St Gregory's Homecare Limited

St Gregory's Homecare Ltd

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Gregory's Homecare Ltd is a domiciliary care service providing care to 209 people at the time of the inspection. The service provides support to the whole population. At the time of inspection, the majority of people receiving personal care from the service were older people and people living with dementia.

Not everyone who used the service received personal care. The Care Quality Commission (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
People did not always receive good quality care. There were significant and widespread shortfalls in the governance of the service, placing people at risk of harm. The provider did not have robust or effective systems in place to monitor quality across the service and drive improvement. The provider did not have a positive culture that promoted person-centred, open care that achieved good outcomes for people.

People did not always receive safe care and were not always protected from the risk of abuse. The provider did not always learn from safeguarding concerns which showed a theme of people experiencing late and missed care visits. People and their relatives told us this remained an issue. Poor communication of rota changes and a lack of care staff travel time contributed to this. People were at risk of harm as information about their risks was not always effectively assessed and managed. People told us effective infection prevention and control practices were not consistently followed.

People did not always receive effective, consistent care; feedback from people and their relatives showed there were times when their care needs and preferences were not met. This included times when people did not receive appropriate support to access food and drink. Care staff did not always receive appropriate training or support to enable them to carry out their duties.

It was not clear that 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 did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. 'Right Support, right care, right culture' is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of 'Right support, right care, right culture'. At the time of inspection, the service was not providing personal

care to any people with a learning disability and/or autism. The provider's policy did not show the provider's model of care would support people to have maximum choice, control and independence, enable people to access the community or follow best practice in relation to its ethos, values and behaviours. The provider told us they would review their policy and whether they could provide care to all the service user groups they were currently registered for.

People did not always feel well supported, cared for or that their dignity was maintained. The service was not organised in a way that promoted person-centred care. This led to people experiencing rushed care visits and not having their preferences listened to or acted on by care staff. People's equality and diversity needs were not well documented. Information about people's communication needs was limited. We have made a recommendation about this.

People and their relatives did not have confidence that they would receive appropriate and responsive care to meet their care needs. They described regularly receiving early and late care visits and at times, care visits being missed. People's care plans were not personalised to reflect their individual needs, including where people required end of life care. Complaints by people and their relatives were not always responded to effectively.

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

Rating at last inspection
The last rating for this service was good (published 05 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the quality of care people were receiving and safeguarding concerns. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has shared information with us, including care visit records to show some improvements have been made.

Enforcement
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.

We have identified breaches in relation to person-centred care, consent, safe care and treatment, safeguarding, nutrition and hydration, complaints, governance and staffing. Please see the action we have told the provider to take at the end of this report.

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 authorities to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

St Gregory's Homecare Ltd

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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and a pharmacy specialist. The pharmacy specialist supported the inspection remotely. Three Experts by Experience made telephone calls to people who use the service and their relatives. 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 homes.

The service had two managers registered with the CQC. 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.

Notice of inspection
We gave a short period of notice of the inspection because some of the people using it could not consent to a telephone call from the inspection team. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 21 July and ended on 14 October 2021. We visited the office location on 21 July and 05 October 2021. The second site visit was carried out following further concerns being raised about the service, including the timings of care visits.

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 authorities who work with the provider. We used the information the provider sent us in the

provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 15 people who use the service and 16 relatives about their experiences of the care provided. We spoke with 20 staff including the nominated individual, director, registered managers, governance officers, assessment officers, care coordinators and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 18 people's care records and eight medicines records. We looked at two staff recruitment files and five staff supervision records. A variety of records relating to the management of the service, including policies and procedures, training information, complaints and safeguarding meeting minutes were reviewed. We spoke with a range of professionals who regularly work alongside the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People were not safe and protected from abuse.
- Staff told us they could recognise signs people may be experiencing abuse and knew how to raise their concerns. However, we found safeguarding concerns were not being raised by the provider in-line with local arrangements.
- People and their relatives gave mixed feedback on whether they felt safe with care staff. One person described feeling frightened by a member of care staff and raising this with the provider. When the provider continued to allocate the care worker to their care visits, the person contacted the police.
- It was not clear lessons were learnt following safeguarding concerns to prevent reoccurrences and keep people safe. For example, a number of safeguarding concerns raised with local authorities in July 2021 related to late and missed care visits. People continued to experience these issues and remained at risk of harm.

We found some evidence that people had been harmed. The provider failed to ensure people received safe care and were protected from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following concerns identified during the inspection, we raised a number of safeguarding concerns with local authorities to enable them to take action to keep people safe.

Assessing risk, safety monitoring and management

- People were at increased risk of harm as information about risks to them was not always in place or sufficiently detailed to guide staff in how to identify and respond. One staff member described not receiving information from the provider about a person they supported. They told us, "This information could have been missed. It felt a bit like I was winging it."
- Care plans and risk assessments did not give enough guidance on how to manage any health emergencies relating to people's conditions, for example, diabetes.
- People were at risk of injury as moving and handling plans did not give sufficient guidance for staff to follow, placing people at risk of harm. This included one person at risk of falls being directed by care staff to dress and use the stairs without support.
- People's behavioural needs were not understood. Care plans did not contain sufficient information to guide staff in how to respond and manage risks linked to behaviours that challenge the service.
- Risks linked to people's safety and security in their own homes was not always managed appropriately.

People and their relatives told us there had been incidents where their properties had been damaged or not secured due to the actions of care staff.

We found some evidence that people had been harmed. Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● We could not be assured that information about people's medicines was current and up to date to ensure they were administered safely to people.
● Information on people's GP medicines lists did not always match with the provider's electronic medication administration records to ensure people received their medicines as prescribed.
● It was not always clear how risks linked to people's medicines were identified and managed. For example, if people frequently refused to take their medicines.
● The provider's medicines policy did not reflect best practice guidance. Staff practice also did not reflect this guidance,

We found no evidence that people had been harmed. However, people's medicines were not always managed safely and in-line with guidance. This placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected from the risk of infection due to inconsistent infection prevention and control practice by care staff.
● Care staff did not always follow infection prevention and control best practice. This included not wearing jewellery, which could present an infection risk. One relative said, "They often wear their watch or bracelet and have scratched my [relative] when they care for them."
● People and their relatives described occasions where staff failed to dispose of soiled continence products and PPE appropriately. One relative said, "Sometimes they [care staff] would put all sorts of things in the washing machine including [incontinence] pads, seat pads, used soiled gloves."

We found no evidence that people had been harmed. However, people were not always protected from the risk of infection. This placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection we made a recommendation that the provider seek guidance on effective planning and monitoring of care visits and for staff requirements and practices to be updated. We found this recommendation had not been followed.

● Care visits requiring more than one care worker were not always organised to enable people to receive safe coordinated care.
● People gave mixed feedback about the timing of their care visits. People told us they often received care visits earlier or later than scheduled, which at times impacted on their wellbeing. One person said, "The times aren't right, we don't know who's coming and we don't know when; they don't tell us of changes."

● Care staff faced challenges around providing people's care on time as travel time was not always allowed for or sufficient. This impacted on the quality of care people received as it meant their visits were sometimes shorter than scheduled or rushed.
● Staff were not always informed of changes to their rotas in a timely way. One care worker said, "Communication and organisation could be better. Some people are sick of it; times changed. Rotas changed with no text, no discussion."
● The provider took on new people without considering the capacity of the service to meet their needs. This meant that staff had more people to visit, which put new and existing people at risk of not receiving their scheduled visits and not having their care needs met.
● The registered manager told us people's care visits were combined on occasions. For example, people received one care visit instead of the morning and lunch time care visits they were contracted to receive. It was not clear if people's permission was sought for this. This information was shared with local authorities and clinical commissioning groups to follow up.

We found no evidence that people had been harmed. However, the provider had failed to ensure there were sufficient staff to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● More recent care visit times we reviewed showed some improvements in the timeliness of care visits.
● We received more recent feedback from commissioners, suggesting the provider had made improvements to understand and work within their service capacity.
● Care staff were recruited safely. Appropriate checks were carried out to protect people against unsuitable staff.
● The provider had implemented innovative solutions to support the recruitment and retention of care staff.
● The provider told us missed care visits were a rare occurrence and three missed care visits had occurred during the period January to July 2021. However, this was not consistent with the experiences of people and their relatives told us.
● The provider told us care visits not logged on their system within an hour would be followed up. Comments from people and their relatives suggested this was not always happening in practice.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 always receive care which reflected their assessed needs and risks.
- People did not always receive safe and effective support to meet their continence needs. One person described to us how they received support with their continence needs in an unsafe way.
- People and their relatives gave mixed feedback on the care they received. 32% of people and relatives raised concerns about the quality of their care. This included issues with the quality of personal care provided by care staff. One relative told us, "Some care staff clean [person] very well, some not, [person] will still smell." Another relative said, "Some care staff would go the extra mile and help [family member], others just can't wait to go out."

We found some evidence people had been harmed. However, the provider had failed to provide people with appropriate care to meet their needs. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People received an assessment from the provider prior to receiving care to consider their care and support needs and whether the provider could meet these.
- It was not clear how the provider would be able to meet the needs of all the different service user groups and specialisms they intended to support, including people with a learning disability and/or autism. The provider told us they would review the service user groups they were currently registered to support.
- The provider's policy for supporting people with autism did not follow best practice guidance.

Supporting people to eat and drink enough to maintain a balanced diet
- People did not always receive appropriate support to eat and drink.
- People's care visits were not always organised in ways that enabled them to receive regular meals and drinks. One relative told us, "Sometimes there is only an hour between visits, i.e. breakfast and lunch, that's too close."
- Safeguarding concerns showed a pattern of people not receiving appropriate support with eating and/ or drinking.
- Information and risks linked to people's dietary requirements were not always identified. This included where people had diabetes.

We found no evidence that people had been harmed. However, the provider failed to ensure people's nutritional and hydration needs were met. This put people at risk of harm. This was a breach of regulation 14

(Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff were not always qualified or sufficiently training to enable them to carry out their roles. For example, staff observing other staff members did not always have experience or training in moving and handling and personal care to inform their observations and ensure best practice was followed.
● It was not clear if staff had received training in areas such as safeguarding, end of life care, first aid or mental capacity.
● Competence checks were not carried out to assess staff knowledge and skills in areas such as moving and handling and medicines.
● People and their relatives told us staff did not always have the knowledge and skills needed to provide effective care. For example, one relative said care staff were not familiar with their family member's continence aid. They said, "Quite often the care staff will say they haven't done it before but will give it a go." The relative said the provider declined an offer of additional training by professionals to support care staff to improve and update their knowledge of continence care.
● The provider did not have robust systems in place to support staff and enable them to carry out their duties, including supervision and appraisal systems.
● The provider had not followed their supervision policy and 62% staff had not received supervision in the last 12 months.

We found no evidence that people had been harmed. However, the provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider advised training was covered within the staff induction. However, we were not assured this training was sufficient to ensure staff had the knowledge required for their roles.
● The provider informed us they had introduced competence checks following our inspection to ensure staff had the knowledge and skills to support people safely and effectively.
● Following the inspection the provider told us they had plans in place to ensure staff received supervision.

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

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.

● It was not clear whether people's capacity to consent to their care arrangements was assessed by the

provider.
● The provider did not always keep records where people had lasting power of attorney in place, which meant staff could not be sure when people had representatives legally authorised to make decisions on their behalf and in their best interests.
● We could not be sure that the provider had processes in place to identify if people were being deprived of their liberty or had a deprivation of liberty order in place.

We found no evidence that people had been harmed. However, the provider failed to act in accordance with the MCA. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave their written consent to their care plans and care arrangements, though it was not always clear they had capacity to do so.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Health and social care professionals had mixed experiences of working with the provider.
● People and their relatives expressed concern that should they or their family members be admitted to hospital this may impact on the continuity of their care.
● Detailed information about people's health conditions was included in their care plans. At times this was generic information about the health condition and used medical language that could be difficult for care staff to understand.

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

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

- People did not always feel well supported, cared for and that their dignity was maintained.
- Care was organised by the provider in a way that was task-centred and was not always person-centred. One relative said, "[Care staff] are in and out like wasps. They buzz in and out so fast they forget to do things."
- People were not always happy with the approach by care staff and did not always feel listened to. One person described how they liked to select the clothes of their choice to wear each day. They said, "[Care staff] say they haven't time to keep messing about and put my clothes on from the previous day. I don't like this at all."
- People and their relatives described occasions where poor quality care had impacted on their wellbeing. For example, one relative described how their family member had been washed with cold water, affecting their emotional wellbeing.
- People's properties were not always treated with respect. On occasions, people's doors and key safes were damaged by care staff.
- It was not clear how people were supported to maintain or gain their independence. People's care plans did not always provide information to guide staff about what they were able to do and what they needed support with.
- People's diverse needs were not always considered or well recorded.

We found no evidence that people had been harmed. However, the provider had failed to provide appropriate care to meet people's needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A representative from the provider advised staffing had been significantly affected at times due to staff self-isolating due to COVID-19 in-line with government guidance, impacting on the service's ability to provide person-centred care.

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

- People told us they were not always supported to make their own choices regarding their daily routines and their preferences were not always respected.
- People's care records did not always include information about people's mental health needs to guide

staff in how to support them and monitor their emotional wellbeing.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People did not always receive care which reflected their needs and preferences. They told us this caused them stress and had a negative impact on their wellbeing. One person said, "If no-one turns up I get stressed and the time changes stress me." A relative told us, "We've asked for [family member] to have regular care staff as it causes [family member] to be anxious."
- People often received care visits either early, late or in some instances the care visit was missed.
- People told us late care visits were not always addressed by the provider in a timely way.
- People's care plans were not always developed to reflect their individual needs and circumstances.
- Care plans and daily care records contained standardised information with limited evidence of person-centred care.

We found no evidence that people had been harmed. However, the provider had failed to have robust systems in place to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Basic information about people's communication needs was included in their care plans. Further work was needed to show compliance with the AIS. For example, including details of what format people required information in to access it.

We recommend that the provider reviews the AIS guidance and implements this.

Improving care quality in response to complaints or concerns

- People, relatives and staff did not always feel able to raise concerns with the provider or confident these would be listened to. Some people and relatives expressed a fear of reprisal if they complained.
- People and their relatives were not always satisfied with how complaints were investigated, addressed or responded to. One relative said, "The director says they're sorry but doesn't resolve the situation."
- The provider did not always follow their complaints policy. The policy did not give people clear guidance

on how to take their complaint further if needed.
● It was not clear that the provider recorded and addressed grievances raised by staff appropriately.
● We could not be assured that the provider took action in response to complaints and learnt lessons to make improvements.

We found no evidence that people had been harmed. However, the provider had failed to investigate and take action in response to a complaint and have effective systems for handling and responding to complaints. This put people at risk of harm. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● The provider was not well prepared for caring for people needing end of life care. The provider's records showed staff had not received training in end of life care to prepare them for providing effective care.
● Where the provider had been commissioned to support people at the end of their life, information to guide staff delivering this care and meeting people's preferences was not sufficiently detailed to enable staff to provide this care.

We found no evidence that people had been harmed. However, the provider had failed to provide care appropriate to people's needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were at risk of harm as effective systems were not in place to monitor quality and safety across the service.
- The provider's quality assurance system was ineffective and did not identify issues we found during inspection or drive improvement. For example, the provider's records of late and missed care visits did not highlight the concerns we found from feedback from people, relatives and staff and care visit records.
- The provider did not have appropriate policies in place to support good practice, including their medicines, learning disability and autism, supervision, appraisal and complaints policies.
- Widespread concerns were identified in relation to the quality of care people received. This included in relation to the timing of people's care visits and organisation of people's care.
- Roles, responsibilities and accountability were not clear within the provider's management and staffing structure. The service had two registered managers in post, who were responsible for the management of the service. They did not always fulfil their management duties. A finance director took on these responsibilities, including addressing complaints from people and their relatives, attending safeguarding meetings and responding to CQC requests for information, bypassing the registered persons.
- Office staff described being assigned to complete care visits, which impacted on their ability to perform their office duties. One member of staff told us, "Your diary will never be completed because you'll get dragged off to do something else."
- Staff described feeling under pressure to work long hours with little or no breaks. This impacted on staff wellbeing.
- The provider did not acknowledge the shortfalls found during this inspection or provide information about the action they would take to ensure the necessary improvements were made.

The provider had failed to assess, monitor and improve the quality of the service. This placed people at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and their relatives had limited opportunities to provide feedback on their experiences of using the service. One relative said, "We have had a questionnaire last week, we filled it in. They seem to listen but don't do anything to remedy things."

● Staff had limited opportunities to share learning and suggest changes to the service. Team meetings did not take place.
● It was not clear that the provider had an effective phone or communication system in place to support communication with people, their relatives and staff. People, relatives and staff all reported instances where they had not been able to make contact with the office.
● The provider did not always understand their responsibilities or those of other professionals. This included their responsibility to report and respond to safeguarding concerns and complaints.
● The provider did not always provide information to other organisations when requested. This included, when information was required as part of safeguarding investigations and contractual agreements with the local authority.

The provider had failed to seek and act on feedback for the purposes of continually evaluating and improving services. They had also failed to have established and effective systems to ensure good governance. This placed people at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider told us they had made changes to their phone system to improve communication with people, their relatives and staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● People told us the service was not well led. One person said, "This company is shambolic. The carers are fine but the organisation is rubbish."
● The provider's vision and values for the service were unclear and did not always promote a positive culture. One staff member told us, "Staff are more bothered about where they are going on their care run rather than what they are doing."
● A large number of concerns were expressed by people, relatives and staff about a variety of issues.
● The registered managers and provider did not appear to understand their duty of candour. The provider did not always apologise to people following issues with their care. It was not clear that they provided open and transparent information to people and their relatives.

Failure to assess, monitor and improve the quality of the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure service users received appropriate care to meet their needs and preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with the Mental Capacity Act 2005. 11 (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide care and treatment in a safe way for service users, assess risks to their health and safety and do all that was reasonably practicable to mitigate those risks. The provider failed to ensure the proper and safe management of medicines. They failed to assess, prevent and control the spread of infections. 12(1)(2)(a)(b)(g)(h)

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure service users were protected from abuse and improper treatment and to ensure effective systems were in place to prevent abuse. 13(1)(2)

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of service users were met. 14(1)(2)(b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure all complaints were investigated and that action was taken in response to any failures identified. They failed to have effective systems in place to identify, receive and respond to complaints by service users, relatives and staff. 16(1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place to ensure good governance and assess, monitor and improve the quality and safety of the service. They failed to seek and act on feedback to evaluate and improve services. 17(1)(2)(a)(e)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were suitably qualified, competent and skilled and received appropriate support, training and professional development. 18(1)(2)(a)(b)