Allicare Limited

Allicare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Allicare is a domiciliary care agency that was providing support to over 130 people at the time of our inspection. 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.

People's experience of using this service and what we found
The provider and registered manager had failed to ensure the quality monitoring systems in place were effective to ensure people received safe care. Oversight of the administration of medicines failed to identify in a timely way where actions were required. In some areas where care was provided, there were not enough staff to ensure all care calls were provided or delivered on time. This had place people at significant risk of harm.

Recruitment processes were not robust, and staff had been knowingly sent to work in people's homes before checks of their suitability had been completed. Not all staff had completed training in safeguarding vulnerable people and we found that not all safeguarding incidents had been reported to the Care Quality Commission. Assessments of risks to people's wellbeing were not robust

Staff training and supervision was not effective to meet the needs of people, we identified widespread gaps in training records. The registered manager and provider did not ensure people's needs were assessed and supported in line with legislation, standards and evidence-based guidance. The registered manager, provider and staff did not demonstrate enough understanding of the Mental Capacity Act 2005 and assessments of people's capacity were not undertaken. Staff did however, seek peoples consent before providing them with care.

Most people told us that staff were kind and caring however, we saw that some staff used terminology and language when referring to people that did not promote their dignity. Care plans did not fully reflect people's life histories and preferences, and staff reported this impacted their ability to meet their needs. Some people did not feel the provider and management team were kind and caring towards them, requests from people for more information about who would be supporting them in their own homes were refused.

Complaints were not managed so that outcomes could be provided and any cause for concerns investigated to improve practice. Some outcomes from complaints had not been actioned, some complaints had not been responded to.

End of life and palliative care needs were not planned for, and staff had not received training to provide this, although the provider advertises that they provide this type of care. Peoples preferences were not always met, this included preferred gender of care staff and call times. The provider and registered manager had failed to audit and check if people received their care on time and for the duration agreed.

People were not supported by a service with effective management and governance systems in place. The provider and registered manager had not ensured that areas of improvement required and risk to people were identified and mitigated. The registered manager was aware of the decline in the quality of care and oversight since expansion of the number of people supported took place, but had failed to take action to address this. This failure exposed people to the ongoing risk of harm.

We have made a recommendation that all staff complete training in end of life and palliative care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection:
The last rating for this service was Good (27 October 2016)

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to safe management of people's medicines, staff training and recruitment, current governance systems, consent to care and treatment, the management of complaints, and the number of staff employed.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Allicare

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector, and two experts by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. CQC support services wrote to service users prior to the start of our inspection to let people know that we may contact them to ask for their views on the support they received from Allicare.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service had 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
This inspection was unannounced. Inspection activity started on 27 June 2019 and ended on 25 July 2019. We visited the office location on 15 and 17 July 2019.

What we did before the inspection
We used information we held about the service which included notifications the provider had sent us about important events that had occurred, which they have to report to us by law. We also received information from professionals involved with monitoring the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to help us plan this inspection.

During the inspection

We used a range of different methods to help us understand people's experiences of the quality of care they received. On 27 and 28 June 2019, we spoke with 17 people over the telephone who received support from Allicare. We also spoke with five people's friends or relatives to gain their feedback. Prior to the inspection, we had spoken with the local authority and emailed staff and asked them to complete a survey. On 15 and 17 July 2019, we visited the office and spoke with the registered manager, human resources manager, care co-ordinator, care manager, a team leader and two care staff. We also spoke with the providers managing director, who is the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. On 25 July 2019, we spoke with two more care staff on the telephone to gain their feedback. We reviewed care plans and daily records for ten people to check they were accurate and up to date. We also looked at staff recruitment and training records, medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included meetings minutes and quality audits.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment

● In some geographical areas where care was delivered, there had been insufficient numbers of staff available leading to people experiencing missed or significantly delayed care provision. Some people we spoke with told us this had been a major cause of anxiety for them and had a negative impact on their lives. This included missing or being late for health appointments, social activities, and having personal care and meals provided at a time that did not suit them.

● Some people told us they felt their care was rushed, with staff either arriving late, leaving early and not staying for the allotted time, because of the pressure they were under to complete all the calls allocated to them. One person told us, "The company seem to be short staffed, sometimes they rush off to see somebody else, the company seem to have taken on too many customers and push their staff too much."

● Some staff we spoke with told us they were often late arriving for peoples calls. They said this was because rotas did not include adequate time for the distances they had to travel between people.

● Staff reported that calls were often missed or people who required two staff to assist them, would only have one staff member arrive. We reviewed daily notes of people's care that confirmed this did occur. However, this had not been identified by the provider because audits and checks of peoples care interventions had not been completed regularly. This meant people were at risk of receiving unsafe moving and handling and receiving care that was not in line with their assessed needs.

● The provider did not have a system in place to monitor people's call times to ensure they were not put at risk by variance in punctuality or call duration. This placed people who were unable to use or access a telephone at increased risk. The registered manager relied on people being able to contact the provider to alert them if a carer had not arrived. This reliance had not been reviewed since an expansion in the number of people supported from around 60 to more than 130.

● Some people we spoke with told us when they had called the staff office or out of hours contact, they did not always get a response. Also, some staff we spoke with told us when they had contacted the out of hours manager to report a delay, or if they were unable to work, that there had been no response.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure staff were recruited safely. There was no system in place for ensuring staff had completed all necessary checks before being employed. The registered manager did not have oversight of recruitment processes to ensure that fit and proper persons were employed. This failure placed people at risk of receiving care from staff who were not of good character.

● We reviewed records where we identified legal requirements had not been met. This included ensuring staff had provided a full employment history, records of an interview and satisfactory references.

● All staff that are employed to provide personal care to people must undertake a check with the Disclosure and Barring Service (DBS) to ensure they are suitable and safe to work with vulnerable people. We identified that three staff had been deployed to work with people before these checks had been completed. On one occasion, this included a staff member who had disclosed they held a conviction for a violent offence.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other geographical areas, people told us that they felt there were enough staff and that their care was mostly provided at the time they expected it

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse. Prior to our inspection, we received concerns that not all staff possessed the skills and knowledge to help people stay safe from the risk of abuse. This included staff not completing training, not understanding procedures to raise concerns and managers not having the time to assess staff competency.
● Training records we reviewed showed us that of the 87 staff listed, 56 did not have a record of completing training in safeguarding vulnerable adults.
● Staff we spoke to told us that recently completed safeguarding training was rushed and brief. One staff member told us they had not completed safeguarding training before providing people with care and as they were new to working in care, was worried they did not have the knowledge required.
● Registered managers and providers are legally responsible for submitting notifications of allegations of abuse to the Care Quality Commission (CQC). We identified in care records an alleged safeguarding incident that although notified to the local authority, was not notified to the CQC.
● The provider and registered manager did not have a system in place to regularly audit records of peoples care that could identify trends or patterns that could indicate where people were at risk of abuse.

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

Using medicines safely
● We found significant shortfalls in the safe administration of people's medicines. Regular audits of records had not taken place which would identify whether errors had occurred. Most people's medicines records had not been audited in 2019.
● Where it had been identified that people had not received their medicines, or records were incomplete, actions had not been taken to reduce the risk of reoccurrence or to assess if there had been any impact.
● Medical advice had not been sought for people or any other action taken to establish if any ill affects had occurred. We saw there had been delays of several weeks until errors were identified by team leaders, and several months before senior managers completed their audits.
● Records we reviewed showed that satisfactory actions were not identified at this stage either. For example, one audit stated that there was "Gaps in chart and medication counts not always filled in." There were no details of what the medicines were or how many occurrences took place. The outcome was recorded as, "Action to team".
● Some staff reported they had not had their competency checked to ensure they gave people their medicines safely, records we reviewed confirmed this. This is not in line with best practice guidance.
● Records we reviewed showed us that some training delivered to staff had been done so by managers who were not accredited to do so.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Most people told us they felt safe when receiving care from staff. This contrasted with our findings where we identified people were not always protected from potential harm. Risks to people's health and wellbeing were not always effectively identified, assessed or mitigated.

● Risk assessments had been completed for people however these were not always detailed enough to give staff the direction they needed to provide safe care. For example, we saw where changes had been made to a person's moving and handling equipment by a community professional, the notes from this had not been accurately transcribed to the person's moving and handling plan. We also saw that clinical intervention prescribed by a community nurse in the management of a person's skin, was recorded in daily notes, but the risk assessment for tissue viability stated they had, "no issues".

● Analysis of incidents, such as medicines errors, had not been undertaken to be able the provider to learn lessons.

● The registered manager was not able to demonstrate how they monitored or managed missed and late calls. There was no system in place to enable this, or for any analysis to be undertaken to make improvements.

● We identified in people's daily care logs incidents that should have been investigated further to establish whether any action could be taken to reduce the risk of reoccurrence. This included minor injuries, conflict between service users and staff, missed calls or calls where two staff were required but only one staff member attended.

● In the records we reviewed, only one event had been recorded in the services incident log in 2019, this was a marked difference to 2018 where 12 incidents were recorded, at a time when the number of people supported was significantly lower. The registered manager could not assure us that the systems used to monitor incidents had been completed as expected.

This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●People told us staff observed good standards of hygiene while supporting them with personal care.

● Staff were provided with the necessary personal protective equipment, including gloves and aprons. We saw from staff meeting minutes that managers reminded staff to ensure they had appropriate supplies with them whilst working.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff training and supervision was not effective to meet the needs of people.
- We received mixed feedback from people about the competency of staff. People who had experienced staff told us they were satisfied with the skills of staff supporting them. Other people raised concerns that newly recruited staff were not competent, and that at times were supported by two members of staff who were in their probation period, without the guidance of an experienced staff member. One person told us, "They're [staff] a bit hit and miss, some of them don't seem to be trained so well."
- Staff with line management responsibilities of other staff told us they felt their team members did not receive enough training. They also told us they did not get the time or support to provide this training themselves. One staff member told us they had just taken it upon themselves to provide training using their own experience.
- Some staff we spoke with told us the training provided was insufficient. Those staff reported their induction training had been rushed and brief. Some staff told us they received minimal opportunities to shadow experienced staff and had little or no checks of their competency before providing people with care. Records we reviewed showed that staff supervisions were infrequent, brief and lacking in detail.
- The provider had made the decision to change the refresher training intervals for staff from one year to three years. we were not provided with a rationale for this or an assessment of whether this would be suitable. Induction training for staff had recently been compressed from three days of training to one, which included the administration of medicines and moving and handling people.
- The services training matrix we reviewed showed widespread gaps in staff training, including mandatory subjects such as first aid. The registered manager and provider had not taken action to address the shortfall in training but recognised staff needed development.

This was a further breach of regulation 18 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

- People's needs and choices were not always planned and reviewed consistently to achieve best outcomes.
- The registered manager and provider had not ensured people's needs had been adequately assessed. Sections of people's care plans had not been completed, and basic initial assessments undertaken at the start of the provision of care had not been revised after time. Where people's needs had changed, care plans were not always reviewed and updated. This meant that staff did not always have the relevant information to meet people's needs.

● The provider and registered manager did not have a comprehensive understanding of current standards, guidance and regulation. As a result, they had not ensured care was delivered in line with expected standards. For example, the provider was not aware of the latest NICE guidance around managing medicines in social care and we identified unsafe practices within medicines management systems.
● Staff training was not always delivered by trainer's that followed current best practice guidance and standards. For example, moving and handling training had been delivered by a trainer who required yearly updates to their own training to keep this qualification valid, but had not refreshed this since 2016. Other trainers delivering this had not completed an accredited qualification in the subject area and did not provide training using best practice guidance as provided by recognised bodies, such as the national back exchange.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.
● Assessments of people's capacity had not always been completed where required. The registered manager and provider were unaware of the requirements of the MCA. The registered manager told us they needed to identify training in the MCA they could complete to increase their knowledge.
● People's care plans did not identify where people may lack capacity and where staff may need to make a decision in the person's best interests. There was no information to guide staff on how they could support a person to make a decision where they may find this difficult.
● Care plans did not identify where a person had given their consent to care and support being provided, for example, for the management of medicines on their behalf. Where a person was able to provide consent, they had not always been asked to provide this by way of signing a document.
● Staff we spoke with had very limited understanding of the MCA and did not demonstrate they understood how to apply its principles in practice. The provider's training matrix we reviewed show that staff had completed training in mental health, but not the mental capacity act.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Although we did not receive concerns from people in relation to accessing health care services, improvements needed to be made to the regular checking of people's daily records so that any concerns can be identified and actioned in a timely way, and direction in care plans for staff to follow amended.
● People told us they were supported by staff to access healthcare services when required. One person told us, "The careers have called a doctor and district nurses about my pressure sores, they are very kind at helping me."
● We saw the service was responsive in prioritising the planning of care for people due to be discharged from hospital and receiving care for the first time.

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

● People told us they were happy with the support they received from staff in relation to eating and drinking. We saw that where people had specialist diets or preferences, these were identified in people's care plans.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence

- Staff did not always use language and terminology that was respectful in people's care records. For example, in one person's record we saw staff had been critical in the way they referred to a person. They referred to the person as "having a moan" and "full of complaints" whilst raising concerns about their preferences not being met.
- During our inspection we heard staff including senior staff and managers referring to people in a way that did not show respect in regard to their life histories, disabilities or protected characteristics.
- Some staff told us that people's care plans did not provide enough detail about people's preferences and life histories, which had led to them causing offence or upset. One staff member told us they upset a person they had been sent to for the first time, because they called them by a name they no longer used, but this hadn't been detailed within their care records.

Ensuring people are well treated and supported; respecting equality and diversity

- Most people told us that staff were kind and caring towards them when providing care and enjoyed a good relationship with them. One person said, "I'd say three out of four of the carers are good, kind, understanding, but the others are a bit hit and miss."
- Some people felt their care was rushed, and that staff did not stay for the time allocated. One person told us, "Some of them are not too bad, but some of them rush me, they seem eager to get out." We reviewed records of people's care that showed staff did not always stay for the allotted time, and this had not been identified by the provider.
- Some staff we spoke with communicated compassion in the way they described supporting people and advocated that they wanted to provide care that benefitted people's wellbeing.

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

- We received feedback from people that senior staff and office-based staff were often unhelpful in their responses when contacted. Some people told us they did not feel able to express their views to managers as this had been dismissed when attempted before. Other people were fearful of raising concerns directly to the service in case the provider cancelled their care. This was not indicative of a caring and open service.

Had they done reviews, or surveys or something to gain views?

- Most people we spoke with told us they wanted to be provided with a rota of staff who were going to be supporting them, even though they accepted that rotas were subject to changes. People told us the registered manager had continually declined to do this. We spoke to the providers managing director about

this, who told us that it was their decision not to provide people with a rota of staff, and that people would have to be accepting of this as they would likely be supported by a member of a small team of staff.

Requires Improvement

Is the service responsive?

Our findings

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

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

Improving care quality in response to complaints or concerns

- Complaints and concerns were not always investigated thoroughly to improve practice. Some people told us and the records showed, that people had not always been informed of an outcome to their complaint. Some people told us they felt afraid or apprehensive about raising complaints to the provider.
- Complaints received were not all logged so they could be monitored and actioned. Managers were logging complaints in two separate documents, one of which was unknown to the registered manager. The logs did not contain information to show that all of these had been responded to or closed if resolved.
- Outcomes were not reviewed by the registered manager or provider to look for themes, trends or make improvements. It had not been identified when an outcome had not been generated or investigation not completed.
- Prior to our inspection, the Care Quality Commission were notified of several complaints that had been raised to the provider via a third party, such as the local authority, or the person's member of Parliament. The provider and registered manager had not logged these as a complaint and was not aware of their regulatory obligations to do so.
- Some people we spoke with told us they did not feel confident in raising a complaint to the provider. Some people told us that although generally satisfied with their care, previous attempts to raise issues had in their opinion, been met with hostility from the provider, including being advised to find another provider if they were not satisfied with the care given.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- People's end of life care needs were not assessed and reviewed.
- The provider advertises that they can deliver palliative care for people. However, we saw that staff had not been trained in delivering palliative or end of life care.
- When reviewing care records, we did not see any evidence that end of life care planning was assessed for any of the people using the service.
- We saw that following a complaint that was received from a relative of a person receiving end of life care, the outcome was that all staff were to receive ongoing updates and training on death, dying and bereavement. We spoke to managers about this who confirmed that this action had not taken place.

We recommend the registered manager and provider identifies and provides training in end of life care and support for all staff to attend.

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

● The provider and registered manager were unable to identify the volume of missed or late calls to people. They did not have an adequate system in place to do this. The information provided to us by them did not correlate with the evidence that we found during the inspection ourselves.

● Most people told us the care and support provided met their needs, although concerns were raised around call times not meeting their needs. People told us call times could vary on a day to day basis and we confirmed this was the case from reviewing care records.

● Care staff we spoke with were aware of most of the needs of people they supported. However, we found they were not always aware of specific mental health needs or risks they should be supporting people to manage.

● Care plans were in place but were not being effectively updated in line with people's needs changed. For example, one persons needs had changed with regards to the management vulnerable skin tissue, but their care plan had not been updated to reflect this.

● We saw that peoples relatives had been included in the initial assessment of a persons care needs. Care plans did not always identify the extent as to their involvement, or whether they were included in any reviews.

● People's preferences of staff were not always met. Some people told us staff they had requested not to be deployed to them had been sent. We asked the member of staff responsible for the rota about this. They told us they didn't have a list of people's preferences but, "Keeps the information in their head."

● Some people told us that their preference of gender of staff was not always met, and this sometimes occurred on a regular basis. We asked about this and were told that due to staffing pressures, meeting people's preferences was not always a possibility.

Meeting people's communication needs

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

● The provider and registered manager had ensured that information was provided for people in a format that was suitable for their needs.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality monitoring systems were not effective to ensure people received safe care.
- The provider and registered manager had failed to develop an effective quality assurance and governance system that identified areas of risk and improvement needed within the service.
- We found the provider and registered manager had a system of reviewing care records including daily care records and medicines administration records. However, they had not been using this system and most records had not been reviewed for several months. This meant they had not identified issues with the quality of care.
- We found the provider and registered manager was failing to ensure that records in the service were comprehensive and accurate. For example, records relating to the recruitment of staff and the management of complaints.
- The service had expanded significantly in the past year, however systems had not been reviewed in line with this growth. There was no system to identify missed or late calls in a timely way to reduce the risk of people using the service experiencing harm.
- The provider had taken the decision to knowingly send staff to provide support to people before checks of their suitability had been completed. This was driven by the service not having enough staff in some geographical areas where they started to provide care.
- The registered manager and provider were not clear as to their regulatory responsibilities. Their understanding of key areas such as the Mental Capacity Act was not sufficient. They had not ensured enough oversight of the quality and safety of care provided due to the impact of expansion and challenges in meeting these additional packages of care. Senior staffs view of who was in day to day charge of running the service was conflicted.

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

- Before and during our inspection we received information of concern from whistle blowers. Whistle blowing is a recognised way in which staff can raise concerns to bodies including the Care Quality Commission (CQC) regarding people's safety and the quality of care. Providers should make arrangements for their staff to raise concerns under their duty of candour arrangements. The provider's system regarding this was ineffective. During our inspection we identified staff were fearful in raising concerns with the provider as they were worried about possible repercussions such as losing their job. We saw evidence the

provider had actively tried to identify a staff member they thought had raised concerns with CQC, rather than dealing with the concern in hand.
● The provider had not created an open and approachable culture with people and staff. Some people we spoke with told us they had felt intimidated by their approach when wanting to raise concerns. Staff told us they did not fell able to raise concerns. We received negative feedback from community and local authority professionals about the providers approach, openness and duty of candour.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recently reviewed the management structure and had appointed five new senior posts. This additional capacity was implemented to meet the expansion in the number of people supported, and to decrease the workload of the registered manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Most people told us they felt that care staff providing support to them listened to their views and opinions. However, people told us the provider and registered manager did not always do this. We found that people's requests for rota's, preference of gender of care staff and timings of care calls were not met or prioritised.
● Staff told us they did not always feel supported by the provider and managers. Staff commented on the pressure they felt they were under to complete people's care quickly, and of the poor training and support provided.
● The provider sent people using the service an annual satisfaction survey. We reviewed response to this which showed for the previous year that most people were satisfied with their care. People were provided with a regular news letter, which contained interesting stories and information about keeping well, such as during a heatwave.
● The provider supported community projects with initiatives such as matching funds that had been raised by staff members.

Working in partnership with others
● The registered manager had not worked effectively enough with commissioners in addressing the challenges that had arisen from taking over additional care packages. Relationships with people receiving these packages of care had broken down and, in some cases, led to a withdrawal of provision.
● The provider had worked flexibly and in partnership with other providers at the request of the local authority in order to provide a responsive package of care for people leaving hospital.

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 11 HSCA RA Regulations 2014 Need for consent The registered manager and provider had not ensured that assessments of people's capacity had taken place where required. The registered manager and staff did not have the training and knowledge required.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. The registered manager and provider did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered manager and provider did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to ensure robust procedures and processes were implemented to make sure that people were protected including the staff competence and knowledge of safeguarding vulnerable people.

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager and provider did not operate an effective system for receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance with the requirements in this regulation. The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager had failed to ensure that staff employed were suitable to work in social care and had undertaken the required checks. Staff had been knowingly deployed to support people without these checks in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider had not ensured there were enough staff available to meet the needs of people. The registered manager and provider did not operate an effective system to monitor and identify that people received their care on time and for the planned duration.