Day and Nite Services Ltd

Day and Nite Services (Kingston)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Day and Nite Services (Kingston) is a domiciliary care agency. 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 they were providing personal care to 51 older people living in their own homes in Kingston, Sutton and Surrey.

People's experience of using this service and what we found
People using the service were generally satisfied with the support and the quality of care they received from their individual care workers, including their prescribed medicines. They also told us they felt safe in the presence of care workers.

The provider had made some improvements in relation to some areas of concern we found last time including recruitment checks for new staff. However, not enough improvement had been made in relation to risk assessments, staffing, statutory notifications and governance.

Risks to people were not always recorded accurately so they could be managed effectively, people's risk assessments contained conflicting information to their care plans.

Although the provider had implemented a new call monitoring system, we received mixed feedback from people regarding call visit times and of poor communication from the office when care workers were running late, especially at weekends. We discussed this staffing issue with the managers at the time of our inspection who were aware this system needed further improvement. The provider had an call monitoring system in place, however it was not being used effectively and there was no data available for the provider to accurately record information related to care worker visits.

The provider failed to submit statutory notifications when safeguarding allegations were made. Governance procedures were not effective in identifying the areas of concern we found during this inspection. Audits to review care plans, risk assessments and medicines records were not in place. The provider was not able to produce contemporaneous records to evidence that action had been taken in response to service concerns or safeguarding allegations.

People told us that the care workers who supported them respected their privacy and dignity and gave us examples of how they promoted and encouraged them to maintain their independence. They said their dietary and nutritional needs were being met.

Despite the above positive feedback, people and their relatives said the communication with the office staff was mixed.

Audits identified some of the issues we found during this inspection, but these were not always addressed and/ or followed up in a timely manner.

We have made a recommendation to the provider in relation to complaints management.

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

Rating at last inspection and update.
The last rating for this service was requires improvement (published 1 April 2021) and there were breaches of regulation in relation to fit and proper persons employed, notifications and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had been made and the provider was not in breach of regulation in relation to fit and proper persons employed. However, we found some new breaches in relation to staffing and safe care and treatment. We also found the provider remained in continued breach in relation to notifications and good governance.

The service has deteriorated to inadequate.

Why we inspected
This inspection was prompted in part by a review of the information we held about this service. There were also ongoing concerns from the local authority and feedback received from whistle-blowers. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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 Day and Nite Services (Kingston) on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, notifications and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Since the last inspection we recognised that the provider had failed to submit statutory notifications. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
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**

Day and Nite Services (Kingston)

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors 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 community care service.

Service and service type
Day and Nite Services (Kingston) 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 08/03/2022 and ended on 15/03/2022. We visited the provider's offices on 08/03/2022 and 15/03/2022.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service

since the last inspection. We sought feedback from the local authority and professionals who work with the service, including commissioners and the safeguarding team. We used all of this information to plan our inspection.

During the inspection
We spoke in-person with the registered manager, the deputy manager, the head of business support and one care co-ordinator when we visited the provider's offices.

We also made telephone contact with seven people using the service, 13 relatives and six care staff to find out their experiences of using or working for or with this provider. We took this into account when we inspected the service and made the judgements in this report.

In addition, we looked at a range of records. This included 14 people's electronic and paper care plans including medicines records, and five staff files in relation to their recruitment, training and supervision. A variety of other records relating to the overall management and governance of the service were also reviewed, including quality assurance audits, stakeholder feedback, complaints and safeguarding documents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care plans, audits and training records.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection in February 2021 we found safe recruitment procedures were not being followed and we could not be assured that care workers were vetted in an appropriate manner to verify their suitability for the role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was not in breach of regulation 19.

- We looked at a sample of recruitment files for care workers that been employed in the past year which showed that appropriate checks had been undertaken prior to them being employed.
- These staff had provided evidence of identity, right to work, proof of address and had Disclosure and Barring Service (DBS) checks in place. A DBS is a criminal records check employers undertake to make safer recruitment decisions.
- The registered manager told us she had started to use the Employer Checking Service. This is a government service used to check a potential employee's immigration status if they cannot show their documents or online immigration status.

At our last inspection we made a recommendation for the provider to review its process and introduce more robust mechanisms for verifying call visits. At this inspection, we found there had not been enough progress in this area.

- As part of the action plan the provider submitted in response to the last inspection, the provider had said they would be introducing a new call monitoring system to monitor care worker visit times. This was still not fully in place during this inspection.
- We checked the call visit times for some people using the service on the electronic call monitoring system. Some care workers were not using this system at all to log in and out, call visit records for those who were using the system showed inconsistency in their visit times and we could not be assured that call visit times were in line with people's expectations.
- The majority of negative feedback we received from people and their relatives was regarding call visit times. Comments included, "They say it (the visit) will be at 11am and it might not be until 2 or 3pm", "They are supposed to come at 07:30, but often they don't, it could be 08:30 or even 09:30 or there have been a couple of occasions when they have not come at all", "Weekends, you never know who is coming" and "Carers on public transport come at different times. Don't know what time they're coming. I spend my life

waiting in."
● The care workers we spoke with told us they did not use the electronic call monitoring app consistently. Some care workers were using the electronic call monitoring system, but their call visits were not being routinely checked by the provider. The deputy manager told us there was no automated way of checking call visit times and this was being done on an ad-hoc basis, calling people and their next of kin to find out if call times were being adhered to. The deputy manager said, "We don't have any data available to us in terms of late or missed visits but this is something we want to start soon."
● In addition, the provider told us a number of care packages were being refused as there were significant staffing issues, especially at weekends. The deputy manager said, "We have found that we have a problem at weekends as we have cover carers then." This was confirmed by the local authority who told us that a significant number of care packages had been returned back, some often with less than a days' notice. This meant that people could be left at risk of not receiving their care.

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

Assessing risk, safety monitoring and management
● Although risk assessments and management plans were available to staff this information was not always accessible to staff from a single source. For example, office-based staff confirmed that approximately only forty percent of peoples' paper records, including risk assessments and management plans, had been transferred onto the providers electronic care planning system, which had been operational for well over a year now. This meant essential information staff needed to help them prevent or appropriately manage risks people might face were not consistently available from one dedicated place, which increased the risk of errors occurring as some of the information in the paper and the electronic records was not consistently recorded.
● We discussed this ongoing record keeping issue with the provider who acknowledged progress to transfer paper records to the providers new electronic system had been slower than expected.
● One person's care plan said they needed support with their catheter. However, in this person's risk assessment in the section for catheter care it stated, 'No catheter in use', this risk assessment had not been reviewed since 2018. The provider was unable to explain this discrepancy. There was an increased risk that the risks around catheter care had not been properly mitigated against.
● In a separate safeguarding enquiry that had been concluded and it was found that an act of neglect/omission had occurred, it was identified that there was a lack of information on the care plan in relation to catheter care.
● In another person's risk assessment it stated that there was an increased risk in relation to self-care, but did not identify what this risk was and how the care workers could support this person in reducing the risk.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Care workers told us they completed Medicine Administration Records (MAR) charts if they supported people to take their medicines. The provider told us that completed MAR charts were brought back to the office once completed for auditing purposes. The provider was not able to produce any MAR charts when we requested these during the first day of the inspection, some were provided on the second day.
● We could not be assured that auditing processes were in place to check MAR charts for accuracy. The provider was asked for evidence of MAR audits but were not able to provide this information to us. We have

further reported on this in the Is the service 'Well-Led' section of this report.
● People and their relatives said they received appropriate medicines support.
● People's medicines support needs were recorded in their care plans, this included a list of their prescribed medicines.
● Staff received medicines training as part of their initial and refresher training.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People and their relatives told us that generally, they felt safe in the presence of care workers. Comments included, "Yes I don't think they are rough or unpleasant to her" and "I'm safe with the carers."
● Care workers were aware of safeguarding procedures and what steps they would take if they suspected that people were at risk of harm or abuse. They told us, "When you see any harm or abuse taking place then you have to report it to the office and record what happened." Records confirmed that care workers had received safeguarding training in the past year.
● The provider had a system in place for care workers to record and report any incidents and accidents that had taken place.
● There had been some safeguarding concerns in the past year, records showed that the provider did respond when concerns were raised. However, where there were follow up actions for the provider to do, it was not always clear if these were followed through. For example, in one safeguarding enquiry, the provider was required to give the care worker refresher training in reporting to the office and communication. However, the provider was not able to evidence that this had been done. We have further reported on this in the Is the service 'well-led' section of this report.

Preventing and controlling infection
● The provider did not operate robust systems to prevent visitors to their office's from catching and spreading COVID-19. On our arrival at the office staff failed to ask us for evidence to show we did not have COVID-19, contrary to the provider's own infection control/COVID-19 procedures for visitors.

We signposted the provider at the time of our inspection to resources to help them develop their infection prevention and control approach.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
Staffing
● The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

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 the last inspection this key question was rated as Requires Improvement. At this inspection, this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- At our last inspection in February 2021 we found that staff supervision had not been carried out as regularly in line with the providers expectations, mainly due to the impact of COVID-19.
- At this inspection, we found that staff were still not receiving regular formal supervision, in addition staff did not receive individual supervision. Out of four staff files we reviewed, three staff had only one recorded group supervision and one group appraisal since January 2021. Group supervision did not allow for individual practice issues or support needs to be discussed. This is not in line with good practice or the providers own policy which stated, "Day and Nite is committed to providing its care staff with formal supervision at least six times a year."
- Care workers told us that they were subject to spot checks but were not able to recall when they had their last individual supervision meetings.
- Staff meeting minutes although available were not recorded accurately. For example, when we reviewed staff group supervision meetings for two different dates, one held in February 2021 and one in September 2021 the recorded minutes were exactly the same verbatim.
- The above issues meant that we could not be assured that staff received the appropriate support and supervision from the provider to enable them to carry out the duties they were employed to perform.

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

- People and their relatives told us they had no concerns around the competency of the care workers that supported them. Comments included, "Sufficiently trained? Totally."
- Staff told us they attended the training as necessary.
- Training records for new staff showed that they received induction training when they first started with the service. Refresher training records that we saw showed that experienced staff were given refresher training in topics that were considered mandatory within the past year. These included, basic life support, dementia awareness, Mental Capacity Act (MCA), Health and Safety and falls prevention, medicines and food hygiene amongst others.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Initial assessments were completed when people first began to use the service. These considered any risk to people and also care plans which included people's support needs.
● People using the service told us that care workers looked after their general health and contacted the appropriate healthcare professionals if needed.
● Care plans included details of health professionals involved in people's care and support such as their GP, social workers and other community professionals such as district nurses.
● Records confirmed care workers had received first aid and health and safety training.

Supporting people to eat and drink enough to maintain a balanced diet
● People using the service and their relatives told us that staff supported them in relation to their dietary needs. Comments included, "The staff monitor what I eat. I need small portions and vegetables" and "They do breakfast. I meet them (the care worker) and tell them what is needed." One relative told us that staff supported their family member to eat food that was appropriate in relation to their medical needs, telling us "They (staff) do (relative's) food in accordance with their diabetes."
● Care plans contained details about people's dietary support needs and any preferences.
● Records confirmed care workers had received food hygiene training. Care workers told us they followed people's care plans but were also careful to ask people if they had any preferences in relation to their food choices. One care worker said, "I help [person] with breakfast, I ask her what she would like and respect her choice."

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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

We checked whether the service was working within the principles of the MCA.

● Care workers were familiar with the term MCA and what it meant in terms of their day to day role. One care worker said, "If someone is not able to make decisions for themselves then you have to help them make a decision and try and help them in the best way you can. We can ask their relatives."
● Relatives told us that care workers supported their family members to make choices and respected their wishes.
● Care plans included information in relation to the MCA, including their capacity to consent.

Good

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 remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- Feedback from people and their relatives was generally positive about the caring attitude of staff and the actual delivery of care. The majority of them told us that the care workers were kind and caring towards them. They said, "I think so we are like friends and feel comfortable with them", "I'm very blessed. Really good carers" and "They are nice to speak to, polite and considerate."
- Care workers told us they treated people equally and without discrimination. They explained how they did this in practice by respecting their religious beliefs and being sensitive to their individual preferences.
- Care records contained reference to people's cultural and religious preferences.
- In the provider's own analysis of survey results dated December 2021, 100% of respondents said their human rights were taken into account.

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

- People and their relatives told us they were involved in the initial assessment and development of their care plans. They said that their views were sought.
- Care plans that we saw included people's views and preferences in relation to how they wanted aspects of their care and support to be delivered, for example their personal care, their habits and their eating and drinking preferences.
- Care workers gave us examples of how they supported people to make their own decisions.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us that care workers encouraged their independence, telling us, "I can't use the bathroom. The carer never complains and I'm slowly getting independence back", "Very supportive. One of them took me for a walk. I can use the bus now. They've given me a new lease of life, quality of life" and "I am master of my own destiny." Care workers told us they encouraged people to maintain their independence without forcing them. One care worker said, "I try and find ways of encouraging people if they refuse any help."
- Care workers respected people's privacy and dignity. Care workers told us ways in which they supported people in a dignified and respectful way when they supported them with personal care. For example, they said that when supporting people with personal care they always made sure to ask people how they liked to be washed and offered them privacy. They said they were careful in respecting people's wishes.
- One person said, "They respect my dignity and reassure me. Excellent." Other comments included, "Yes, privacy and dignity are respected as is our home" and "They definitely treat me with dignity."

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 Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; Meeting people's communication needs;

- The provider had a system of both electronic and paper care plans in place. These plans included information about people's personal and physical health care needs and daily routines including, the start and finish times of their calls and what tasks staff were expected to complete during their home visits. The provider told us they were still in the process of migrating to one system but this had not been fully completed yet.
- People confirmed that copies of their care plans were kept at home.

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

End of life care and support
- Where appropriate, people's end of life wishes and contacts were known and recorded for staff to refer to.

Improving care quality in response to complaints or concerns
- There were systems in place to record and respond to complaints, however it was difficult to follow these through as the records were not always in place.
- We were not assured that the provider was capturing and recording all the complaints that had been received. The provider told us they had not received any formal complaints from people or their relatives which did not reflect the feedback that we received.
- Feedback from people and their relatives regarding complaints management was mixed, one person told us, "I have not made a formal complaint, as if I do they will just tell me to go elsewhere for care", "I have phoned them up when no one came and it was 09.30, they said they would get back to me, sometimes they do sometimes not" and another person told us, "I have never had to complain."
- The provider told us that all of the formal complaints received had been raised by the local authority as 'service concerns'. The provider kept a record of any concerns or complaints that had been received. However, it was difficult to review these to see if the provider had taken appropriate action. For example, where a concern had been raised in relation to missed visits, the provider said the care worker would be given a written warning and extra supervision. However, they were not able to provide us with the evidence to show that this had been done.

● One of the concerns raised following a quality assurance visit from the local authority in July 2021 was a delay by the provider in responding and meeting deadlines in relation to service concerns. During this inspection, we were not assured that the provider had made any improvements in this area.
● In the provider's own analysis of survey results dated December 2021, 45% of respondents had answered 'no' or 'sometimes' in response to the question, 'Are you satisfied that any problems or questions that you may have been dealt with as quickly as possible and answered?' We could not see any that the provider had acted on this feedback in their improvement plan.

We recommend the provider reviews how it captures, records and follows up the concerns and complaints received in a more responsive manner. We will follow this up at the next inspection of this service.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection in February 2021 we found the provider did not always operate effective governance systems which failed to identify or take appropriate action to address all the issues we identified at the time of that inspection. 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 was still in breach of regulation 17.

● Although the provider had made improvements in relation to some of breaches we found at the last inspection, the governance and quality assurance checks failed to identify the issues we found in relation to staff timekeeping.
● The deputy manager told us they had implemented a new electronic care planning and call monitoring system to monitor timekeeping. This issue had been noted in the last inspection and the provider had told us in their action plan that this would be in place by the time of our next inspection, however we found that it was still not being operated effectively.
● Call monitoring times were not routinely checked to see if care workers were attending on time or if there were any late or missed visits. The deputy manager said they would start to monitor these times more closely in future but at the current time there were no records in relation to auditing call visit time, "At the moment, we are auditing manually. I am just calling carers to remind them but there are no records. We are manually monitoring call visit times."
● In the last 12 months most staff had only received one unannounced spot check conducted by their line manager during a scheduled visit to observe staff working practices. This meant these staff monitoring checks were not being carried out at least once a quarter, contrary to the providers own governance and staff support policies and procedures. This menat that care workers were not subject to regular observation of their practice.
● In addition, the office-based managers and staff were unable to show us any completed medicines administration record (MAR) sheets, which we had requested to see as part of our inspection. The deputy manager told us completed MAR sheets were meant to be sent to their offices' to be audited by the office-

based staff every month as part of the providers quality monitoring of staff medicines handling practices. In the absence of these medicines records, the provider lacked the ability to check medicines were safely managed by staff and ensure any medicines errors or incidents that may occur were swiftly and appropriately dealt with.

● People and relatives we spoke with were generally happy with the quality of care they received but less so with the management and communication from the office. Feedback about the service was mixed, comments included, "I think the whole place is a shambles, it is not well managed", "They manage within the realms of what they do", "As far as I am concerned it is well managed" and "I don't think there is enough at the top. They need extra manpower."

● Staff told us they mainly communicated with the office staff and there was little contact with the registered manager of the service.

● The registered manager was not a visible presence at the service and there had been periods where she was not in day to day charge of the service. People and staff told us the deputy manager was their main point of contact.

● There were a number of records such as staff files and care records that we requested during the course of the inspection which the provider told us were in archive. However, they were not able to find these for us. The records stored in the archive room were not readily accessible and there was no organised filing system in place.

● A quality assurance visit completed by the local authority in November 2021 identified a number of concerns around staffing, timekeeping, governance and management of the service. This was a follow-up visit from previous visits in July 2021 and June 2021 where similar concerns had been raised by the local authority. We were not assured that the provider had the necessary management oversight to address these concerns.

● Although there were some evidence of quality assurance checks, we were not assured about how robust these were or whether the provider was proactive in addressing these. A quality assurance report dated December 2021 failed to identify the areas of concern we found during the inspection or to address those identified by the local authority in their quality visits throughout 2021. Where some improvement actions had been identified, there was no evidence of any progress against these in subsequent quality checks.

● In the provider's own analysis of survey results dated December 2021, where there had been some negative responses to questions, it was not clear if these had been followed up.

● Although the provider had an action and improvement plan in place we were not assured that the identified improvement actions had been acted upon.

We found no evidence that people had been harmed as a direct result of all the continued and new management oversight and scrutiny failures described above however, the providers established governance systems were clearly still not always being effectively operated. This placed people at risk of harm and was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to fulfil their regulatory responsibilities to notify the CQC without delay about certain incidents that adversely affected the health, safety and well-being of people using the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● One local authority told us they had received a total of 11 safeguarding concerns in 2021, of which eight

had progressed to a section 42 enquiry. Section 42 of the Care Act 2014 requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect. Another local authority said there had been five safeguarding concerns in 2021. The provider failed to submit a notification about these in line with their regulatory responsibilities.

We found no evidence that people had been harmed as a result of this failure to keep the CQC informed about such incidents however, it did place people at risk of harm. This represents a continued breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had established a range of methods to gather people's views about their experiences of using this home care agency. For example, the office-based staff made weekly telephone contact with people using the service to enquire how they were and if they had any concerns about the standard of home care they received.
- Care workers told us they did not have regular staff meetings and neither was their feedback sought. A number of them said there were often delays with their pay, with their wages sometimes not paid on time or not accurate according to the hours they had worked. They said these would usually be resolved when they contacted the office but found this frustrating.

Working in partnership with others

- There was evidence the provider was struggling to manage the care packages that they had been given. One healthcare professional told us, "The provider is emailing on a Sunday advising they are unable to attend service users, advising they are handing packages back to us the next day, which only gives the brokerage officers a few hours on a Monday to find new providers." This was acknowledged by the deputy manager.
- There had been some quality assurance visits undertaken by the local authority where concerns had been raised around the providers management and responsiveness to service concerns that had been raised.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC without delay about allegations of abuse or neglect involving people using the service. Regulation 18 (1) (2) (e).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to assess and mitigate the risks to the health and safety of service users of receiving the care or treatment. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure sufficient numbers of suitably qualified were deployed and persons employed received appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems to assess, monitor and improve the quality and safety of the service they provided people. The registered person did not always maintain complete and accessible records in respect of people using the service, staff they employed, and the management of the care home. The registered person did not act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; and did not evaluate and improve their practice. Regulation 17 (2) (a) (c) (d) (i) (ii)(e) (f).

The enforcement action we took:

We issued a warning notice