Horizon Homecare (Southern) Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Horizon Homecare (Southern) Ltd is a domiciliary care service. It provides personal care to adults living in their own homes in the Swanage, Poole, Bournemouth and Christchurch area. This includes a team of twilight staff, who provide night visits across the area. There were around 349 people using the service at the time of the inspection. Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

People's experience of using this service and what we found
People had varied experiences of Horizon Homecare (Southern) Ltd. Whilst we received some feedback from people who told us they felt safe and happy with the service provided, other people told us they felt unsafe and we identified areas the service needed to improve to ensure people received safe, effective and responsive care according to their individual needs.

The service did not have robust systems to identify when people's care calls were late or missed. This had led to people not receiving care calls and had placed people at risk of harm. Staffing levels were unsafe and did not meet the needs of the people using the service, yet the service had continued to take on new packages of care. People's care calls were often cut short and staff were sometimes booked to be in two or three places at once.

Medicines were not managed safely. The service had failed to identify low stocks of medicines, where staff were responsible for ordering, and where people had missed doses of medicines. Risks associated with high risk medicines had not been assessed and staff lacked the skills to manage these safely. The service could not provide assurances that people had been given their medicines as prescribed.

Risks to people had not always been assessed and where risks had been identified, staff did not have clear instructions on how to support people with those risks. People were at risk from the spread of infection, as the provider had not fully assessed and managed the risk of this.

The service had not always identified incidents as safeguarding concerns and had not appropriately reported safeguarding concerns to the local authority. This placed people at risk of not having safe care and treatment.

People's nutrition and hydration needs had not always been met. This had placed people at risk of malnutrition and dehydration.

People told us the care staff they knew well were friendly and caring but did not feel safe when these carers were not on duty. A relative said, "It is a different story when the usual carer has a day off or holiday, you never know who is coming or at what time. This is very disconcerting for an elderly person who needs to be

reassured." Some people had not always been treated with dignity and respect.

Robust systems and processes were not in place to ensure people were receiving care according to their needs. There were not enough staff to safely meet every person's care needs. Complaints had not always been investigated and responded to. This resulted in people's care needs not always being met and placed people at risk of neglect.

The provider had failed to monitor the quality of the service. This meant areas of improvement were not identified and people had been placed at risk of harm.

Staff felt listened to and supported in their job roles. Staff said the induction and training was informative.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, Right care, Right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was supporting only a small number of people who had a learning disability and or/autism. We looked at the care they received and found the service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
Right Support – The service worked with people, their family and social workers to maximise people's choice, control and independence.
Right Care – The service carried out regular reviews with people with a learning disability and/or autism and requested input from their social workers to ensure the right package of care was in place.
Right Culture – Staff empowered people with a learning disability and/or autism to lead their lives with confidence.

Since the inspection the provider has sent CQC an action plan to demonstrate how they will reduce the risk of missed and late care visits to people using the service. The provider has given assurances that medicines are being reviewed to ensure people receive medicines as prescribed. The provider has been open throughout the inspection and acknowledged the areas identified in the inspection need improving. The provider made the decision to not take on any new packages of care until such time the service has managed to put effective systems in place to oversee and monitor the quality of the service delivery.

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 (published 22 June 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. The information CQC received about the incident indicated concerns about the management of care delivery. This inspection examined those risks.

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

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

We sought urgent assurances around missed and late visits and the safe management of medicines. The provider gave assurances that systems and processes have been put in place to mitigate the risk of missed and late visits and medicines are being reviewed to ensure people's medicines are administered safely. The provider told us they were working with specialist consultants to provide medicine training for all staff and were arranging for the in-house trainer to undertake a medication "train the trainer" course to ensure staff training is reviewed and kept up to date.

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, dignity and respect, safe care and treatment, safeguarding people from abuse, receiving and acting on complaints, good governance, staffing and notification of other incidents to CQC.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Horizon Homecare (Southern) Ltd

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 team consisted of two inspectors, one medicines inspector, two assistant inspectors and three 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service is required to have 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. There was not a registered manager at the time of the inspection. The provider had taken over the duties of the registered manager in the interim and is referred to as the provider throughout this report.

Notice of inspection
This inspection was unannounced. We attempted to give a 24-hour notice of the inspection. This was to ensure a member of staff would be in the office. Unfortunately, the service did not respond to our telephone calls and messages and were not aware of our visit before we arrived.

Inspection activity started on 19 January 2022 and ended on 17 February 2022. We visited the location's

office on 19 January 2022, 27 January 2022 and 3 February 2022.

What we did before the inspection
We used information gathered as part of monitoring activity that took place on 15 December 2021 to help plan the inspection and inform our judgements. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with two people who use the service and 31 relatives about their experience of the care provided. We spoke with 28 members of staff including the provider who is also the nominated individual, head of care, locality manager, welfare administrator and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. These included ten people's care records and six medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We liaised with the local authority who continued to provide support to the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely. People taking anticoagulant medication had not been assessed for risks associated with a high-risk medication that could cause excessive bleeding and bruising. This meant staff had not received instructions to mitigate risk and placed the person at risk of harm.
- We checked the records of four people for whom the service was responsible for ordering medicines. These records all showed people had not had medicines administered as prescribed; one person should have taken an antipsychotic medicine daily but had not had it for 13 days. The system was not robust and had failed to identify low stock and missed medicines. This had placed people at risk of harm.
- Medication Administration Records (MAR) were not always accurate, kept up to date or completed in accordance with best practice guidance. Medicine allergies were not always recorded, and additional specific instructions had not always been included. This meant staff had not been provided with information they needed to administer medicines safely.
- One person was prescribed a transdermal patch to be changed every three days and this had not been managed well. Over the period of 28 days on six occasions the patch was either applied a day late, or a day early. Staff failed to record where the patch had been applied. The service had not identified errors with the application of the patch, which placed the person at significant risk of harm.
- Whilst staff had completed basic medicines training, this was not sufficient. Staff had not identified the concerns we found in relation to high risk medicines such as anticoagulants and controlled medicines such as transdermal patches. Staff communication records were reviewed and showed staff were not confident in administering warfarin. This had put one person at risk of harm due to staff administering to low a dose of warfarin for six days placing the person at risk of blood clots.
- The medicines policy did not contain information specific to the service. The policy did not set out the systems and processes to ensure the robust management of medicines. This meant staff had not been provided with the information they required to ensure medicines were managed safely and had placed people at risk of harm.

Medicines had not been managed safely and people had been exposed to risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider for assurances that people would receive their medicines as prescribed. The provider sent us an action plan to demonstrate how they would mitigate risk of harm to people. After the inspection the provider told us they had sought professional consultant advice and was reviewing their medicine policy. The service was reviewing people's needs, conducting refresher medicine training and ensuring staff received a full competency assessment to confirm they had understood the training and their roles and responsibilities.

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

● People had been placed at risk of neglect. Risks associated with missed and late visits had not been assessed and plans had not been made to manage the risk of neglect and harm. Eleven relatives told us that their loved one had their visits missed; seven relatives reported multiple missed visits. Comments included: "There has been times when they have not turned up, we've had four missed calls", "When someone has a day off, they can't cover the call but they don't let you know" and, "The missed calls meant late medication and late personal care." During the inspection we found three people had visits missed which had resulted in missed meals and/or missed medication.

● One person and 13 relatives told us care calls were two hours or more late. Comments from relatives included: "The 'morning' carer did not arrive until way past noon… the time for taking tablets were late. The lateness of taking tablets affects the time between doses, which is a concern", "They're late all the time, can be up two hours late and they don't ring to inform you" and, "There's times mum has got herself up early for her morning carers to wash and dress her, only to be sat on the toilet for at least two hours."

● People's long-term health conditions such as diabetes had not been risk assessed and care plans contained no instructions to staff to provide person-centred support including signs and symptoms staff should monitor the person for. A person with a diagnosis of epilepsy did not have specific seizure risk assessments. Their care plans did not include guidance to tell staff what triggers may lead to a seizure, what signs the person may display before having a seizure or what different types of seizure the person may have. This meant staff did not have the instructions to provide support to the person and had placed the person at risk of harm.

● Risk assessments were not always effective at identifying and mitigating risks to achieve good outcomes for people and had placed people at risk of harm. One person had been identified at risk of falls; this had not been transferred to the persons care plan and did not include a plan of how staff should support the person to prevent them from falling. Staff told us they looked at care plans and followed risk assessments, this meant people were at risk of not having their needs identified and met.

● The service did not have systems and processes in place to gather and monitor safety related information. Accidents and incidents were not analysed, and concerns were not always investigated. This meant the service did not learn from concerns, accidents, incidents and adverse events which placed people at risk of harm.

Risks to people had not been effectively assessed or mitigated and people had been placed at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider for assurances that the risk of people having missed or late calls would be managed. The provider sent us an action plan, two new members of staff were monitoring care calls and making telephone calls where concerns were found to ensure people received their visits.

Staffing and recruitment

● Staffing levels were unsafe and did not meet the needs of the people using the service. The provider and staff told us staff recruitment had been a challenge; however, the service had continued to take on new packages of care. This had led to staff not being able to meet people's care needs.

● The service did not ensure staff had time to give people the care and support they needed or to respond to emergencies or incidents. Staff told us they had limited travel time between care calls and often found they had been double, or triple booked for one time. We received comments from relatives such as: "Staff do not stay the full half hour and rush off", "Visits are often rushed" and, "Dad has not always had his full allocated time for visits, carers don't always stay the full amount of time and I suspect this is because they need to travel and fit in their other visits." Records showed staff did not stay for the allocated time. The provider told

us they were aware that staff were cutting calls short. This meant people were at risk of not having their needs met.

The service had not recruited enough staff to make sure that they could meet people's care and treatment needs and this had placed people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment systems were robust and made sure that the right staff were recruited to support people to stay safe. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as required by the regulations.
● Since the inspection the provider has stopped taking on new packages of care. The provider has acknowledged they need to make the service safe for the people using it and are reviewing their staffing levels against the needs of people. Where the service is unable to meet a person's care needs, they have discussed with the local authority and given notice to ensure all people's care needs are met.

Preventing and controlling infection
● Risks to people's health and welfare had not been assessed in relation to infection prevention and control. This placed people at risk of the spread of infections and placed people at risk of harm.

The provider had not assessed the risks associated with infection in order to detect, control and prevent the spread of infections. This had placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not all taking part in routine COVID-19 testing as advised by the government. This put people at risk of getting COVID-19 from staff, yet the provider had not assessed and managed this risk.
● Staff had plentiful access to Personal Protective Equipment (PPE). People and relatives told us staff wore PPE appropriately.
● Staff had received training in Infection Prevention and Control
● Since the inspection the service has introduced regular COVID-19 testing in accordance with the current government guidance.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes to safeguard people from abuse were not effective, which had led to the service failing to identify neglect and abuse. We found nine safeguarding incidents during the inspection that had not been identified by the service. This meant concerns had not been investigated, lessons had not been learned and actions had not been taken to help prevent reoccurrence.
● The service had not made appropriate referrals to the local safeguarding team. This prevented external scrutiny to ensure people were safeguarded from abuse and people had been placed at risk of harm.
● Safeguarding policies and procedures were not fully embedded. Staff had received training in safeguarding adults. However, the safeguarding policy had not been followed when information of concern was reported to the service and people had been placed at risk.
● We received mixed feedback from people who use the service and relatives. One relative said, "She is in safe hands, she likes them, and I feel happy she is in good hands." Another relative said, "She does not feel safe with them" and a further relative said, "No [person] does not feel safe really."

People had not been safeguarded from the risk of harm and this had placed people at risk of neglect and abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider has strengthened the reporting processes to ensure all safeguarding concerns are investigated and reported to external bodies as required. Further training for staff is being sourced to ensure staff know how to identify safeguarding concerns.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's nutritional and hydration needs were not always met. One person had been identified as at risk of dehydration. A food and fluid chart had been put in place; however, it did not contain instructions to staff including what fluid target the person should be aiming for, what to do if the person did not reach the target or signs and symptoms of dehydration staff should monitor the person for. The food and fluid chart had not been checked and we found days where no information had been recorded. This meant the person was at risk of dehydration and staff not seeking appropriate medical advice if required.
- Nutrition and hydration assessments were not always effective at identifying risks and robust plans were not always in place to ensure people's needs were met. One person whom the service was responsible for meeting their eating and drinking needs, had been identified as needing food and fluids little and often. The assessments and care plan did not state how staff should ensure the person had access to regular snacks and drinks in between care calls. This put the person at risk of not having enough food and drink.
- We received feedback from relatives and people regarding the support they received to eat and drink. Comments included: "Cooking isn't good, tend to burn her meals. They will often grill something which needs to be cooked in the oven", "Meals have been served too hot, straight from the microwave which has burned her mouth" and "Food is a problem, one of them put a slice of gala pie to heat up in the microwave, with two baby bels on top!" We also received feedback from relatives that staff did not always check use by dates and had served out of date food to their loved one.

The service had not always ensured the nutritional and hydration needs of people were met which had placed people at risk of malnutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider told us they are currently reviewing their documents and assessments to ensure they are more robust.

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

- People's had needs were assessed before the service started supporting them. People and relatives told us they were involved in the planning of their care with social services, who passed on the details to the service. The service completed their own assessments with this information.
- The assessments were not comprehensive and did not capture information such as people's preferences for how they would like their tea or coffee or how to support people with their oral hygiene needs.
- Protected characteristics under the Equality Act 2010 were considered. For example, people were asked

about any religious or cultural needs so these could be met.

Staff support: induction, training, skills and experience
● Staff told us they felt supported in their role. Staff had regular formal supervisions and spot checks, which were two-way conversations and opportunities to learn, develop and ask questions.
● We received mixed feedback about staff skills from relatives and people using the service. Comments included: "Most of the carers do [know how to work properly] but there are carers we have who do not know what they are doing", "Staff are well trained, they do know what they are doing" and "I'm not sure… some are better than others."
● Staff had undertaken core training and were required to complete annual refresher training. This included moving and handling, fire safety, medication and infection control.
● Staff told us they had received a comprehensive induction. Staff new to care were required to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of 15 minimum standards that should form part of a robust induction programme.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access healthcare services. The service had a dedicated welfare team to seek medical advice from the appropriate healthcare professional when concerns were reported to them from staff, people or relatives. We received comments from relatives including: "The nurse has been called before and a few times they have called the paramedics, they have been brilliant" and, "The carer was concerned about [person's] pains and they called the GP." Other relatives said, "Often he or I have to make contact as staff are reluctant or unable to do so" and, "I don't think they notice things, they didn't pick up on her cough or swelling in her legs."
● We sought feedback from social workers, occupational therapists and GP's. None provided feedback of concern and one district nurse said, "As a team we don't have any concerns."
● Horizon Homecare (Southern) Ltd worked with other care agencies to provide support to people including a roving nights service, which one commissioning team said was "running very well".

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

● Staff knew about people's individual capacity to make decisions and understood their responsibilities for supporting people to make their own decisions.
● Where a person had appointed someone to have lasting power of attorney for their health and welfare, they consented to care on the person's behalf.

● People's consent was sought to confirm their agreement to have care provided. If there were concerns that someone might lack the mental capacity to give consent, this was assessed and where a person was found to lack capacity, a best interests decision had been recorded so the person's needs were met in the least restrictive way possible.

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 good. At this inspection the rating has changed 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

- People using the service were not always treated with dignity and respect. One relative told us, I was on the phone with mum and heard her ask for dessert. I heard the carer say she had already eaten and 'you don't need desserts.' I felt like he was telling her off." Another relative told us, "Most carers do not talk to mum and don't respect her wishes."
- One person requiring one female care worker told us they had felt uncomfortable when a male member of staff had accompanied a female member of staff to a care call and stayed in the room whilst the person was being assisted onto the commode.
- We received feedback from other relatives with comments including: "Yes carers are kind and caring and they tend to be very helpful and treat mum with dignity and respect.", "Yes, very kind and respectful" and, "Yes carers are very kind and caring and always respect her dignity."

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People and relatives spoke highly about their regular care staff. One person said, "They are kind and caring." A relative said, "We have found the staff to be very kind and caring." A further relative said, "They are kind, caring and basically listen to [person's] wishes."
- People and their relatives had been involved in creating their care plans. Records showed people were asked to express their views in reviews, changes to plans had happened when requested.
- People's cultural and spiritual needs were respected. People were asked about their beliefs and practices during their assessment.

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 good. At this inspection the rating has changed to Requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The service did not have a robust system in place to identity, receive, record and handle complaints. This had led to a shortfall in identifying concerns and actions not put in place to mitigate risk and had placed people at risk of harm.
- The complaints policy was not embedded into the service. We found written records of complaints being phoned into the service by relatives which had not been investigated and responded to. This meant the service had missed opportunities to improve the quality of care. One relative told us they had raised concerns regarding poor care delivery, late and missed visits and received no response. The concerns continued and had placed the person at risk of harm.
- People and relatives were not aware of the complaints policy. One relative told us they had tried to find the complaints policy including checking Horizon Homecare (Southern) Ltd website and were not able to find one. Another relative told us, "I asked for a copy of Horizons complaints policy and was told to write to the local authority if I had a problem by [a manager]. I actually wanted to make a formal complaint but was unsure how to do it."
- Comments from relatives included; "Yes, I've complained about late calls and the cooking, nothing changes", "Concerns are rarely rectified these days sadly, you are told they are taken seriously and that is that, you are lucky if you get a reply to any kind of outcome no matter how serious the matter is" and, "I've had emails that have not been acknowledged when I have brought up issues of concern such as soiled bedding and food past its use-before date."
- The service did not have effective systems to monitor complaints over time. This meant the service was unable to look for trends and areas of risk that may be addressed. This included areas of concern we found in the inspection which had placed people at risk of harm.

The service had not ensured a robust complaints system and process was in place. People were not aware of how to complain and concerns had not been acknowledged, investigated and responded to. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider told us they were reviewing their internal processes so that more robust procedures are in place and embedded into the service.

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

- People did not always receive personalised care that reflected their preferences and met their needs. Relatives reported a noticeable decrease in person centred care, particularly when the routine carer staff were not at work. One relative said, "It really is a game of two halves, the normal two main carers are good,

but her relief carers, are not reliable." Another relative said, "They don't personalise her care. I have only once heard someone say to her 'How do you like your tea?' It's the little things that matter."

● Care plans were not always person-centred, so staff did not have the information they needed to provide for people's individual care needs and preferences. Consequently, there was a risk that people's needs would go unmet. For example, information identified in risk assessments, such as "[person] may cease communicating if they become confused", had not been reflected in people's care plans.

● The service sent male care staff to people who had requested female only staff. The service told inspectors they had contacted people to let them know; however, relatives told us they had not been contacted and this had caused distress. One relative said, "They sent in a male carer which really upset [person], they did not inform us beforehand. [person] woke up to find a man standing over her in her bedroom and was totally shocked."

● Staff told us care was not delivered as per the care plan on the days they were not on duty. One staff member said, "When I have a day off I feel guilty as I read the [daily notes] system and see things like they have not been taking her teeth out or not let her have a little wash or not put her to bed with a pad. There is a care plan in there and it is so clear and plain as day what you have to do."

● One relative told us they were concerned their loved one was still in bed past 11am. When the daily records were checked the entry for this care call did not contain a brief summary of the care that should have been provided as per the care plan, nor why the person had been left in bed.

The care and treatment of people had not always been appropriate and had not always met their needs or reflected their preferences. This is a breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider told us they were reviewing their documents so that clear risk assessments are in place where information can be transferred to care workers.

Meeting people's communication needs

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

● The service had not established an effective system to ensure the Accessible Information Standard was met. Peoples communication needs were identified by assessments, but care plans were not always reflective of this and did not contain enough information for staff.

● One person unable to communicate verbally had a care plan which told staff the person communicated with facial expressions and body language but did not explain what the expressions and body language meant.

● Relatives told us their loved one would not understand the care plan and the service had not helped them understand. Comments included; "I don't think so, they don't help her understand", "This has not happened" and, "He is able, but I don't think he has the care plan."

The care and treatment of people had not always been appropriate and had not always met their needs or reflected their preferences. This is a breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider told us "At the time of assessment, the assessor will always try to include the service user and family members where possible. Where the service user finds difficulty in

communicating their needs, the assessor will always ensure an advocate or family member is present." The provider told us they would review all their documentation.

End of life care and support

● Horizon Homecare (Southern) Ltd were not providing end of life support at the time of our inspection. Staff told us they had completed end of life training and felt confident in their roles and responsibilities.

● People's end of life wishes had not been sought through assessments and care planning. We fed this back to the provider who told us risk assessments were carried out at the point a person required end of life care and would review their documents.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- People and relatives did not feel the service was well-led. Comments from relatives included: "Management could be much better with improved procedures", "Seriously lacking, a not very well led organisation" and "The management are not interested."
- Due to a lack of governance and quality checks, we found not all people had received care and treatment that meet their needs or preferences. Risks had not always been assessed and managed, which placed people at risk of harm, of potential abuse and of not having their care needs met.
- The service did not have a robust system and process to ensure incidents, risks, issues and concerns were reported. This had led to concerns being missed and had placed people at risk of harm. One relative had not been informed for several weeks about an incident which had resulted in harm for their loved one. The incident had not been reported correctly, meaning it had not been investigated and actions taken to prevent a further occurrence.

Systems were either not in place or robust enough to ensure the quality and safety of services was effectively managed to provide good outcomes for people. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was open and honest throughout the inspection. They told us they recognised the matters that needed to be addressed and the improvements that needed to be made.
- The provider made the decision not to take on any new packages of care until such time effective systems were in place to oversee and monitor the quality of the service delivery.
- Since the inspection the provider had started weekly meetings with staff from each department of the service. This meant they could review what had occurred the week previously and could plan for the current week. Through this improvement, the provider had identified people who required more support to have their needs met and put this in place.
- The service worked with other agencies to provide care to people including other care agencies and the social services team in the local authority.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully

considering their equality characteristics; Continuous learning and improving care

● The structure of the service was not clear. Job roles did not accurately reflect staff responsibilities. For such a large service the job structure did not support it, and this had led to poor communication, poor review of records to ensure people's needs were being met and lack of oversight, which had placed people at risk of harm.

● The registered manager had recently left. The provider had stepped into this role and told us they planned to do this until they recruited another registered manager.

● Governance systems were not robust or effective. The provider was not aware of the concerns found during the inspection that had led to people being at risk of not having their needs met and at risk of harm. For example, a lack of monitoring had failed to detect missed and late visits.

● The provider did not have consistent systems for effective communication, which had led to some of the shortfalls found at this inspection. Comments from relatives included: "This business does not communicate effectively", "They need someone on call, not just for us to leave a message, it could be an emergency" and "Communication is their biggest issue."

● Staff were not always able to get through on the on-call system. This meant people might be unsafe or that staff might not be able to meet their needs. Comments from staff included; "You seldom get through to a person, it's more likely to be an answerphone", "The on-call system does not work" and "It can be hit and miss."

● The service was unable to learn and improve as it lacked the systems and processes to identify areas of improvement. This had led to the concerns found during the inspection.

Systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider has told us they are in the process of re registering as the registered manager until a permanent manager is recruited. The provider told us a permanent Deputy Manager has been recruited and due to start in April. The provider told us they have started working with specialist consultants to improve the areas of the service identified in our inspection. The provider told us they were reviewing their governance systems and processes.

● The law requires services to notify CQC of certain significant incidents, such as serious injury, death and actual or suspected abuse. This assists CQC to monitor the service and take any action needed to support people's health and safety. The registered manager failed to notify CQC of two incidents where people had been placed at risk of harm and abuse.

The service had failed to notify CQC of incidents that affected the health, safety and welfare of people who use the service which is their legal obligation to do so. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 People did not always receive person-centred care according to their needs.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service had not always ensured the nutritional and hydration needs of people were met which had placed people at risk of malnutrition and dehydration.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not always investigate complaints received from relatives regarding the safe care and treatment of their loved one. The service did not have a robust system in place to identity, receive, record and handle complaints.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of staff to make sure that they could meet people's care and treatment needs.

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 service had not always provided safe care and treatment. We found some people had received late care calls which had impacted on their medicines and meal time. We found some people had their care calls missed impacting on missed medicines and missed meals. Medicines were not managed safely and risks to people had not been assessed to mitigate risk of harm. The service had not assessed peoples risk to prevent the spread of infections.

The enforcement action we took:

We issued a notice of proposal with positive conditions to drive improvements in the service.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse. Effective systems had not been established to identify, investigate and report safeguarding concerns.

The enforcement action we took:

We issued a warning notice which requires the provide to make improvements by a date set in the warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance systems in place to oversee the service to ensure safe quality care delivery. The provider did not have effective systems and processes such as regular audits of the service provided to identify themes and trends for areas

of improvement.
The provider did not have robust system and processes in place to ensure the monitoring of missed and late visits was embedded into their quality assurance systems.
The provider failed to have consistent systems in place to facilitate effective communication. This included having a robust on call system.

The enforcement action we took:

We issued a notice of proposal with positive conditions to drive improvements in the service.