Diyana Ltd

Care-D/UK

Inspection report

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26 April 2022
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10 May 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Care-D/UK is a home care agency providing personal care to people living in their own houses and flats. At the time of our inspection there were 25 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. The provider told us 14 people were supported with personal care.

People's experience of using this service and what we found
Staffing levels, deployment and monitoring of visits were inadequate to meet people's assessed care and support needs. There was limited action taken to reduce the impact on people of regular missed or late calls. Some risk assessments were insufficiently detailed. There was no analysis of safeguarding themes and trends to reduce the risk of reoccurrence. Staff were not always recruited safely. People told us staff did not always wear personal protective equipment (PPE) in line with government guidance. It was not demonstrated lessons had been learned from the last inspection.

Whilst people received an assessment of their needs and preferences when they joined the service, it was not demonstrated how people's need were consistently met following frequent late, missed and shortened visits. People gave mixed feedback about care workers. Whilst some were described as kind and caring, this was inconsistent. The provider did not schedule visits in a way that always enabled staff to provide a caring service. People described being rushed, having to rely on family and friends, or trying to carry out their own care unsupported when staff did not arrive.

Care plans were in place and being reviewed. However, records were not always completed, which meant changes to people's care needs might be missed. The provider logged and responded to complaints. However, there was no effective action to address the main underlying cause of complaints which were late, missed and shortened calls.

Systems and processes for governance, oversight and improvement were not comprehensively established or embedded. Actions the provider told us had been taken since the last CQC inspection had not all been implemented effectively. Audits did not always identify concerns or show the action to take as a result. Mechanisms for engaging with people and seeking feedback about the quality of the service were not effective.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff received training to support them in their role, including for specific health needs such as diabetes and

epilepsy. Staff received 'spot check' supervisions whilst carrying out visits. The provider worked with other health and social care professionals. Staff could explain the steps they should take to support a person's privacy and dignity. A policy was in place for meeting the Accessible Information Standard and for end of life care. Most staff told us they felt supported by management.

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 15 January 2021) and there were multiple breaches of regulation. 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 review recruitment files to make sure safe recruitment checks were carried out. At this inspection we found the provider had not improved recruitment processes.

This service has been rated requires improvement or inadequate for the last two consecutive inspections.

Why we inspected
We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

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 and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse or improper treatment, staffing numbers and deployment, recruitment practices and governance and oversight of the service.

We issued two Warning Notices as a result of our findings at this inspection.

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 authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Care-D/UK

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 carried out by two inspectors and one 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 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. The registered manager is also the owner and provider of this service.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 26 April 2022 and ended on 10 May 2022. We visited the location's office on 29 April 2022.

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. We used information gathered as part of monitoring activity that took place on 21 March 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 eight people to gain their views about the service. We also spoke with six people's relatives or advocates. We spoke with seven members of staff, including care workers, senior care workers, the finance manager, the administrator, and the registered manager, who is also the provider. We reviewed three people's care plans, two staff recruitment files and a variety of policies, procedures, audits and other systems used for managing 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 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

At our last inspection systems to assess and manage concerns and risks were not robust to keep people safe, placing people at risk of unsafe care. This was a breach of regulation 12 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 12.

- At the last inspection people experienced late, missed and shortened visits. An electronic call monitoring system was in place but was not used effectively. At this inspection, limited action had been taken to address these concerns, placing people at potential risk.
- People told us they did not receive their visits as planned. One person's relative told us, "We've had a lot of problems with missed visits and late calls." Another person's relative said, "There are times when they [the care workers] just don't come. If the carers don't visit it means [my person] doesn't get a wash."
- One person who should receive a 30 minute visit said, "Some [care workers] stay with me, some don't, and are gone in 15 minutes." Another person told us, "They [Care/D-UK] charge me for 45 minutes but usually only stay for 20 minutes." This was reflected in electronic records reviewed, for example, a 30 minute visit was completed in nine minutes.
- At our last inspection we found risk assessments were not always sufficiently detailed to guide staff on how to respond when incidents took place. Whilst there had been improvements in some areas, such as what to do when someone has a seizure, this approach was inconsistently applied.
- One person's care plan showed they were prone to falls. However, the only information recorded on the care plan was "Ensure that [person] is able to move around the home as much as they wish using whatever aids are appropriate." This did not tell staff how to safely mitigate this risk.

Preventing and controlling infection

- Staff confirmed they had access to personal protective equipment (PPE). One staff member told us, "We have enough supply of PPE. I wear a mask, gloves and apron."
- Staff received training in infection prevention control, including the management of COVID-19. This had not been effective in ensuring staff followed up to date guidance to mitigate the risk of infection.
- However, some care workers did not wear PPE in a way that followed government guidance, and people we spoke with were not confident staff always washed their hands. This placed people at the risk of infections, including COVID-19.
- One person told us, "They wear blue overalls and gloves but not masks now." Another person said, "Now

they just wear their uniform. Some of them wear masks but I would rather they all wore them."

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, including the impact of missed and late visits and poor infection control. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised our concerns about PPE with the provider to follow up during the inspection. The provider told us they would take action to ensure staff understood current government guidance on the use of PPE.

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

At our last inspection systems were either not in place or robust enough to ensure that appropriate actions had been taken following safeguarding concerns, placing people at risk of harm. This was a breach of regulation 13 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 13.

● At the last inspection, the provider did not recognise and act upon the potential safeguarding implications of missed and late calls. We also found staff did not always keep accurate records of the care and support provided to support any investigations. These concerns had continued.
● There was also still no meaningful analysis of safeguarding themes and trends. The provider had failed to reduce the risk to people and learn lessons from incidents, exposing people to the potential risk of harm.
● Staff received training in safeguarding but could not always explain the steps they would take to escalate concerns externally. This was a continued concern from the last inspection.
● A safeguarding policy and procedure was in place, but referred throughout to an incorrect local authority area, which could cause confusion about who to contact in the case of suspected abuse or neglect.
● Lessons had not been learned from the previous inspection and numerous shortfalls had not been addressed.

Systems and processes were not established and operated effectively to safeguard people from the risk of abuse or improper treatment. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised an organisational safeguarding alert with the local authority following feedback from people using the service about missed and late calls and the quality of the care.

Staffing and recruitment

At our last inspection we recommended the provider review all recruitment files to ensure they meet Schedule 3 of the Health and Social Care Act 2008 and demonstrate safe recruitment practices. The provider had not made improvements.
● Staff files did not always demonstrate the provider had checked staff were safe and suitable for the role.
● We found gaps in employment history that had not been explored, references not completed and a member of staff without a current Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● We raised this with the provider, who told us staff without a DBS or references only shadow visits and do not work alone. However, they were unable to demonstrate this using electronic call monitoring records or written logs.
● One staff recruitment file suggested the staff member was working in a number of different jobs. This had not been followed up to check they were working a safe number of hours, or to check for any potential cross-infection risk during the COVID-19 pandemic.

Recruitment procedures were not established and operated effectively to ensure the safety and suitability of persons employed. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were insufficient staff deployed to meet people's care and support needs and ensure safe, good quality and person-centred care.
● One care worker told us, "There are not enough staff here and there haven't been enough for a while." Another care worker said, "There are definitely not enough staff. There are enough of us if there was an emergency but there are not enough of us on the rota."
● Staff were not deployed or monitored effectively. For example, one rota showed a care worker had been scheduled four morning care visits starting at the same time on one day. Another staff member told us, "It is a struggle sometimes. Everyone wants 8.30am-9am [visit times] but if you have nine clients to go to [in the morning] you're going to have issues."
● We raised this with the provider who told us staff were 'double booked' because people did not need the amount of time they were assessed to require. This did not reflect feedback from people.
● Electronic call logging systems showed the location of staff when they 'logged in' to a visit did not always correlate with the person's home address. Some visits were counted as 'started' despite the staff member being over a mile away. This meant records were inaccurate.
● The provider told us staff were not cooperative with accurately logging visits. However, the provider was not following its own policy and procedure for poor staff conduct in response to missed and late calls.

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

● The provider told us they had experienced challenges with staff recruitment and retention and had covered care visits during periods of high staff absence. They had also applied for a sponsor licence for workers from overseas.

Using medicines safely
● At the time of inspection, the service was not responsible for directly administering medicine to people. However, the impact of missed and late visits caused uncertainty for people, for example where people needed to eat before taking their medicines.
● Where people were reminded or prompted to take their medicines this was recorded on their daily care notes. However, as the notes were not being consistently completed it was not always clear whether people had taken their medicines as prescribed.
● One person's relative said, "We have to go in and check things like if [person] has had their medication, food and fluids. Staff are supposed to supervise medicines, but we have found a tablet on the floor."
● We informed the local authority safeguarding team of our concerns about medicines.

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 requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People received an assessment of their needs and preferences when they joined the service. This included information such as people's medical background, medicines, preferences and personal care needs.
- However, the provider could not demonstrate how people's needs, preferences and choices were consistently met due to frequent late, missed and shortened visits.

Staff support: induction, training, skills and experience

- Staff received an induction and training when they started working for the service. One staff member told us, "I did have an induction and various different training including manual handling, safeguarding and infection control."
- Records showed staff received training on specific health conditions such as diabetes and epilepsy, to develop their knowledge and understanding.
- However, the system used for showing which staff had completed training was out of date and did not include an accurate list of staff currently employed.
- Staff received spot checks where their performance was assessed during visits to people, and feedback provided.
- Staff told us they were not always given regular formal supervisions as well as spot checks, to support their development. One member of staff told us, "I don't know how often they do them [supervisions] to be honest." Another care worker said, "I do not know what a supervision is, and I don't think I have ever had a 1:1 with my manager, but if I need them, they come."

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

- Care plans recorded people's preferred food and drinks for staff. For example, one person's care plan said, "Carers to help with preparing meals for [person] in the morning for breakfast. Make [person] toast or crumpets with butter and jam, with a cup of tea."
- However, due to missed and late calls it was not demonstrated support with food and drinks was consistent.
- One person told us, "Sometimes I'm waiting until 1pm to get washed, dressed and have my breakfast." Another person's relative said, "It means mealtimes are late for the rest of the day."
- Poor record keeping also created a risk people were not receiving enough to eat and drink throughout the day. One person's relative told us, "Carers have been instructed to write all details of food and fluids down in the folder in house, which doesn't always happen."

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

● The provider worked with other organisations and agencies, such as GPs, occupational therapists, paramedics and the local authority.

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 provider told us that most people currently being supported had the capacity to provide consent. Information was recorded in people's care plans where this was not the case, including the details of any legal representatives.

● Care plans recorded the need for staff to gain consent from people using the service before carrying out any care or support.

● Staff could explain how they worked within the principles of the MCA. One care worker said, "I know about the Mental Capacity Act and that we need to have meetings about decisions when service users can't make their own decisions."

● However, there was no evidence of formal capacity assessments or detailed best interests decision making within the care plans of people living with dementia.

● We asked the provider to ask people's consent to speak with us during the inspection before telephone calls were made. This had not been carried out as all the people we spoke with told us they were not expecting a telephone call.

● People gave us mixed feedback on staff practice around providing choices. One person told us, "[Care workers] ask me if I want a shower or a wash." Another person's relative said, "They don't automatically give [my person] choices." We raised this with the provider to follow up.

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 requires improvement. At this inspection the rating has remained 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

- The impact of staffing levels and poor planning or deployment meant people were not always supported in a respectful way. This was a continued concern from the last inspection.
- One person's relative told us, "Bar one, the other carers are quite shocking in terms of speed. Some carers get [my person] out of bed, washed and dressed in 10 minutes. Another person said, "They [the care workers] try to rush me, and I have to tell them to stop and wait because I'm out of breath."
- The effect of late, missed and short or rushed visits impacted negatively on people's wellbeing. One person said, "It means I have to struggle to get washed and dressed [by myself] at a very, very slow pace."
- Despite the provider failing to ensure systems were in place to enable a caring service, some of the care staff were described as being kind and compassionate. One person's relative said, "[My person's] usual carer is an angel and stays for the full amount of time." However, this was not consistently the case.

Respecting and promoting people's privacy, dignity and independence

- Staff could explain how to support people's privacy and dignity. One staff member said, "I would make sure doors are closed if giving [a person] a shower or helping with any other personal care."
- Despite this, we received mixed feedback about the staff team, and supporting people's dignity when rushing visits. One person told us, "Most of them [the care workers] are lovely but some aren't very caring. They do personal care in a hurry and just go." Another person's relative told us care workers did not remove their coats during care visits.
- People's relatives told us they could not always rely on the service to provide the care and support required for people to be independent. One person's relative said, "It makes it difficult for me to be confident to leave [my person]. I can't rely on the carers to come three times a day."

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

- The provider carried out checks with people to see whether they were satisfied with the quality of the service. However, concerns raised during the inspection showed this was not effective.

Whilst we found no evidence people had been harmed, the provider did not demonstrate they had taken all reasonable steps to make sure that people using the service were always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; 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

- The provider had not planned care to meet people's needs in terms of when they could expect a visit, and oversight of this was chaotic. One person said, "I find out sometimes they forget to put my name down for a visit." Another person said, "I have no rota. I have no idea who is going to come and at what time."
- One staff member said, "We have a window of visits between 6am-11am, any time between them is a morning call." The impact on people's wellbeing caused by staff making ad hoc decisions about visit times had not been considered.
- Very late morning calls were also disruptive to people's days. One person's relative told us, "[Care workers] don't turn up until midday sometimes, which means [my person] gets themself out of bed and sits waiting in their nightclothes for hours."

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.

- An Accessible Information Standard policy and procedure was in place, and information was available in different formats upon request.
- It was recorded in people's care plans if they required any aids such as glasses to access information.

Improving care quality in response to complaints or concerns

- Although the provider was logging and responding to complaints, they had failed to address the underlying cause of persistent missed and late visits. One person's relative said, "I have raised issues in the past and they [the provider] has tried to resolve them, but they just haven't got enough staff."
- The provider did not carry out any analysis of themes and trends in complaints, to demonstrate how they acted to improve the service in response to people's feedback.
- Information needed for people to complain was not clear. The service user guide referred to both Loughton and Southend-on-Sea social services and did not give contact details for the CQC or the Local Government Ombudsman for further external escalation.

End of life care and support

● A policy and procedure for end of life care planning was available to staff.
● At the time of inspection, the provider told us there was no one who was receiving end of life care. However, it was not demonstrated any plans had been put in place for people's changing needs.

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 systems and processes were not robust enough to demonstrate quality and safety were effectively managed. This placed people at risk of harm. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider could not demonstrate oversight of the quality and safety of the service. This had led to the local authority commissioners placing a suspension on the service, which had not been lifted at the time of inspection.
- Audits carried out were not effective, and there was no clear action plan linked to observations made. For example, an audit of one person's daily care notes showed no entries for nine care visits over the course of eight days. There was no evidence this had been followed up.
- Information requested for review as part of the inspection was not provided in a timely way.
- It was not demonstrated the provider was reviewing and analysing missed and late calls. There was no oversight or accurate information on whether visits had been completed as planned, which could impact on 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

- A duty of candour policy was in place setting out the need to be open and transparent when things go wrong.
- However, as the provider had failed to recognise the serious impact of persistent missed and late calls on people, concerns had not always been investigated fully. This meant they were unable to be open with people and apologise if necessary.
- Inaccurate call logging by staff did not show transparency in terms of visit times, an indicator of a potential poor or closed staff culture. No effective action had been taken by the provider to resolve this.

Continuous learning and improving care

● Limited action had been taken to resolve shortfalls identified at the last inspection, and the provider remains in breach of multiple regulations. The provider had failed to meet many of its own action plan objectives. This meant people continued to receive poor care.

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

● People gave mixed feedback about regularity of communication from the office and confidence in management. One person's relative told us, "[The provider] seems nice enough but I don't really think they are very good at managing their team."

● The provider had carried out a recent survey for people using the service which recorded positive feedback. However, this did not concur with negative feedback provided to the CQC or to the local authority. This had not been explored by the provider to understand reasons why.

● Some people's relatives told us they were not confident action would be taken if they shared concerns, or were worried to speak to the service, One person's relative told us, "I don't want any backlash for [my person]."

We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the provider told us they would introduce anonymous surveys to allow people to provide their view on the service more openly.

● Staff received training in equality, diversity and human rights.

● Despite concerns about oversight and management of the service, most staff told us they felt supported by the provider, and regular team meetings were held. One staff member said, "[The provider] really listens and always takes on our advice and feedback."

Working in partnership with others

● The provider was working with the local authority, completing an action plan to try to drive improvement at the service.

● The service worked alongside other relevant professionals such as GPs, occupational therapists and district nurses.

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 Whilst we found no evidence people had been harmed, the provider did not demonstrate they had taken all reasonable steps to make sure that people using the service were always treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, including the impact of missed and late visits and poor infection control. This placed people at risk of harm.

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 safeguard people from the risk of abuse or improper treatment.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure the safety

and suitability of persons employed.

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 We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed.

The enforcement action we took:

Warning notice

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

The enforcement action we took:

Warning notice