatives told us that privacy and dignity was not always promoted. Staff did not always ensure peoples' dignity was preserved when their personal care was provided. One person's relative told us, they had spoken to staff members who had left their relatives body uncovered whilst they were just washing their face and did not ensure their dignity was maintained.

The provider did not ensure all staff treated people with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

● Most staff we spoke with understood peoples' support needs and told us how they supported people to do as much for themselves as they were able to help them maintain some independence.

Supporting people to express their views and be involved in making decisions about their care
● Care plans and care records were not easily accessible to people, these were held electronically. We discussed this with the nominated individual who explained they were happy to provide a paper copy of the care plan should people require this.
● People and relatives told us they had not been made aware that this was an option as it had not been communicated with them. Similar issues had been identified at the last inspection. We were told the provider would make this clearer to people.
● People told us care plans were not always developed with the involvement of people and their relatives and they had never been asked about their care needs and wishes. One person told us, "I don't have a care plan, or anything written down." A relative also said, "I haven't had any discussions about care plans, if we have, I have never seen anything in writing." Another relative said, "I have been asking for mums care plan but seemingly they can't e-mail or post it to me. They don't hold any notes here as they are all on the app."
● We found staff did not always have clear information about people's communication needs in order to ensure they were able to involve them in decisions.

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

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 care staff, 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's information return (PIR) stated. 'Our service always starts new care packages with a care needs and risk assessment. Part of the reason for this is to identify protected and other characteristics under the Equality Act which makes it necessary to remove barriers.'
- On speaking with people and relatives, people had not been offered their care plans in an alternative format. For example, one relative told us, "[Person] cannot speak or read English. They had not been offered the care plan in their chosen language." Another person told us, "I had not been made aware I could have my care plan in another language so they could share this with my relatives." There were no examples of accessible information available. The nominated individual told us they would provide alternative formats if they needed to and people made them aware they required an alternative format.

Improving care quality in response to complaints or concerns

- People were not confident that their concerns and complaints were listened to or resulted in any changes to their care.
- The provider's PIR stated, 'We have a robust complaints procedure. The complaints that we have received are to do with carers running late for care calls.' We saw there was a complaints process in place, however, we could see where complaints had been raised, they had not always been thoroughly investigated, acted on, responded to and outcomes had not been recorded or triggered adjustments to be implemented.
- People and relatives told us they were able to raise complaints with the service but not everyone was confident the issues would be dealt with. For example; people and relatives told us they had complained about short, missed and late calls and had not seen improvements in this area. People also told us they never received a call back from the registered manager and the issues persisted. In addition, people told us they did not receive any acknowledgement or a written response to their concerns.
- They also told us the on-call systems were poor as when they needed to raise concerns, often they had no response out of office hours. One person told us they had called one weekend over 150 times with no answer. Others told us they had given up making complaints as no-one called them back and they felt nothing would change anyway.
- Similar issues had been raised during the previous inspection, but we still found these were on-going.

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.

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

● We saw from records and people and their relatives told us; care plans were not reviewed periodically or as people's needs changed. Staff we spoke with told us about people's current care needs although their care plans did not reflect this information to guide staff.

● People often felt the care and support was not responsive to their needs. One relative told us how they had changed the call times to suit the service as they were continually late for calls. Another relative told us how the person only wanted the same sex care staff members to attend their calls, but at times this was not the case, making the person feel uncomfortable.

● Staff told us, and we saw from care records they recognised when a person was unwell and required additional support such as a GP or ambulance.

End of life care and support

● At the time of the inspection, no one supported by the service was receiving end of life care.

● The nominated individual told us they understood the need to work closely with people, their relatives and healthcare professionals, including GPs, to ensure people's preferences and choices for their end of life care were acted on and they had the support they needed.

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.

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

- The registered manager was not in the service on a full time basis as they are the registered manager for the providers other location, although they were contactable by telephone or e-mail. The nominated individual was located at the office and reported back to the registered manager. Lack of management oversight had contributed to the shortfalls identified. The provider had failed to ensure good quality assurance systems and processes were maintained and this meant the service lacked any sustained and effective improvement.
- Although there was a system to audit aspects of the service, we found these had failed to identify people were not supported safely in a way they chose. They did not identify the concerns with; care plans and risk assessments which required more robust information, inadequate call times such as short, late and missed calls, medication, safeguarding issues, poor recruitment processes and staffing issues which we identified.
- The management of safety, risk and governance had not been effective. Actions had not been taken by the provider or registered manager to ensure the systems and processes were robust and operated effectively.
- Care records and risk assessments required more detail to ensure information was detailed and current for staff to refer to. The provider's own audits had failed to identify these shortfalls. Although there were records to evidence when reviews of care plans and risk assessments took place, we found they were not effective as the concerns we found had not been addressed. This included; missing health care plans, lack of information for staff to follow and unclear risk assessments.
- We could not be assured the system used for staff to log in and out of calls and record their notes was safe. Staff could log in to a call when they were not in attendance. This meant there were no assurances staff attended the calls, on time or for the correct length of time.
- Audits had failed to identify the concerns around medication such as given at the incorrect times or potentially not given at all and the lack of information for safe administration in care plans.
- The provider had failed to implement and operate systems ensuring all staff had the knowledge, training and skills to carry out their roles correctly and safely.
- The provider had failed to implement processes to effectively recruit, train, monitor staff to carry out their roles safely. This included the lack of regular supportive supervisions to provide support and feedback on performance and areas of improvement.
- The provider understood the need to notify us about relevant changes, events and incidents affecting the service and people who used it. However, we found their systems were not always robust and did not identify when their processes had not been followed.

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 provider had a registered manager in post. However, they were unavailable at the time of our inspection and we met with the nominated individual in their absence.
● The staff we spoke with were clear about their respective roles and responsibilities and what was expected of them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Annual surveys were not consistently sent to people and their relatives to invite their feedback on the service. We found that feedback provided was not reviewed to identify learning for the service and issues to be addressed.
● People and relatives understood how to contact the office to discuss concerns and had an on-call number they could use when this was closed. However, they found that this was often not answered or if it was their concerns were not responded to.
● Staff were not consistently made aware of meetings so did not attend. This meant staff were not consistently provided with important updates and involved in decisions about changes to ways of working.
● Staff did not always feel able to raise any concerns or worries they may have about the care provided. They were not always confident issues raised with management would be investigated and felt when they reported issues to the office, office staff could be rude and unhelpful.
● People's equality characteristics were not always taken into account to ensure their needs could be met.

Continuous learning and improving care
● Staff completed on-line training however, there were no on-going competency assessments to ensure staff understood their training or that they were implementing this to provide safe care and support.
● Complaints which the provider had recorded did not reflect all of the complaints people and their relatives told us they had raised. Staff and relatives, we spoke with, told us they had raised concerns with the registered manager and provider but felt they were not always listened to. A relative told us, "I don't think the managers are very good. It's just not good enough and it can be improved. They [provider] don't allow travel time, they are not flexible when you ask for additional things and they [staff] don't do what is in the care package." The action taken by the provider to resolve issues raised in complaints received was not consistent nor was there evidence the provider had monitored complaints for recurring themes to help them improve the service.
● People and relatives told us that when they had called the office to say the carer had not turned up for the call, the office staff told them they had attended the calls because they had logged in. People and relatives also told us they had observed staff sat in their cars but did not come into the house to provide the support required. Although people's care calls were monitored, frequent late calls remained a concern to many people and their relatives and the provider had not identified an effective means of ensuring staff punctuality.
● Incidents which had been recorded did not demonstrate that any actions had been taken in relation to these concerns. There was no evidence that care plans and risk assessments had been updated. This meant information was not shared, reflective practices had not been adopted and no lessons had been learnt.
● The provider had quality assurance systems and processes in place designed to enable them monitor and improve the safety and quality of people's care. This included audits of people's care plans, accidents and incidents, medicines and complaints. However, we found these were not robust and did not identify the concerns we found at this inspection.

● The management team were receptive to our feedback from the inspection. Following our inspection, they shared further details of actions being taken to address these concerns, including people's late care calls.

Working in partnership with others

●The provider told us they understood the need 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 there was evidence of ineffective working with others, including the Local Authority.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.

● We found from documentation and speaking to people, that the service did not always promote a person centred approach. People's individual needs were not always considered or met. Such as; Accessible Information Standard, communication and the impact of late, short or missed calls had on people's overall well-being.

● People and relatives also told us they had not been invited to attend care reviews to discuss the continuing care and support required. This meant the provider could not be assured the care plans and risk assessments reflected people's current needs and wishes.

● Some staff we spoke with told us that they did not often see or speak with the registered manager and did not always feel supported by the office team or nominated individual. Staff told us they were not approachable.

● The provider was not displaying their most recent inspection rating as they are required to by law, this was brought to the nominated individual's attention who told us he would address this.

● Spot checks to confirm staff were working in line with the provider's expectations had not routinely been completed since the start of the Covid-19 pandemic. However, monitoring calls were made to a random sample of people each day to obtain direct feedback on how well staff were meeting their needs.

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 nominated individual 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, we found they were not fulfilling 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 had failed to ensure that risks to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including; missed late and short calls to support people, medicines, Infection Prevention and Control, care plans and risk assessments for peoples known health conditions. As a result, people were exposed to the risk of serious harm.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people using the service had their privacy and dignity maintained at all times.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to consistently ensure people's consent was gained prior to providing support.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people using the service received safe care and treatment. 1. The provider failed to ensure care plans and risk assessments were in place and completed with enough detail to give care staff the knowledge and information they needed, to be able to support people safely. This included the lack of care plans and risk assessments for people with known, complex, health conditions. 2. The provider failed to ensure people received their medication safely. 3. The provider failed to ensure people received their commissioned length of calls or frequency, placing people at risk.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure they had robust systems in place to identify when people had been placed at risk of harm or abuse and take actins to mitigate further incidents of abuse occurring.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	The provider failed to operate a robust complaints system. The provider failed to keep a record of these complaints received. There was no evidence of action been taken to resolve the issues or to enable them to monitor for recurring themes to help them improve the service.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust to effectively assess, monitor and mitigate the risks of the health, safety and welfare people and staff who use the service. Thus failed to identify the concerns we found during the inspection.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment processes were not followed to ensure fit and proper people were employed at the service. The provider failed to ensure they carried out audits thus failed to identify the concerns we found during the inspection. The provider failed to follow the correct safe recruitment procedures to ensure staff employed were fit to work in the service. They failed to consistently obtain; Carry out risk assessments for staff working without a positive DBS, suitable references and assess the skills and competencies of staff employed

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had

received assessments of their knowledge, skills and competencies to support people safely. They also failed to ensure staff were supported by completing regular, supportive supervisions and appraisal.
There were not sufficient numbers of staff deployed in order to meet people's needs. This placed people at risk of harm.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.