Golden Hands Home Care Ltd

OFFICE

Inspection report

21a North Hill
Colchester
CO1 1EG

Tel: 01206580692

Date of inspection visit:
13 June 2023

Date of publication:
17 August 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

About the service
OFFICE (known as Golden Hands Home Care) is a domiciliary care agency providing personal care. The service provides support to people with a physical disability or sensory impairment. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found

Right Support: Care visits were organised to suit staffing availability, and not to consistently meet people's needs and preferences.

People were not always supported by staff of their preferred gender to meet their values and support a sense of dignity. Agency staff were not always aware of people's specific needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

However, whilst regular staff promoted independence and considered capacity and consent, the systems in place at the service did not always enable staff to provide the right support.

Staff received an induction, mandatory training, and spot checks to support their development. Staff did not receive specialist training in supporting people with a learning disability and or autistic people. Some training was out of date.

Right Care: Whilst staff were described as being friendly, kind and compassionate, the service was not consistently person-centred due to provider shortfalls in oversight and monitoring.

Safeguarding measures were inconsistent, which meant people were at increased risk of harm or not receiving the right care. People told us they did not have access to their up-to-date care plan, or involvement

in regular reviews.

Equality and diversity characteristics were considered as part of the care planning process.

People told us staff respected their privacy and independence.

Right Culture: The ethos, values, attitudes and behaviours of leaders did not ensure all people using the service could lead confident, inclusive and empowered lives.

Limited action had been taken since the last inspection to drive improvement at the service. Registered persons and the management team were not responsive to people raising concerns, or to professional feedback.

There was a poor understanding of legal and regulatory requirements. Systems for oversight and governance were absent, poorly developed, incomplete, or ineffective.

Whilst the management team completed care visits to people in their own homes, and were described as approachable, there was no robust strategic oversight for the service 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 and update
The last rating for this service was requires improvement (published 22 June 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. At our last inspection we recommended that the provider fully explore all gaps in staff employment history during recruitment and keep a log of all missed calls at the service. At this inspection we found improvements had not been consistently made.

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

We carried out an announced comprehensive inspection of this service on 23 May 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance and oversight.

We undertook a focused inspection in relation to the key questions Safe, Responsive and Well-led to check they had followed their action plan and to confirm they now met legal requirements. We inspected and found there were continued concerns about governance and oversight which impacted on other areas of the service, so we widened the scope of the inspection to become a comprehensive inspection, which included all of the key questions.

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

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

Enforcement

We have identified breaches in relation to dignity and respect, safe care and treatment, safeguarding people from abuse, governance and oversight and staffing. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We have issued the provider with a Warning Notice.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

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.

OFFICE

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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, who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. However, the registered manager was not present during the inspection process. We therefore spoke with the company director and the care manager. We formally wrote to the registered manager during the inspection to seek assurances on governance and oversight in their absence.

Notice of inspection
We gave the service short notice of the inspection. This was because it is a small service and we needed to be sure that a member of the management team would be in the office to support the inspection.

Inspection activity started on 9 June 2023 and ended on 28 June 2023 We visited the location's office on 13 June 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the Well-led section of the full inspection report for further details. We used information gathered as part of monitoring activity that took place on 21 February 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people and 2 people's relatives to understand their views on the care and support provided. We reviewed 3 staff recruitment files, 6 people's care plans and multiple call logs and medication records. A variety of documents relating to the oversight and governance of the service were reviewed, including audits, policies, and procedures. A specialist CQC team analysed data from the provider's electronic call monitoring system. We spoke with 3 members of staff including the company director, the care manager and 1 care worker. We also sent out written surveys and received and reviewed responses from 4 care workers. We corresponded by email with the registered manager, who is also the nominated individual, as they were not in the country at the time of inspection.

Requires Improvement

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- There was an inconsistent approach to safeguarding, and policies were not well developed and embedded, placing people at the risk of harm from potential abuse or neglect.
- The system for recording safeguarding matters raised by the provider was incomplete. Although detailed investigations took place, there was no effective mechanism for analysing wider themes and trends, to share lessons learned with staff and reduce the risk of reoccurrence.
- People told us of accidents and incidents which had not been recorded, creating a risk not all potential safeguarding concerns were being identified and escalated appropriately. This was a continued concern from our last inspection in 2019.
- Where safeguarding incidents had occurred, people did not always feel well supported. One person told us, "[Management] told me that I wasn't allowed to talk to anybody about [the incident], especially not any of the other care workers and they generally made me feel as though I was a criminal. Although later on they did apologise about what had happened they didn't offer me any support."
- Many of the staff working for Golden Hands Home Care were related or had personal relationships. There was no robust policy in place to safeguard people and staff from potential conflict of interests or the formation of a closed culture arising from this practice.

Systems and processes were not established and operated effectively to protect people from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised an organisational safeguard alert with the local authority for investigation during the inspection as a result of people's feedback.
- Despite these concerns, most people told us they felt safe. One person said, "I feel safe with [the care workers] because they are all friendly and pleasant." Another person's relative said, "I do feel [my person] is safe but I feel the company have overloaded themselves with clients and they don't have enough staff."

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection we recommended a record of missed calls is kept. The provider had not made improvements.

- Visits were organised and recorded through an electronic call monitoring system. Records showed visits were mostly on time, and for the duration people were assessed to receive. People told us they had not had

any missed calls, but if care workers were late, they were not always informed of this. One person said, "I understand if they're held up (staff) but they just don't tell me."
● Data did not show how the provider maintained consistent oversight of potential missed visits. Analysis of a sample of call monitoring data showed 31% of visits were not logged. There was no system or log in place to explain the reason for this, such as people being in hospital or cancelling calls.
● At our last inspection we found medicines audits were irregular due to paperwork not being returned to the office. Despite the introduction of readily accessible electronic medication administration records (MARs), there had been no auditing on medicines completed since March 2023. This placed people at the potential risk of not receiving their medicines as prescribed.

Whilst we found no evidence people had been harmed, the provider did not take all reasonable steps to assess, monitor and mitigate potential risks to people's safety. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risk assessments were in place covering areas such as mobility, falls, the home environment, catheters, and pressure care. One person told us, "[Care workers] do use a hoist and I do feel safe with them. I also have a bad ulcer and they're very careful."
● People's medicine support needs were clearly set out in their care plans, showing staff responsibilities for ordering and administration, and assessing potential risks.
● People told us they received their medicines safely. One person told us, "[The care workers] do help me with my medication; they give me the tablets from the original boxes and as far as I know it's always been fine."

Staffing and recruitment

At our last inspection we recommended the provider obtains a full employment history and any gaps in employment are checked as part of the staff recruitment process. The provider had made some improvements, but more work was still required to strengthen record keeping.

● Safe recruitment checks took place including referencing and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Although information on employment history was included in staff files, further action was still required to record how gaps had been explored more clearly. The company director told us they would add this as an interview question going forwards and store this on file.

Preventing and controlling infection
● People told us they were satisfied with the hygiene measures employed by staff, including the use of personal protective equipment (PPE). One person told us, "[Care workers] wear aprons and gloves."
● Staff received training in infection prevention and control.

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.

Staff support: induction, training, skills and experience

- People told us they did not feel staff always had sufficient training in specific health conditions, or more specialised areas such as catheter care or dysphagia. We requested evidence of training certificates on these topics, but this was not provided during the inspection process.
- One person told us, "Often, when [care workers] come on my regular care worker's days off they don't really know what to do and I have to guide them. They don't really know how I like things done. For example, they aren't very familiar with my catheter."
- The service did not have a consistent approach to supporting staff to maintain their professional skills or knowledge of best practice. For example, there was no evidence agency staff members received an induction to support them when working for the service.
- One person told us, "My regular carers know me and know my routine. With the agency staff some don't understand what you're trying to tell them because they don't speak a lot of English. That's not so much the problem but when I'm trying to explain what it is that I need them to do they just say, 'yeah, yeah' as though they know, but they don't know. It's tiring to keep explaining things."
- Practical moving and handling training was out of date for 10 of 25 staff. The company director acted promptly to book this training during the inspection process.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regular staff received an induction, supervisions and mandatory training, including the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

- People received an assessment of their needs when joining the service using nationally recognised tools. This was used to develop care plans which were stored on an electronic system.
- One staff member told us, "By looking at people's care plan we can understand the individuality of a person, so that we can provide them with the appropriate care and support."
- However, whilst care plans and assessments were in place, people told us they did not always have access

to their care plans or involvement in reviews.
● One person's relative said, "All we've ever had is an A4 sheet with some telephone numbers on it, and none of those are up to date and correct. No, I don't think there is a copy of the care plan that we've seen in recent times." Another person told us, "I don't have a care plan as far as I know but I know they make notes on their phone when they've been to see me."

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● It was recorded in people's care plans where referrals might need to be made to other healthcare professionals, such as the occupational therapist, district nurses or the GP. One person's relative told us, "[The care workers] are pretty professional. For example, they do check [my person's] skin for pressure areas and are quite diligent with any sore places."
● However, we received mixed feedback from people on support to access other services. One person told us, "No, [Golden Hands Home Care] have never pointed me in the direction of any other healthcare or community services."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● The service was working within the principles of the MCA. Care plans set out the need to seek people's consent, and people's capacity to make decisions was considered. However, the shortfalls in wider systems at the service meant people's choices and preferences were not always met.
● One staff member told us, "Everyone we have supported has the capacity to consent at the moment, moreover, the next of kin is extremely helpful in making decisions that are in the best interests of the individual we've assisted."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to have enough to eat and drink, and likes and dislikes recorded. One person's care plan said, "[Person] likes to have pancake with butter, tea with milk and 1 sugar and orange juice for breakfast."
● People confirmed they were offered choice. One person said, "[Care worker] gets me some breakfast which I choose, and I have sausage or bacon sandwich."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Supporting people to express their views and be involved in making decisions about their care
- Systems were not in place to enable staff to provide a consistently caring service. For example, staff shortages and the use of agency staff who did not know people's care and support needs well impacted on the quality and consistency of the care.
- One person told us, "A couple of months ago lots of the care workers went to the Philippines for the owner's son's wedding and this left them very short of staff. So, for about 3 weeks we had mainly agency staff and for example they were turning up at 8pm for a teatime call. One of the [agency staff] was trying to put me to bed at 7pm even though I can get myself to bed."
- Although people had expressed their views on this to the office, there had been no changes or improvements made as a result. This meant people did not feel listened to.
- One person told us, "I have mentioned to [the management team] about the agency staff but they just say that unfortunately there are no other care workers available."
- The company director told us recruitment had improved and this should reduce the need for agency usage going forwards.

Ensuring people are well treated and supported; respecting equality and diversity
- People described their regular care workers as friendly and kind. One person said, "[Care workers] are caring, and they always ask me how I am before they start to help me with my care. We have nice conversations and lots of banter." Another person said, "[The care workers] are all very kind and gentle. I feel sorry for them as they are so overworked."
- Equality and diversity characteristics such as ethnicity, religion and sexual orientation were considered and recorded in people's care plans.
- Staff spoke warmly about the people they supported. One staff member told us, "We just give the best care for [people] and support for their needs, their choices and keep doing our best to keep them safe."

Respecting and promoting people's privacy, dignity and independence
- Care plans gave guidance to staff on how to promote people's independence, such as completing their own oral care. One person told us, "My regular care worker is very good and helps me to do the things I can still do. For example, [care worker] gives me time to do things and helps to keep me more independent."
- People told us the care workers respected their privacy during personal care. One person said, "[Care workers] are very good at being respectful and making sure that I'm kept covered and with as much dignity as possible."

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 requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The provider failed to ensure care and support was delivered in a way which ensured flexibility, choice and continuity of care. Whilst people told us their regular care workers were kind, professional and compassionate, the provider did not organise and plan people's care to holistically meet their needs.
- Visits were scheduled to meet the needs of staffing availability and not people's preferences, which could impact on people's dignity. One person told us, "No [Golden Hands Home Care] are not terribly flexible. For example, I am incontinent and if I [experience incontinence] between visits I don't bother phoning the office as I know they won't send anyone to help me until the next visit is due."
- Leaders failed to understand or recognise people's needs based on their values and beliefs and did not take these into account when planning or providing care, treatment, and support. People told us their preference for the gender of staff supporting them with their personal care was not always met, contrary to their wishes and values. This was a continued concern from our last inspection which had still not been resolved.
- One person's relative told us, "I really don't care for the fact that there are 2 male care workers assisting my [person] with very personal care. I have spoken to the office, but they say they have not got the staff." Another person said, "It is mostly women care workers but occasionally men as well. I'd prefer just to have the women care workers."
- Whilst some care plans were written in a detailed and person-centred way, this was inconsistent. The language used to describe people in some care records was not always positive and respectful. This includes examples such as describing people as 'moody' or 'manipulative' and using slang terms for bodily parts and functions.
- Care reviews were irregular and not person-centred. People did not always feel their needs were understood and responded to. One person told us, "My situation is getting worse, and my needs are changing but I can't recall any review of my care plan."

The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Concerns were not always dealt with in an open, transparent, timely and objective way to improve the quality of the care provided. The service did not always take people's views fully on board, investigate them thoroughly and in a timely way, or change practice to improve.
- People did not find it easy to raise concerns or complaints or were worried about doing so. One person said, "They [office staff] often say they will get back to me, but they never do. The owners never contact me."

Another person said, "If I made a formal complaint, I'd be frightened that they'd pull out of my care and as I like my current regular care worker, I don't want to risk it."

● The service kept a log of concerns and action taken, but this was not always robust. For example, one complaint about lateness was marked as 'resolved' by the provider. However, the only action taken was to inform the person they were short staffed.

● The service had also received some compliments.

End of life care and support

● The service did not consistently engage people in planning their end of life care or demonstrate how they record and act on individual wishes.

● Records did not show how the care and treatment for people who may be approaching the end of their life was managed in a way that meets their health, social or cultural needs, wishes and preferences. The need for further detail in end of life care plans was identified at our last inspection, but had not been acted upon.

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.

● Information was recorded in people's care plans on how they preferred to communicate, including any aids required due to sensory loss.

● One person told us, "The care workers are always polite and careful. I am hard of hearing and one or two speak English but it's not their first language and it's harder to hear what they're saying so I have to ask them to speak clearer, and they generally do."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to go out to reduce the risk of social isolation, such as visiting the park or shops. One person said, "[Care worker] will help me with all sorts of things and will often take me out shopping and things like that."

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 requires improvement. 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.

At our last inspection the provider had failed to ensure governance processes were robust enough to identify shortfalls in the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- The registered manager, who is also the nominated individual, was not in the country at the time of the inspection and failed to respond to multiple requests to contact the CQC. We had to write using our formal powers to seek assurances on governance and oversight in their absence.
- The company director was responsible for overseeing the service in the absence of the registered manager but could not demonstrate a good understanding of the functionality of the electronic call monitoring system for oversight and reporting purposes.
- Not all abuse or allegations of abuse had been notified to the CQC as required by law. We asked the company director to make a retrospective notification for one safeguarding matter, but this was not completed by the close of the inspection.
- The provider failed to meet the minimum requirement to submit the CQC's provider information return (PIR) for 3 consecutive years. This is requested by the CQC annually to check for up-to-date information on the running of the service. This showed a poor understanding of regulatory responsibilities.
- The company director was not aware of a change in the law requiring staff to receive mandatory training on supporting people with a learning disability and or autistic people. Not all staff had received specific training in this area, despite the service being registered to provide this specialist support.

Working in partnership with others; Continuous learning and improving care

- The service did not consistently work well in partnership with other stakeholders to drive improvement. For example, limited action had been taken in response to concerns identified at a recent local authority quality audit.
- Action taken since the last inspection in response to recommendations and breach of regulations was inconsistent and ineffective.

Systems and processes had not been established and operated effectively to assess, monitor, and improve

the quality and safety of the services provided. This placed people at the risk of harm. This was a continued breach of regulation 17 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

● People told us they were extremely dissatisfied with responsiveness from the office. One person told us, "I do get frustrated as I seem to go in circles with communicating with [Golden Hands Home Care]. If I phone the office and ask them about something I can't get to speak to someone and get an answer. They say they will phone back but they pass the buck from one to the other and nobody phones back, and I don't get an answer. I won't bother phoning the office anymore as it's a waste of my time."

● Whilst the management team completed some care visits and so were involved in the day to day running of the service, strategic oversight was still lacking.

● One person said, "The manager does come out occasionally as a care worker and is easy to get on with, very nice." Another person said, "I do see [manager] every so often as they come out to do my care sometimes, I think it's often when they're short of staff." And "[Manager] seems very pleasant."

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

● Due to poor oversight mechanisms for accidents, incidents, safeguarding matters and complaints, the provider was unable to show they had been open and honest with people when things went wrong.

● A duty of candour policy was in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Whilst a satisfaction survey had been introduced to seek people's views, no action plan was generated from the information gathered, and the feedback did not reflect the comments we received from people during the inspection.

● One person said, "When [Golden Hands Home Care] ask me to do a survey or a questionnaire, I won't do it now because they won't listen." Another person's relative said, "[Management] say they will sort things, but they never do. With Golden Hands it's hard to get through to someone in the office and get an answer."

● The company director told us they would begin analysis of responses, as well as consider how to send feedback forms out in a way which allowed people to respond anonymously if they preferred to do so.

● Staff told us they felt supported in their roles and attended regular team meetings. One staff member told us, "Yes I am well supported by the management, they are always available to talk to me about any issues I want to raise and often contact me to ask about the wellbeing of the clients."

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Whilst we found no evidence people had been harmed, the provider did not take all reasonable steps to assess, monitor and mitigate potential risks to people's safety.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to protect people from the risk of abuse. This placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor, and improve the quality and safety of the services provided. This placed people at the risk of harm.

The enforcement action we took:

Warning Notice