Health Vision UK Limited

Healthvision - Hounslow

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Healthvision Hounslow provides a range of services to people in their own home including personal care. Most of the people who used the service were older people, some of whom were living with the experience of dementia. The majority of people were funded by the local authority.

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. At the time of our inspection, 109 people were receiving personal care.

People's experience of using this service and what we found
During the inspection we found the management of risks was not always effective as risk management plans were not always developed to provide care workers with guidance on mitigating the identified risks. Medicines were not always managed appropriately to help ensure people received their medicines safely. Care workers were not always appropriately deployed so that care visits were carried out at the planned time and for the length of time allocated. Robust COVID-19 risk assessments were not completed.

We found a few shortfalls around the arrangements relating to infection prevention and control and we have recommended the provider follow the government guidance in relation to risk assessments.

People were not always 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.

Care plans were not always person centred or updated appropriately to meet people's current needs. Communication and end of life care plans were not robust enough to meet people's individual needs.

Safe recruitment procedures were not always followed. The provider had systems in place to monitor, manage and improve service delivery, however these were not always effective.

The provider had procedures to safeguard people from the risk of abuse and systems in place to record safeguarding alerts, complaints, and incidents appropriately.

Staff followed appropriate infection prevention and control practices. Care workers were supported in their roles through training and supervision, but we have made a recommendation about reviewing the training of staff, including new staff so they all have the skills and knowledge to care for staff safely.

Most people and relatives reported senior staff or managers were available and responsive when they contacted the office or when they needed support.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 July 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up on action we told the provider to take at the last inspection.

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.

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

We have identified breaches in relation to person centred care, the need for consent, safe care and treatment, good governance, staffing and fit and proper persons employed.

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 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 always safe. Details are in our safe findings below.	**Requires Improvement**
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**

Healthvision - Hounslow

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 conducted by two inspectors and two Experts by Experience who made phone calls to people and their relatives after the site inspection. 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.

The service had a manager registered with the Care Quality Commission. 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 the service 24 hours' notice of the inspection. This was because we needed to be sure the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 17 February 2022 and ended on 3 March 2022. We visited the location's office on 17 and 18 February 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the action plan the provider sent to us following the previous inspection saying what they would do and by when to improve. We sought feedback from the local authority and professionals who work with the service. We also used information gathered as part of monitoring activity that took place on 22 October 2021, to help plan

the inspection and inform our judgements. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account in making our judgements in this report.

During the inspection
We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We viewed a range of records. This included eleven people's care records and multiple medicines records. A variety of records relating to the management of the service, including audits were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke with 16 people who used the service and 10 of their relatives about their experience of the service. We emailed 54 staff and had responses from four staff.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
At our last inspection of the service the provider had failed to robustly assess and manage the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• The provider did not have effective arrangements to manage risks to people. We found that when a risk was identified, care plans did not always provide adequate guidelines for care workers to meet the person's needs and reduce the risk of harm. For example, the mobility care plan for one person indicated they required a grabrail to move from their bed to a wheelchair but did not include enough information about the person's mobility to ensure this was suitable or guidance for care workers to transfer the person.
• Some records lacked information around people's medical conditions. The risk assessment and care plan for one person had a summary of symptoms for their specific condition and noted this caused frequent falls but did not provide guidance for care workers about how to manage the condition.
• The same person required their food to be cut up due to problems with swallowing, but there was not a risk assessment around choking. This meant the person was at risk of choking as there was not an adequate risk assessment or mitigation plan.
• For a third person, bedrails were used but there was no risk assessment around their use.
• When there was an incident, the care plans were not always updated. The falls risk assessment for one person indicated their last fall was in January 2020. However, we found an incident form indicating they had a fall in October 2021 which was not reflected in the risk assessment.

Systems had not been used effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This included updating care plans. This placed people at risk of harm. This was a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At the last inspection we found systems were not in place to ensure the safe management of medicines. This placed people at risk of harm and was a breach of Regulation 12 (safe care and treatment) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvements had been made in relation to medicines management and the provider remained in breach of regulation 12.

• Medicines were not always managed safely. 'The provider did not always have effective systems for supporting people with 'as required' (PRN) medicines.' One person had a PRN medicine prescribed but it was not listed on the medicines administration records (MAR). Also, there was no PRN protocol in place, to give care workers clear guidance about when it was appropriate to administer the medicine. Additionally, the medicines listed in the risk assessment and support plan did not reflect the information listed on the MAR. The MAR chart audit for 20- 26 January 2022, did not identify these issues.
• MARs were not always completed correctly. The MARs for one person showed one or two tablets of a medicine should be given four times a day. However, the MAR recorded that the medicine was generally given twice a day and did not record how many tablets were administered each time.
• The care plan for another person stated care workers should prompt with medicines but this had changed to administering medicines two weekly earlier. The care plan had not been updated which meant care workers did not have the correct information to administer medicines safely. Medicated creams were not always correctly identified or recorded. The provider did not maintain a record such as a topical medicines administration record (TMAR) to show which part of the body these medicines should be applied to. The daily records for one person recorded care workers had applied a medicated cream to the person, but this was not recorded on the MAR. The registered manager clarified this was changed to a non-prescription cream but the care plan had not been updated to reflect this and there was no record to show where the cream should be applied.
• This person also had a medicated skin patch. However, there was no guidance on how to administer the patch and no record to confirm where it was applied, as the site needed to be rotated. Furthermore, the skin patch dosage in the care plan did not reflect the dosage on the MAR, indicating the care plan had not been updated.
• The registered manager confirmed they were working on PRN medicines, skin patch and eye drop recording documents and also guidance for care workers for when they have to use a medicated patch.
• Medicines audits were not effective as they had not identified the issues raised during the inspection.

The provider had not ensured people's medicines were always managed appropriately and safely. This was a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care workers had completed medicines training. Annual medicines competency testing was recorded as medicines supervision. Although not clear on the record, the registered manager confirmed this included observations of care workers supporting people with their medicines. The provider told us they would update the forms to reflect this.

Staffing and recruitment
• The provider did not always follow safe recruitment procedures to help ensure new care workers were suitable for the work they were undertaking. The provider was not able to show us application forms at the time of the inspection as the officer responsible for them was on leave. This meant we could not confirm if the provider had met the legal requirement of checking whether applicants' had a full employment history together with a satisfactory written explanation of any gaps in employment. The provider did not always make checks on care workers' suitability for the job, including criminal checks and references. We looked at four new starter files and identified that two applicants did not have any record of a criminal record check being carried out. We also found two applicants did not have two references in line with the provider's own recruitment procedures which meant the provider did not follow their own procedures when seeking seek adequate evidence of satisfactory conduct from previous employers before employing people in their

service.

The provider did not always follow their own recruitment procedures to ensure new care workers were suitable for the care worker role. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider did not always include travel time in some care workers' calls, which meant they did not have time to complete the full call. There were also calls where the planned visit times for two people overlapped which meant at least one of the people was not receiving care at the agreed time. The provider used an electronic monitoring system that showed in real time when care workers arrived and left people's homes. However, the provider's system was not effectively monitoring late and missed calls which meant they could not respond effectively.
• We found the actual times of calls made to people did not always reflect the planned time of the call. We reviewed the call times for 25 care workers for the period of 31 January to 6 February 2022 and identified all 25 care workers had some planned calls without allocated travel time which impacted on their punctuality and length of the call. For example, one care worker had 33 calls that week and 22 of them did not have travel time. This meant people might not have received the care they needed in a timely manner and according to their preferences.
• The systems the provider had in place were not always effective in monitoring care calls which meant they were not responding quickly enough when things went wrong, including when care workers were not arriving to scheduled home visits on time.
• Feedback from people and their relatives indicated regular care workers attended during the week and it was possible to get in contact with the office, but on the weekends there were care workers with less experience, more time keeping issues and messages left at the office did not always get passed on to the relevant person. Comments included, "The core group weekdays are good but at weekends on Sundays they can be one and a half to two hours late as the carer has to come by bus. If they are going to be late the carer will phone but never the office and at the weekends messages don't get passed on", "The caring during the week is fine but at weekends it is chaotic" and "One problem we have is when new carers turn up is they don't seem to know what is needed and this is worse at weekends."
• While some people and relatives were happy with the consistency and punctuality of calls others were not. People told us, "Timing is not their strong point but they never rush [person] and do everything that is needed", "Carers came at 7.10am instead of 8am which is too early for [person] to get up", "Last month the times were all over the place with the evening visit scheduled for 7.30 to 8pm but they were turning up at 6.15pm to put [person] to bed which is far too early. In the morning when the visit is 8 to 9am they are coming an hour or more late", "If carer is going to be really late the office calls me. When this happened before it depends on what manpower they have available as to whether they can send a different carer", "They don't let us know if there is a new carer coming especially when or if our regular carer is off sick" and "Some are very good while others don't seem to know what they are doing. For some carers it is hard to make them understand what is needed. I do seem to get someone different each day."

Care workers were not always appropriately deployed to help ensure care visits were carried out as planned. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manger and nominated individual felt the national shortage of care workers had affected their recruitment and retention of care workers which in turn had contributed to late calls as they found it difficult to provide additional cover. However this did not explained why calls were overlapped with no time added to travel between calls.
• The provider was trying to minimise the impact by continuing to recruit and reducing the amount of care

packages they were willing to take on.

Preventing and controlling infection
• The provider had systems in place to help prevent and control infection. However, they did not have COVID-19 risk assessments in place for care workers. COVID-19 risk assessments for people using the service were not robust enough as health was the only indicator used as a risk factor. This meant indicators such as ethnicity and age which could have increased the level of risk to a person if they were to develop COVID-19 had not been considered.

We recommend the provider seek and implement government guidance on carrying out COVID-19 risk assessments for staff and people using the service.

• Care workers had completed infection control training and were provided with ongoing up to date guidance during the COVID-19 pandemic. They also had enough personal protective equipment (PPE) to help minimise the risk of spreading infection. People told us, "They [staff] do wear full PPE and in fact the office left a supply here in the house with me" and "The regular carer wears full PPE and brings spares and replacements with her."
• Spot checks of care workers carried out in people's homes checked that they were wearing and disposing of PPE correctly.
• Care workers tested regularly for COVID-19 and most care workers had been vaccinated against COVID-19.

Systems and processes to safeguard people from the risk of abuse
• The provider had safeguarding policies and procedures in place to help keep people safe from the risk of abuse and avoidable harm. People and their relatives told us they felt safe with their regular care workers but did not have confidence in other care workers. Comments included, "I feel very safe with the carers that support me", "I do feel absolutely safe with the regular carers that call on me" and "Regular carer is fine and knows how to care for [person] but it is the other carers we have and have had problems with which has led us to feel that [person] is not safe with all the carers who come to support them."
• The provider worked with other agencies to help protect people. This included raising safeguarding concerns with the local authority and notifying CQC.
• Most care workers had up to date safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe and knew how to respond.

Learning lessons when things go wrong
• Incidents and accidents were recorded, and we saw that appropriate learning too place to help prevent reoccurrence.
• The registered manager investigated incidents appropriately. They carried out investigations, care worker interviews, disciplinaries, refresher training and spot checks in response to incidents and safeguarding alerts. Action taken and lessons learnt were recorded to make improvements and help mitigate similar risks in the future.
• The registered manager told us when things went wrong, they shared this with the care workers, so they understood what the issues were and the learning from it. We saw the registered manager regularly emailed care workers with safeguarding and complaints scenarios to learn from.

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.

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.

At our last inspection systems were either not in place or robust enough to ensure people's care was provided in line with the principles of the MCA. This was a beach of regulation 11 (need to consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we checked whether the service was working within the principles of the MCA and found not enough improvement had been made. The provider remained in breach of regulation 11.

• The provider's processes for identifying and supporting people who lacked mental capacity in relation to decision making were not robust. Where it was indicated a person may not have capacity to consent to their care, a mental capacity assessment or a best interest decision had not been carried out.
• Additionally, some care plans had contradictory information about whether the person had capacity. For example, the care plan for one person indicated they struggled to retain information around care needs and support planning, but that they had capacity to sign their care plans. Another person forgot about completing personal care and had short term memory issues, and they had signed their care plan without a mental capacity assessment to confirm they could consent to their care.
• The care records for a person with vascular dementia indicated they required encouragement and assistance with most daily tasks, including remembering to eat. The person had signed their own care plan, but we saw no evidence that a mental capacity assessment had been undertaken to determine if the person had the capacity to consent to their care. This was not in line with the provider's procedures which stated, 'The care service then makes sure that any service user who might not have the mental capacity to give informed valid consent about any care and treatment proposed is properly assessed in line with the

requirements of the Mental Capacity Act 2005. If from the assessment it is clear that the person cannot give their informed consent on account of their mental incapacity, a decision will be taken in their 'best interests' following Mental Capacity Act procedures.'
• A fourth person's care records stated they forget to make meals, needed to be prompted to eat and they can become lost if they go out. However, they had also signed their care plan without a mental capacity assessment to decide if they had the capacity to do so. Their file recorded two relatives held lasting power of attorney but did not say if it was for health and social care or finance and there was no evidence the provider had done any checks to confirm this.

The provider had not ensured people always received care in line with the principles of the MCA. This was a repeated breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• There were systems in place to review people assessed needs before they were offered a service. The registered manager told us they received an initial assessment of people's needs from the referring local authority so they can make a decision about accepting people and the care package. This helped ensure an appropriate level of support could be provided.
•The information was used by the provider to help develop a care plan within 48 hours of taking on the care package, so staff had the necessary information to care for the person.

Staff support: induction, training, skills and experience
• The provider had a training programme in place to help ensure people were supported by care workers who had relevant training and support from the provider. However, we identified from the provider's training spreadsheet, for key training such as dementia awareness, safeguarding adults, medicines awareness and infection control training, only 68% of care workers had up to date training in these areas.
• People and relatives told us in general they believed their regular care workers were well trained, but new workers were not. Comments included, "Our regular carers are really good with [person]… They don't tell us if they are sending any new carers and as far as I know they have not done any shadowing of [person's] regular carers", "Whilst some [care workers] are okay many have no idea what is needed as they don't have enough training" and "[Person's] regular carer is well trained and cares for [person] really well, but the new carers are not well trained and many are very inexperienced on how to do deal with people with dementia." We recommend that the registered person review their training programme to make sure all the staff, including new staff have the necessary skills and knowledge to care for people safely.
• The provider undertook regular spot checks of care workers to monitor care workers' competency when delivering care.
• The provider had an out of hours on call system, so care workers could access support when they needed it.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to have enough to eat and drink. People who were supported with meals told us, "The carers look at what is available in the fridge and [person] will decide what they want. [The care workers] make [person] tea or coffee when they are there and leave them with plenty of water and fruit juices" and "I am glad that I don't have to rely on the carers at weekend for my meals as timings and care is far worse than in the week."
• Care plans included information about people's nutritional and dietary needs.

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 health and social care services to help ensure people's needs were met appropriately.
• People and relatives were positive about the support they received to meet their healthcare needs and to access healthcare services. They told us, "My regular carer does use their initiative and when my [condition] changed…they took pictures of it and sent them to my GP" and "The carer has to come with me when I go to the hospital. On the rare occasions that I am unwell the carer will contact my GP on my behalf."

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. The rating for this key question 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 lack of consistency of care workers supporting people, meant care workers were not always familiar with people's individual needs and this did not enable caring relationship to develop between care workers and people and their relatives.
• Care records included references to people's cultural or religious preferences and likes and dislikes. However not all people felt their needs were met. One person said, "I don't feel that our culture is really respected properly by the weekend carers" and a relative said, "They try to respect the cultural things but are not always successful." One person's care records we reviewed stated they were [a nationality] but there was no indication of the language they preferred or any other information about the person's cultural needs.

• People told us that they were not asked if they preferred a male or female care worker. Some people had asked specifically for a male or female carer and this was not always respected. People also raised that some care workers' faith could be a barrier to providing appropriate support. Comment included, "My needs are met by my regular carers but not by those from [specific] faith. I have told the office I don't care who comes as long as they can meet my needs and do the job", "[I] object to having carers whose cultural beliefs mean they cannot undertake all of my personal care" and " A couple of the carers are [a specific faith] and they won't shower me so I don't have a shower on their days."

Not being able to always deliver person centred care to meet people's individual needs was a breach of Regulation 9 (person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other people had a more positive experience of the care provided and told us how care workers treated them well and with respect. People and relatives told us, "We have been having Healthvision for about a year and it is absolutely wonderful", "The carers are always kind, caring and friendly. They sit and talk to [person], cheer them up when they are down or upset and they are a big help to us as a family", "On the whole the carers do meet my needs really well. My regular carer has gone over and beyond expectations at times" and "My carers are really good at meeting my needs and the carers are kind, polite and very friendly. They do meet all my needs and will if I require something else from normal will often go the extra mile to carry it out."

Supporting people to express their views and be involved in making decisions about their care
• People using the service told us their care workers gave them a choice when providing support. Comments

included, "Yes they do ask me what I want and how I want it done" and "They ask me what I want done on each visit and don't take anything for granted."
• The registered manager told us people were contacted either in person or by telephone to provide feedback about their care.

Respecting and promoting people's privacy, dignity and independence
• Most people felt care workers tried to ensure people's privacy, dignity and independence were respected when providing care. Comments included, "The carers do all they can to ensure I have privacy when undertaking my personal care and they protect my dignity… They also respect the fact that I like to try whenever possible to be as independent with their help as I can be", "The carers assist me to maintain my independence" and "Yes they encourage me to wash the parts of me I can reach."

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; Meeting people's communication needs

• Care plans were not always personalised to indicate people's current needs and wishes. For example, one person required support with shopping. The care plan indicated care workers could withdraw money on the person's bank card to do the shopping. When we discussed this with the registered manager, they told us this was no longer the case. However, the care plan was not updated to reflect the current support measures in place.

• Another person's care plan indicated care workers should support the person to exercise with named equipment that helps them to stand, but there was no exercise plan to indicate what exercises should be done.

• People's personal care sections were not detailed enough to be person centred. For example, one file recorded, 'Please assist me with a wash and shave daily and if I refuse please contact the office.' There was no information about how the person liked to wash or what steps to take to encourage them so they did not refuse support. This person also had a medical condition but there was no medical information about this in the care plan and how this impacted on their needs.

• One person had a fall from their mobility equipment in January 2022. The incident form indicated care workers should remind the person to turn it off. However, the care plan was not updated to reflect the new guidance and did not reference the use of the mobility equipment. The care plan was last reviewed in April 2021 which was before the fall and did not appear to have been reviewed since. This meant care workers did not have guidance that was not up to date about how to meet the person's 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.

• Care plans included information about people's communication needs, including if they required assistive aids such as glasses or a hearing aid. However, the quality of the guidance around communication was not always meaningful. We saw several files indicated care workers should use verbal and nonverbal communication skills but did not identify what the nonverbal communication skills were that suited that person's needs or how people communicated their needs and wishes.

• Care plans did not always identify people's preferred language for communication, and we did not see means of communication with people in any other languages or formats such as easy read or large font.

People's care plans were not always person centred and detailed enough which meant there was a risk they might not receive appropriate care according to their needs and preferences. This was a repeated breach of

Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they did have input into planning their care and that supervisors from the service sought feedback from them. Comments included, "The family and [person] were involved in the setting up of [person's] care plan just over 12 months ago. It has been reviewed fairly regularly and no changes have been required", "I have a care plan and was involved in the content of it", "I did have input into the content of my plan and had a review a few months ago" and "Yes we have been involved in the setting of the care plan and the reviews. Not necessarily got what was agreed."
• The registered manager told us how they tried to meet people's individual needs. For example, one person needed support with their garden, and we saw evidence the service had signposted them to have gardening support. The registered manager said for another person, they got in touch with a local chef who was able to provide food from the person's own culture.

• People and relatives told us, "Communication between me and the carers is very good", "Carers are very good with communicating with [person]. They give [them] any information that is required in a way [they] can understand, and they check [person] has understood them" and "Care workers require better training on how to relate and communicate with those with dementia."

End of life care and support
• No one was being supported with end of life care at the time of the inspection.
• The care plans for eight out of nine people whose care plans we looked at regarding end of life care, recorded the person did not want to discuss their end of life wishes. This meant people's wishes and preferences for care at the end of their lives were not always known in the event they required this support.

We recommend that the registered person explore ways and training to ensure staff have the knowledge and skills to engage with people about end of life care.
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 'about me' section of the care plan identified who was important in the person's life and any interests they had. Staff were in the main involved in the provision of personal care to people. Where necessary staff talked with people and engaged socially with them to help prevent isolation.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure and systems in place to appropriately respond to any complaints received. Most people and their relatives were satisfied with how complaints were dealt with and actions taken to help resolve the complaints. They told us, "We have had to raise our concerns about the issues that have arisen relating to [person's] medication. This was dealt with to our satisfaction. I have also raised issues relating to the out of hours telephone service as they don't pass on messages appropriately. The latter has not improved", "My complaints relating to carers having cultural needs that prevented them from doing part of my personal care resulted in someone coming to see me and undertaking spot checks from time to time" and "I have made complaints about the carers who have no idea what they need to do as well as the one who was rude and told them I didn't want them sent to me again and they haven't sent them."
• Complaint records showed details of the complaint, the actions taken to address the concern and the lessons learned to avoid repetition and improve service delivery. We saw the registered manager responded directly to people making the complaint and took further action such as disciplinaries, when necessary, and followed up with training and spot checks.

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. The rating for this key question has changed to inadequate.
This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At the previous inspection the provider did not have robust arrangements to assess, monitor and improve the quality of service provided to people. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 17.

• Quality assurance systems such as audits were not being operated effectively as demonstrated by the number of shortfalls identified during the inspection. This is the third inspection of the service where no significant improvements have been made to the quality and safety of the service provision and regulations remained unmet. This was despite the provider sending us an action plan to confirm the improvements they would make at the service.
• The provider completed audits of MAR charts, but these were not robust enough as we identified concerns the audits had not. This included having clear protocols for recording medicines prescribed to be given when required.
• The provider's systems to manage risks were not always effective as not all care plans had adequate guidelines for care workers to follow to meet people's needs safely and to minimise risks to people.
• The provider did not always have proper arrangements to help deliver person centred care. Their checks and audits have not identified that care plans were not always updated to reflect people's current needs. For example, in some cases information about people's mental capacity was conflicting and their checks and audits have not effectively identified these shortfalls.
• The provider did not have robust procedures for monitoring the rotas and electronic call system to ensure staff were appropriately deployed so people always received their care visits as planned for them. The provider has not identified instances where more than one care visit had been scheduled at the same time for a care worker and appropriate travel time had not been allocated as part of the rota to enable care workers to arrive at people's homes on time. As a result, planned call times were inconsistent with the actual times people had requested for their care workers to visit, which meant there was a risk people might not receive their care as planned for them.
• The checks and audits by the provider have not identified that safe recruitment procedures were not always followed, so they could make the necessary improvements

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a repeated breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The care records of people using the service were audited, including weekly MAR audits, and the registered manager met with other managers weekly to discuss service delivery. The weekly report considered planned visits, new referrals, quality alerts, safeguarding, supervisions and appraisals.
• The provider kept a spreadsheet of care workers' appraisals, supervisions and spot checks to help ensure these were up to date and for staff to be supported appropriately.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• There was a clear management structure in place and people knew to contact the office for support. Comments included, " There is a lack of communication between office and carers at times especially when it is the out of office one has spoken to", "The supervisors do listen when I ring and tell them about problems with carers or timings", "I have no idea who the manager is, but I do think the service is well managed."
• We contacted 54 care workers for feedback and only four responded. They provided mixed feedback on the support they received from management. One care worked said, "I feel supported. Our staff work hard, and they are very supportive and friendly."

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 understood their responsibility around the duty of candour and of the requirement to notify appropriate agencies including CQC if things went wrong.
• The provider had policies and procedures in place to respond to incidents, safeguarding alerts and complaints and knew who to notify. We saw the registered manager had been open and honest when things went wrong and had responded appropriately to people raising concerns.
• People and their relatives knew who to contact if something went wrong. A relative told us, "Issues that have arisen with [person's] care has been handled really well by three of the staff in the office who used to be carers. They sort things out ASAP."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and relatives had the opportunity to feedback about the service through spot checks and phone calls. Relatives told us, "I have been asked for feedback a couple of times and each time I have raised the same points… and nothing has changed" and "I have received a survey previously and filled it in but as I had no issues there was nothing to amend."
• Team meetings were held to share information and give care workers the opportunity to raise any issues.
• One social care professional told us, "When they respond to [concerns], they say this is what we found and this is what we learnt. They have worked really hard."

Working in partnership with others
• The provider worked in partnership with various other health and social care professionals to ensure people get the support and care they need.
• Where appropriate they liaised with other relevant agencies, such as the local authority, occupational therapist and dementia nurse to help ensure people's needs were met.
• The registered manager participated in local authority provider forums to share information and best practice with other providers in the area. They received regular updates through social care organisations such as Skills for Care.

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 registered persons did not always ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons did not ensure that care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons did not always ensure fit and proper persons were employed. Regulation 19 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons did not ensure that sufficient numbers of suitably qualified, competent, skilled experienced persons were

deployed to meet the needs of service users.

Regulation 18 (1)

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 registered persons had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)

The enforcement action we took:

We issued a warning notice to the registered manager and the provider requiring them to comply with the regulation by 20 May 2022.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

We issued a warning notice to the registered manager and the provider requiring them to comply with the regulation by 20 May 2022.