Continuity Healthcare Services Ltd

Continuity Healthcare Services Private Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Continuity Healthcare Services Private Limited is a domiciliary care agency providing personal care to adults in their own homes. This includes people with dementia, learning disabilities or autistic spectrum disorder, mental health needs, sensory impairments and physical disabilities. 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. At the time of inspection, the provider was unable to confirm the number of people it was providing personal care to and stated figures between 319 to 340 people.

People's experience of using this service and what we found
There had been significant changes in the staffing structure of the service since August 2021. The provider failed to have sufficient oversight of the changes, which meant governance systems were not established and events which called into question people's safety were not always identified and managed to protect people. The provider was not aware of many of their legal responsibilities as the registered person.

There were significant gaps in training for all staff and senior staff told us they had not received essential training required for their role when they started work.

The provider was unable to demonstrate whether there were sufficient numbers of staff to meet each person's scheduled care calls.

People's medicines were not always administered as prescribed. There were no processes in place to manage how people received their time critical medicines. There was no system in place to ensure staff always recorded when people received their medicines.

It was not clear if people were supported to have maximum choice and control of their lives and if staff supported them in the least restrictive way possible and in their best interests, because there were no policies or systems in place to 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 autistic people. We were not assured people were supported to make decisions about their care and welfare in their best interests.

People had conflicting views about whether staff supported them in a caring way. People were involved in their assessments and decisions regarding care planning. One person told us, "I was involved and a person from the office visited to check what was needed." However, people's care plans did not always include risk mitigation plans for people with specific health conditions, or guidance for staff about how to care for people safely.

People felt able to raise any concerns with staff. However, complaints had not been managed in accordance with the provider's policy.

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

Rating at last inspection
This service was registered with us on 22 April 2021 and this was the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about missed care calls and increased 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 all the sections of this full report for details.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care, safeguarding, good governance and employing fit and proper person's, at this inspection.

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.

Follow up
We wrote to the provider and requested some information to be sent to us urgently and asked what they were going to do to mitigate the risks identified and to keep people safe. The provider responded demonstrating some immediate actions taken.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Continuity Healthcare Services Private Limited

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 who visited the service and two Experts by Experience who made telephone calls to people who used the service. 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. 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 no registered manager in post. However, an acting registered manager was promoted internally in November 2021 and they are referred to as the manager in this report.

Notice of inspection
We gave a short period of notice of the inspection to ensure the manager and provider were available. Inspection activity started on 3 May 2022 and ended on 23 May 2022. We visited the office location on 4 and 11 May 2022.

What we did before the inspection
We reviewed information we had received about the service since it registered with CQC and sought

feedback from the local authority and commissioners 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 refer to the Well Led section of the full inspection report for further details.

During the inspection.
We looked at 14 people's care plans, four recruitment records and a variety of information relating to management of the service. The inspectors spoke with 19 staff including the provider, the manager, the chief operating officer, two team coordinators, an administration assistant, a human resources administration assistant, the administration executive, the operations and business development manager, the risk and safety manager, the risk and safety officer, the quality and customer services officer and nine care staff. We also received written feedback from an additional two members of care staff. The Experts by Experience contacted 27 people and their relatives by telephone to gather feedback of their experiences of the service. An inspector telephoned one relative to obtain their views of 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.

This is the first inspection of this newly registered service. This key question has been rated 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

- The inspection was prompted in part due to concerns around an increase in safeguarding events during December 2021. We were not assured safeguarding concerns were managed appropriately because we found some safeguarding events had not been identified or managed to ensure people were made safe in a timely way.
- We identified two allegations of abuse which had not been managed appropriately and had not been referred to the local authority safeguarding team or CQC. The manager conducted a retrospective investigation into the concerns and referred the information to the local safeguarding authority and the CQC.
- The manager told us they were responsible for managing safeguarding events and referring concerns to external agencies. However, they told us they had not read the provider's safeguarding policy and there were gaps in their knowledge about how to manage safeguarding events, including staff disciplinary processes. For example, no action was taken following a safeguarding incident to protect one person until six days after the event, following advice from an external agency. The person was made safe following the delay, however, the provider failed to ensure the staff disciplinary process was followed to prevent future failures of this nature. We asked the provider to take further action to complete the staff disciplinary process. The provider told us the staff no longer supported people at the service, but has not yet confirmed they have taken steps to finalise the disciplinary process to protect people.
- The provider did not have a clear procedure to manage safeguarding events. Therefore, information about events was shared inconsistently with the manager and information was often shared verbally by staff. When events were recorded, it was not always clear what actions had been taken, the reason why and what lessons had been learnt. The local safeguarding authority contact details were not readily available to staff or customers to use if they needed to raise a concern.
- Staff told us, and records confirmed, staff, including senior staff and the manager, had not received safeguarding training to ensure they knew how to recognise and report signs of abuse. For example, senior staff whose responsibility it was to initially assess people's needs before their support started, told us they had not had mandatory training, including safeguarding training since they began their role in November 2021 and confirmed this was a gap in their knowledge.

This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of our inspection visit, senior staff were provided with safeguarding training.

Assessing risk, safety monitoring and management

● The inspection was prompted in part due to concerns around missed care calls, where staff did not attend people's homes to provide care. One person received no care calls for 7 days, leaving them at serious risk of harm. Other instances of missed calls were due to a failure to set up care calls when people first started using the service. The provider agreed that missed calls had put people at risk.
● The provider failed to have a procedure in place to direct staff on how to monitor and manage late or missed calls. There was no record of late or missed calls and staff told us these events were shared inconsistently and often verbally between staff. We shared these concerns with the manager following the first day of our visit and they told us they were putting a new process in place to improve the way calls were monitored and managed.
● Although staff told us there had been no missed calls since January 2022, people's care records showed both late and missed calls. For example, one person received multiple late calls in April 2022 and these had not been identified. In addition, this person required two carers to support them and records showed that only one carer attended their calls on several dates in April 2022. This placed the person at risk.
● Risk assessments and risk mitigation plans were not always in place or were not effective, in protecting people who had specific health conditions such as diabetes, risks of choking and catheters. For example, catheter plans did not state the signs of infection, and what staff should do if the catheter site became infected. This meant we were not assured staff were provided with sufficient information to care for people safely.
● Some care plans and risk assessments for specific needs were produced for people following the first day of our inspection visit. However, one person's catheter care plan was not consistent with their risk assessment, which meant staff were provided with conflicting information about how to support the person safely. Following our inspection visit the manager told us all care plans would be reviewed by 15 July 2022 to identify any missing information.
● It was not clear if reviews of risks and people's health were taking place regularly. This meant we could not be assured care records reflected people's current needs.

Using medicines safely
● Medicines were not always managed safely. The provider did not have a system in place to ensure staff always recorded when people received their medicines. People's medicine administration records (MAR) were held electronically. If staff were unable to access records on their personal phones due to poor internet connection, people's records were not updated. This meant we could not be sure people received their medicines as prescribed. We shared these concerns with the manager and provider and following our inspection visit they advised they had ensured there were paper MARs available where people had poor internet connection.
● The provider had failed to establish a procedure to identify and manage how people received their time critical medicines. This meant care calls were not scheduled at a specific frequency to ensure people received their medicines in accordance with their prescription and to prevent them from receiving too much medicine.
● One person required medicine to be given at a specific time of day, to manage their health condition of Parkinson's. Records showed on several occasions in May 2022, their care calls were not spaced out in accordance to the prescribing instructions, so their medicine could be administered as prescribed, which was a risk to this person's health.
● There was insufficient guidance available to staff on how to administer 'as required' medicines. For example, where people had topical medicine applied to their skin, there was a lack of information on people's records to guide staff on where and when the medicine should be applied.
● One person was supported to use transdermal patch medicine which was prescribed weekly. Records were not in accordance with best practice and did not show where on the body patches had been applied or removed, to prevent skin irritation. Records showed the patch had been applied three times in one week

during April, which did not follow the prescriber's instructions. This error had not been identified because the person's MAR had not been audited since the beginning of 2022. Following our feedback the manager undertook an investigation which identified this was a recording error.

Staffing and recruitment

● Some people told us they felt their care was rushed by staff. One relative told us, "[Name] sometimes feels a bit rushed." Another relative told us, "It feels like the organisation is short staffed. The rotas don't seem to take into account the length of time in between visits sometimes. For example, [Name] often gets their evening call about 7.00pm and then the breakfast call at 7.50am, which is too long when [Name's] been wearing an incontinence pad all night."

● The lack of governance around whether people received their calls on time, and for the right amount of time, meant the provider was unable to demonstrate whether there were sufficient numbers of staff to meet each person's scheduled care calls. The manager told us there were reduced staffing levels in December 2021 because some staff had left the service. They told us care coordinators had supported care calls and they had recruited new care staff to ensure people's calls were not missed at that time. The provider told us they had sufficient staff at present to support care calls, however, were not currently taking on new packages of care. A member of care staff told us some people's care packages were stopped, "Due to staff shortages, it was hard to cover them in February and March 2022". Therefore, there was inconsistent information around staffing levels and the provider was not able to demonstrate there were sufficient staff to meet people's needs.

● There was a risk people were not being supported safely because staff did not have the appropriate qualifications, competence, or skills.

● Some staff who were supporting people had not received mandatory training, including safeguarding training. One member of staff told us they had not had any training or checks of their performance, since returning to work following an absence. They told us they worked alongside experienced staff. Records showed their mandatory training was carried out three years ago and had not been refreshed, they had not received a medicine competency check although they administered people's medicines. We asked the manager about this and they told us if care staff's training was not up to date they would carry out care calls with staff whose training was up to date. This put people at risk.

● Senior staff told us they had not received essential training when they started work, which was required for their role. One senior member of staff responsible for maintaining people's records told us, "The only thing (training) I've done is medication." They described their training on the new electronic care planning system which they managed and told us, "People with knowledge showed us bits and bobs." This indicated gaps in the staff member's knowledge about how to maintain people's records. Some senior staff who had not received mandatory training, including safeguarding training, told us they were training other staff in key areas. There was a risk people would not receive safe care because staff had not been adequately trained.

● Significant numbers of care staff had received no training for specific health conditions such as diabetes, or end of life care. For example, 88 staff had not received diabetes awareness training. A member of staff told us they supported someone with diabetes but had received no training. However, they were able to explain some of the symptoms to look for if someone they supported became ill. There was a risk people would not receive safe care because staff had not been trained to meet people's needs.

Systems were not sufficient to demonstrate risk associated with people's care was effectively managed. Staff were not sufficiently trained to provide safe care. 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.

Following our inspection visit the provider shared their training action plan which stated all staff were to

complete mandatory training and care staff to complete training specific to people's needs by 2 September 2022.

Learning lessons when things go wrong

● The provider failed to maintain accurate records of events which called into question people's safety, so that a review and analysis of these events could take place and lessons could be learnt.

● There was no process to identify and manage events which called into question people's safety, such as late or missed calls and medicine errors. Information about events was shared inconsistently with the manager and often shared verbally by staff.

● The manager explained they had started to record incidents when they began their role. Three events had been recorded, however, it was not always clear what actions had been taken, the reason why and what lessons had been learnt. For example, one person had suffered a head wound in April 2022. Due to poor recording it was not clear what treatment they received and whether this was in accordance with the provider's accident and incident policy. We shared this concern with the manager and following the first day of our visit the manager told us they were putting a new process in place to improve the way incidents were identified and managed.

Preventing and controlling infection

● People told us care staff wore personal protective equipment (PPE) when they were supported. One person told us, "Carers wear aprons, masks and gloves and when they finish put it in a plastic bag and then in a bin."

● Over 40 staff had not received training in safe infection prevention and control for over two years or had not received it at all. However, staff we spoke with understood safe infection control guidelines.

● A member of administrative staff managed staff testing for Covid-19. However, the manager made no checks that testing was being carried out appropriately. It was not clear if staff testing was carried out in accordance with national guidance.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Safe recruitment procedures were not being followed, to ensure people received care from suitable staff of good character.
- The provider had failed to ensure the identity of prospective staff was always ascertained, by checking photographic identification.
- The provider had failed to ensure references were obtained from the person's previous or current employer if they had worked in the care sector or with vulnerable adults or children, before they were employed.
- The provider had no process to support staff to complete the Care Certificate and there was no record of other qualifications staff may have had. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The provider told us the Care Certificate had, "Not been prioritised due to the pandemic." This was not in accordance with best practice.

This was a breach of Regulation 19 (Fit and Proper Person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was mixed opinion from staff about the frequency of meetings they had with their manager on an individual basis to discuss their development. However, staff told us they could access support from their line manager whenever they needed it.

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.

- People told us staff obtained people's consent when they supported them. One relative told us, "The

carers will tell (Name) what they are doing and will ask if it is OK. They involve (Name)."
● People's capacity to make their own decisions, was assessed at the beginning of their care package with Continuity Healthcare. We were not assured people were supported to make decisions about their care and welfare in their best interests. For example, one person's family members had been asked to sign consent for their care and treatment on the person's behalf. This is not in accordance with the principles of the MCA.
● There was no evidence of decisions being made in people's best interest. For example, there was no record of consultation with people's representatives or health professionals before decisions about their care were made.
● Senior staff who were responsible for assessing people's capacity had not received any training relating to MCA. Ninety-three care staff had not received training in MCA. Following our inspection visit the manager advised training would be given to all staff by the end of July 2022.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed before they began using the service. Protected characteristics under the Equality Act 2010 were considered in people's assessment of needs. For example, people were asked about any religious or cultural needs they had and care was tailored to meet these needs. For example, the manager explained some people wanted only female care staff in accordance with their religion and this was accommodated.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people received food and drinks prepared by care staff. Staff prepared meals in line with people's choices and ensured they had enough to eat and drink to maintain their well-being. A relative gave positive feedback about how care staff supported their family member to drink sufficient fluids to maintain their wellbeing.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had been referred to other healthcare professionals to promote their wellbeing, such as the occupational therapist and the district nursing team.
● Staff told us they reported any concerns or changes in people's health to the office. One member of staff told us, "If there is a deterioration (in someone's health), for example their mobility, we record this in their logbook and inform the office." Relatives we spoke with confirmed this was the case.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- People had conflicting views about whether staff supported them in a caring way. One person told us, "I have a really lovely team with a caring attitude. Genuine people." However, a relative told us, "Some of the carers are really nice; they sing with [Name], but others are not always nice. [Name] can witter on a bit at times, and they (care staff) just ignore them and look away." Another relative said, "Some carers are good and know what to do, but many aren't and do a bad job."
- Care coordinators visited people at home to gather their views of the service. However, there was no evidence of any analysis of the data that was collected and how it was used to improve the service people received.
- Most staff felt well treated by the provider and were positive about the service they provided. However, one member of staff explained they had been treated in a negative way at work and had not felt confident to raise the experience with their manager.

Respecting and promoting people's privacy, dignity and independence

- The provider used a mobile messaging application to share confidential information about people. The application was not in line with the general data protection regulation (GDPR) and this placed people's information at risk of being disclosed to people who did not have the right to it.
- People told us when staff supported them they maintained their dignity. A relative told us, "The carers will cover [Name] when washing them and pull the curtains when they use the commode."

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

- People and their relatives had been involved with developing their care plans. One relative told us, "We were part of a discussion to put the care plan together when [Name] came out of hospital. Our views were taken into consideration and we're very happy with the care [Name] gets."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider was not aware of their legal responsibilities under the NHS's Accessible Information Standards. No consideration had been made to provide information to people in different formats to suit their communication needs.
- Staff told us because they knew people well, they could communicate with those people who had complex communication needs. However, there was no evidence in people's care plans of guidance for staff about how to communicate with people.
- A care coordinator told us about one person with a learning disability who found it easier to understand information using pictures. They explained how they had created 'social stories', using pictures to increase the person's understanding of certain aspects of their care. However, there was no communication plan or assessment of risk in the person's care records, which meant staff were not provided with guidance about how to consistently meet the person's specific communication needs. No consideration had been made about how the person might be affected when staff wore masks whilst supporting them, given their specific communication needs and this was not in accordance with the provider's personal protection equipment policy.

Improving care quality in response to complaints or concerns

- The quality assurance service officer and the manager explained there had been 11 complaints since the beginning of 2022.
- Complaints had not been recorded accurately and it was not always clear what actions had been taken, the reason why and what lessons had been learnt.
- Complaints had not been managed in accordance with the provider's policy, because people had not received a record of the outcome of their complaint.
- Two complaints contained safeguarding concerns which had not been managed under the provider's safeguarding process or referred to appropriate agencies including the CQC.
- The quality assurance service officer who was responsible for managing complaints, was supported by the manager. They had not received quality assurance or safeguarding training since they began their role in November 2021. There was no evidence of any quality assurance checks made by the manager or provider.

End of life care and support

● The service supported some people who received end of life care. The manager was unable to advise us how many people they supported with these needs. Records showed 167 staff had not received awareness training in end of life care. This included all senior staff apart from one.
● A relative gave us positive feedback and told us, "[Name] has two carers who visit four times each day and they provide end of life care. They [care staff] are very careful with [Name]…They [care staff] turn them each time they visit and they do it carefully so as not to hurt them."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Most people told us they were included in planning their care and were supported to review their care with senior staff who came to their home. One relative told us, "A few weeks ago someone [from the office] came out and discussed the care provided with [Name] and [Name] said they were happy with it."

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider demonstrated no oversight of the service and told us they had carried out no quality assurance checks on the service since April 2021. They had been out of the country from that time until April 2022. They advised us they did not feel they had the skills to be a nominated individual or to oversee the manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
- The service had no registered manager and there had been significant changes in the staffing structure since August 2021. The previous registered manager left in October 2021. The current manager was promoted internally to become acting registered manager in November 2021. The chief operating officer told us there had been a stable staff group until the previous manager left in October 2021 and the service was "Still recovering from that." They acknowledged some processes were not in place and were currently being implemented and, "Still bedding in." Staff were confused about their roles because they had been given new responsibilities in a restructure in 2021. Staff called each other by different job titles and gave inconsistent information about what their responsibilities were.
- The manager and provider had little knowledge of the people supported by the service. We found it difficult to obtain information about people's care needs during our inspection visit due to their lack of oversight. For example, the provider was unable to confirm the number of people the service supported with personal care, or the number of staff they employed.
- The provider was not aware of their responsibilities as the registered person. For example, the provider had not returned the provider information request to us, which was requested on 16 February 2022.

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

- The provider and the manager were not aware of the registered person's statutory responsibilities to notify the CQC of important events. The manager told us they had identified that six retrospective death statutory notifications were required. In addition, two safeguarding concerns had not been identified and notifications had not been submitted to CQC in a timely way.
- The provider and the manager were not aware of their legal responsibilities under the NHS's Accessible Information Standards.
- The manager told us they had not received a one to one meeting with their manager to discuss their progress and development since they began their current role. The manager acknowledged they had gaps in their knowledge including, staff recruitment processes, managing staff performance issues safely,

safeguarding and the complaints process. The provider had demonstrated no oversight of the manager's performance or development, which meant the provider's legal responsibilities were not being carried out.
● The provider had no process in place to identify and manage events which called into question people's safety, including late or missed calls, medicine errors and safeguarding events. Two safeguarding concerns had not been identified and managed appropriately. There had been an increase in safeguarding events in December 2021 where people had been at risk of harm due to missed care calls. When we discussed this with the manager they told us the increase in events was due to, "New staff and job roles were changing." They were, "Finding their feet." Senior staff had not been trained in safeguarding before our inspection and the manager had not read the provider's safeguarding policy. Following our inspection visit the manager investigated some concerns we raised. However, there was no evidence the safeguarding process had been improved or that all the safeguarding incidents we identified during our visits had been investigated by the manager or the provider and that appropriate referrals had been made where required following our visit.
● Medicines were not always managed safely. The provider did not have a system in place to ensure staff always recorded when people received their medicines. There was no process in place to identify and manage how people received their time critical medicines.
● The lack of governance around whether people received their calls on time, and for the right amount of time, meant the provider was unable to demonstrate whether there were sufficient numbers of staff to meet each person's scheduled care calls.
● Records were not accurate or complete. For example, care records did not contain management plans and risk assessments relating to some people's specific needs such as diabetes and learning disabilities.
● The manager, the provider and senior staff gave inconsistent information about how care records were stored, whether electronically or on paper. They told us care records had been transferred from a paper to electronic format recently, however, there was no plan in place to manage the transfer of information. Care staff explained there were difficulties recording care call information on the new electronic format because the application did not work in everyone's homes. It was not clear whose records were recorded electronically or on paper, or how records were checked for accuracy.
● People's personal data was not held in accordance with GDPR because staff used a mobile messaging application to share confidential information about people. The provider was not aware of the risk that people's confidential information could be disclosed to people who did not have the right to access it and had continued to use the application.

Continuous learning and improving care;
● Quality Assurance processes were not in place and were not effective. The provider told us they had not had oversight of audits since April 2021.
● One person who was supported with a transdermal patch, had not had their medicine administration records checked by staff at all in 2022. We identified multiple errors on their records which had not been identified or managed by staff. The quality assurance service officer told us audits on people's medicine records had not been carried out in January and February 2022, when records were transferred to the new electronic application. However, this did not explain why this person's records had not been checked at all in 2022. There was no evidence of any oversight of the audits by the manager or the provider.
● There was no evidence of audits of people's daily records. Senior staff told us audits were carried out on people's communication logs, however they were unable to provide us with evidence of this. We requested a copy of the communication log audit relating to one person's care between particular dates in April 2022, because we had identified late and missed calls for this person. Staff could not provide us with any audits of this person's daily records including care call times. There was no system in place to check calls had been carried out in accordance with the person's care needs.
● There was no evidence of any oversight by the provider or manager that spot checks had been made on care staff to quality assure their performance. Some staff told us they had not been observed recently or had

a recent medicine competency assessment. The provider's records confirmed 24 staff had never received a medicine competency check, which placed people at risk.
● There was no evidence quality assurance checks were made by the manager or provider to ensure complaints had been managed in accordance with the provider's policy.
● There were significant gaps in training for all staff and senior staff told us they had not received essential training required for their role when they started work. This meant there was a risk staff did not have the skills to support people safely or to carry out their role effectively.

Working in partnership with others
● The provider had failed to make improvements to the service in line with feedback from the local authority commissioner following an increase in safeguarding concerns in December 2021. They had failed to provide all the requested information or make the required improvements in accordance with their contract with the local authority. As a result, the local authority had taken action against the service to reduce the number of care packages they provided. The provider had not supported the manager to be aware of the content of the improvement action plan.

The provider failed to have oversight and governance systems were not established or effective. 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.

Following our inspection visit the manager shared their plans to introduce new processes and audits to improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● No quality assurance surveys had been carried out since the service had been registered. However, people told us senior staff visited them at home and asked for their opinion of the care they received. We saw evidence of these visits, however, there was no analysis of the information collected to help improve the service.
● There had been only one meeting for care staff in 2022. This had not been fully inclusive and had not included all staff members.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff gave us mixed opinions about feeling supported by the provider. Some staff told us they had not received regular one to one meetings with their manager to discuss their development.
● Most relatives were satisfied with the service provided and spoke positively about the manager. Two relatives told us, "Very good care except for the timings issue" and "Average to good care. The only concern is that the carers are rushed at times."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure systems and processes were in place to prevent people from abuse or to investigate immediately on becoming aware of an allegation of abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have procedures in place to ensure staff were of good character. Regulation 19 (1) (2) (3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to identify and mitigate such risks. The provider did not ensure staff had adequate qualifications, competence and skills to provide safe care. The provider did not ensure the safe management of medicines. Regulation 12 (1) (2) (a)(b)(c)(g)

The enforcement action we took:

We served a Warning Notice on the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems or processes operated effectively to assess, monitor and improve the quality of the service and mitigate the risks relating to the health, safety and welfare of service users. The provider had not maintained accurate and complete records in respect of each service user or staff employed. The provider had not evaluated or improved their practice in respect of all the above. Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

We served a Warning Notice on the provider.