Nation Care Agency Ltd

Nation Care Agency

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
Nation Care Agency is a domiciliary care service providing personal care and support to people living in their own homes. The majority of people receiving support had their care funded by the local authority. At the time of the inspection the service provided support for approximately 170 adults, which included a majority of older people and a few younger adults. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not ensure the management of risks was effective as risk management plans for identified risks were not always developed to provide care workers with guidance on mitigating the risks. Medicines were not always managed appropriately to ensure people received their medicines safely. The provider did not always deploy care workers appropriately to ensure care visits were carried out at the planned time and for the length of the allocated time.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The provider could not demonstrate care workers had completed training they had identified as mandatory in line with their policy.

Care plans were not written in a person-centred manner which identified the person's wishes in relation to how they wanted their care provided. The daily records of care provided during each visit, which were completed by care workers, were task focused and did not reflect the experiences of the person receiving support. People's wishes in relation to how they wanted their care provided towards the end of their life were not identified and addressed. People's communication support needs were also not always identified so appropriate plans were put in place to meet these needs.

The provider had a quality assurance system and carried out a number of checks to monitor the quality of the service, but these were not robust enough to identify where there were issues and improvements were required, so these could be addressed.

Care workers had access to the personal protective equipment they required when providing support such as gloves and face masks. The provider had a safe recruitment process in place. Care plans identified if people required support to prepare and/or eat meals. People were supported in making decisions about their care. Care workers felt they were supported and that the service was well-led. The provider worked in partnership with the local authority.

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 (26 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received from the local authority about care visits not being carried out as planned, visits being cut short, staffing levels, training and the provider's quality assurance procedures. A decision was made for us to inspect and examine those risks.

We initially undertook a focused inspection to follow up on the concerns raised by the local authority. We inspected and found wide ranging concerns, so we widened the scope of the inspection to look at all the key questions.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, need for consent, safe care and treatment, receiving and acting on complaints, good governance and staffing.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Nation Care Agency

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. Following the inspection two Experts by Experience undertook telephone interviews with people receiving support and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 2 November 2021 and ended on 11 November 2021. We visited the office location on 2 and 3 November 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commissioned care packages from the service. 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 took this into account when we inspected the service and made the judgements in this report. We reviewed notification and any other information received from the provider since the last inspection. This information helps support our inspections. We used all of this information to plan our

inspection.

During the inspection
We spoke with the registered manager, business and quality assurance manager, operations manager and two care coordinators. We reviewed 11 people's care plans and the employment records for 10 care workers. We also looked at multiple medication records and a range of records relating to the management of the service including audits.

After the inspection
We obtained feedback about the service as we carried out telephone interviews with 13 people who received support and 11 relatives. We also received feedback from 17 care workers. We continued to seek clarification from the provider to validate evidence found. We looked at training records and electronic call monitoring 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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider did not ensure the management of risks was effective as risk management plans for identified risks were not always developed to provide care workers with guidance to minimise the risks.
• The care plan for one person indicated they had complex support needs which included the use of oxygen but the guidance provided in the environment risk assessment, which was completed in 2018, only stated that the person's oxygen mask needed to be removed before care duties. A risk management plan had not been developed and a risk assessment for the use of oxygen had not been completed. The moving and handling risk assessment for this person had not been reviewed since 2018. The person required a number of equipment to enable care workers to move the person safely and the risk assessment had not been reviewed to ensure there had not been any changes in the person's support needs or in the use of the equipment required to care for them.
• We saw that when a person had been identified as having a specific risk, a risk management plan had not been developed to provide care workers with guidance on how to mitigate possible risks. Where a person had been identified as living with diabetes there was no guidance in place for care workers on how this illness can impact the person and possible risks to them. Another person's care plan stated they had a tracheostomy, even though the care workers were not providing direct support for the tracheostomy, a risk management plan had not been developed to provide them guidance in relation any impact this may have on how care was provided and what to do if complications arose while they were providing personal care. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe.
• The provider had not developed COVID-19 risk assessments or management plans for people they were supporting and care workers. This meant possible factors which could have increased the level of risks to a person if they were to develop COVID-19 such as existing medical conditions and ethnic background had not been considered.

The fact that risks were not always identified, and management plans were not always put in place or reviewed meant people were at risk of not receiving care in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, the provider completed a risk management plan for people's home environment which included flooring, electrical equipment, kitchen equipment and the position of furniture.

• A moving and handling risk assessment was also completed for each person which identified any equipment used, any health issues and how many care workers were required to provide appropriate care.

Using medicines safely
• The provider did not ensure medicines were always managed safety. .
• The medicines administration record (MAR) chart for one person indicated they had been prescribed a medicine for pain relief and a second medicine to assist with sleeping which were to be administered as and when required (PRN). The provider did not have a PRN protocol in place to provide care workers with guidance on when they should administer these medicines.
• The MAR chart for one person indicated they had been prescribed a laxative with the direction of to be administered every night. The MAR charts for July and August 2021 showed that the care workers had not always administered this medicine, but no reason was recorded. The MAR audit dated 3 September 2021 identified this medicine had not been regularly administered as prescribed as care workers decided the person did not require it. However, a care coordinator explained that the instructions to take the medicine have been reviewed and were to be given when required, but the MAR chart had not been updated to reflect the change. The care coordinator agreed that the MAR chart should have been updated.
• One person's MAR chart indicated they had been prescribed a variable dose of a medicine which meant staff could decide whether to support the person with one or two of the tablets. There was no indication on the MAR chart how many tablets had been administered on each occasion. The provider did not have a PRN protocol in place to show when care workers should administer one or two tablets. This meant the care workers could not monitor the effect of the medicine on the person or the stock level of the medicine to ensure they do not run out.
• The provider had not completed medicines risk assessments for people receiving support with their prescribed medicines to identify any possible risk and they did not have a list of the prescribed medicines. This did not follow the National Institute for Health and Social Care Excellence guidance 'Managing medicines for adults receiving social care in the community'.

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

Staffing and recruitment
• The provider did not ensure care workers were deployed appropriately to ensure people's care visits happened at the agreed time and as planned for them.
• People and relatives, we spoke with told us they experienced issues with care workers not arriving on time and not staying for the full visit time. One person told us, "They don't always let me know if they are going to be late. My [relative] rang them when no one had arrived, and it was three hours past the normal time. They did eventually send someone."
• Relatives commented, "We have time keeping issues, they are frequently not good, they don't inform us if they are going to be late. They are always 30 minutes to one hour late. I do all the chasing, they don't inform us", and "This is an issue at times. One or two hours late is an issue especially when you have to find out when the carers are coming. They should be doing the first call at 7am but sometimes they are not here until 9am." One relative told us the care workers only supported their family member to manage their continence care but did not wash the person as they were meant to and were "in and out, they are meant to stay 30 minutes."
• We reviewed the electronic call monitoring records for the week of 25 October 2021 to 31 October 2021. These records showed the planned and actual visit times for all the care visits completed by 98 care workers during this week. We found that 120 care visits had been scheduled for 31 care workers which overlapped a visit for another person. We also found 46 care visits had been allocated to 23 care workers without travel time for the next visit so one visit ended at the same time the next visit started. This meant these care visits did not always happen at the planned time with some visits occurring over one hour later or earlier than planned.

The above showed that the provider had not ensured care workers were always appropriately deployed to make sure care visits occurred as planned. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had an effective recruitment process in place which supported them to check new staff were suitable for the role.
• During the inspection we looked at the recruitment records for four new staff members who had been recruited during 2021. We saw each staff member's records included a full employment history, two references and a criminal record check which followed the provider's process.

Learning lessons when things go wrong
• The provider had a processes for recording incidents and accidents and safeguarding concerns, but these were not always robust enough as they did not always identify where lessons had been learnt, what remedial actions were required to prevent reoccurrence and risk assessments were not always updated.
• We reviewed the records for four incidents/accidents. We saw the one record related to a fall which occurred in September 2021 where the incident form stated the person's moving and handling risk assessment should be updated but we found this had not been reviewed. We raised this with the registered manager, and they provided an updated risk assessment following the inspection.
• The records for three safeguarding concerns were reviewed and we saw that there was limited information recorded about what happened with no lessons identified as to how to mitigate risks. The records for one safeguarding stated that the ambulance service was called but the reason was not recorded. The record had been signed off by the registered manager but there was no indication if any lessons had been identified and any further actions to reduce the risk of reoccurrence. The records for another safeguarding concern did not include any information on any actions taken and lessons learned. Two other records stated spot checks should be carried out but there was no indication these had occurred.

The provider did not always ensure learning took place with care plans and risk assessments being updated appropriately when things go wrong. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People we spoke with told us they felt safe when they received care in their home. One person commented, "It's the way they treat me, the way they act that makes me feel safe." Relatives we spoke felt that in general their family member was safe during care visits. One relative said, "We feel our family member is safe with the carers who come and there is always a family member around."
• The provider was familiar with the safeguarding adult procedures and reported safeguarding concerns to the local authority, when these were identified.
• Care workers who responded to us demonstrated they had an understanding of what safeguarding means and impact it had when providing care and support. One care worker told us "Safeguarding in my view is ensuring an individual is free from abuse and neglect & promoting their rights to be safe."

Preventing and controlling infection
• The provider had an infection control procedure and had provided care workers with infection control training.
• People receiving support and relatives confirmed care workers wore the appropriate personal protective equipment (PPE) during a visit. One person told us, "They do wear full PPE and before they go they make sure my bathroom and kitchen is cleaned after they have used it" and a relative commented, "They wear their masks all of the time and use disposable aprons and gloves. I assume they wash their hands as well frequently. They also ensure they dispose of my family member's soiled incontinence pads in the right waste

bag."
• Care workers told us they had completed infection control training and they had a good supply of PPE when they carried out a visit.

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

Staff support: induction, training, skills and experience
• The provider did not ensure care workers had completed training in line with their procedures so that their skills were up to date, and they could meet people's care needs appropriately.
• The registered manager confirmed that all care workers should complete the training they had identified as mandatory with annual refreshers. The mandatory training was the 15 Care Certificate standards which included safeguarding adults, fluids and nutrition and basic life support. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.
• The training records indicated that 64 care workers had completed training in relation to dementia, medicines and moving and handling during 2020 but the registered manager could not demonstrate they had completed any other mandatory training since they commenced their employment. This meant the provider could not demonstrate the care workers had completed the additional 12 training courses they identified as mandatory which included safeguarding adults and health and safety.
• The training records for 103 staff members showed that not all staff had completed the annual refreshers for mandatory training. The records indicated that 19 care workers had completed the 15 mandatory training courses in 2020 but 11 of the care workers had not completed their annual refresher courses within the one year timescale in line with the provider's procedure. For example, one out of the 11 care workers had last completed their annual training in January 2020 with another one completing it is March 2020.
• Out of the 11 care plans we reviewed the care plan for one person indicated that care workers supported this person to eat their food. The registered manager confirmed that care worker had not received specific training on how to safely support people when helping them eat. This meant the person may be at an increased risk of choking.

The provider had not ensured care workers always received appropriate training and support so they were appropriately skilled to meet people's care needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The training records identified that 20 care workers who started their employment during 2021 had completed mandatory training courses as required.
• The registered manager confirmed that care workers should have four types of supervision yearly which included a one to one meeting, an appraisal, a spot check and attending a group supervision which is a staff meeting. The supervision records for care workers that we reviewed indicated supervisions had taken place

as required.
• People receiving support and relatives we spoke with, in general, felt the care workers had appropriate training and skills to care for them.

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

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

• The provider did not always undertake mental capacity assessments where people might not have the capacity to consent to their care, in line with the MCA. Also, they did not ensure the principles of the MCA were followed in relation to people's representatives consenting to the person's care on their behalf.
• As part of the care plan there was a section which identified if the person using the service wished another person to act as their representative. We saw the care plan for one person stated that they wanted a family member to act as their representative. This section had been signed by the family member but there was no indication that the person using the service had made this decision. Also, there was no indication that the person had the capacity to make this decision. We found the care plan section for five other people had been completed in the same way.
• The care plan for one person stated that the person's memory had deteriorated. The profile section of the care plan indicated the person had an appointment with the memory clinic but there was no information on the outcome of the appointment. The person had signed their care plan to consent to care but the provider had not undertaken a mental capacity assessment to ensure they had the capacity to consent to the care being provided.
• The care plan for one person who had complex care needs had been signed by a relative but there was no indication that the person receiving care did not have capacity to make their own decisions relating to their care as mental capacity assessments had not been carried out.

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

• The care plans included a section which identified if a person's representative making decision on behalf of the person, had a Lasting Power of Attorney and if a copy had been seen. A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people to help them make decisions or to make decisions on their behalf.
• Care workers demonstrated they had an understanding of the principles of the MCA.

Supporting people to eat and drink enough to maintain a balanced diet
• People and relatives, we spoke with confirmed care workers provided support with preparing meals and supporting people to eat.
• Comments from people receiving support included "I can no longer get into my kitchen so their help with my meals is essential. They always ask me what I would like, and they are happy to do me a sandwich or

microwave a meal for me. They also make me cups of tea or coffee. They also leave me with plenty to drink such as water in between their calls" and "My family member does my food shopping, so I always have plenty of choice in the fridge. The carers always ask me what I would like and do it for me."
• A relative confirmed the care worker appropriately supported their family member to eat as they were unable to do this independently.
• The care plans identified if the person required support with preparing meals and/or with eating. The care plans did not indicate if the person had any preferences or dislikes in relation to food and drink and there was no record of any food allergies. The lack of person-centred information in the care plans was discussed with the registered manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider carried out an assessment of people's support needs before the first visit to provide care occurred. The assessments appropriately addressed people's needs and where possible people or their relatives had been involved in the assessments. Information was received from the local authority relating to a person's care needs which was used to develop the care plan.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access relevant external organisations and healthcare professionals to receive additional support.
• Relatives we spoke with confirmed that if their family member became unwell the care workers would contact the GP or district nurse to visit or provide guidance on the support required. The relatives told us they were informed of any changes in their family members health so they were aware and could take action.
• One relative said "If [my family member] is unwell the carers will bring it to the family's attention, and they will deal with the GP etc. The district nurse comes three times a week as [my family member] has developed bedsores."
• Records demonstrated that the care coordinators had been in contact with a range of healthcare professionals including pharmacists, GPs, district nurses and physiotherapists according to people's needs.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• People and relatives told us that in the most part they were happy with the care provided by the care workers and their dignity was respected but they also identified issues that they had experienced when receiving care which was not always positive.

• Some people identified issues with how they received their care with comments including, "Some carers are very good and caring and spend time with me, others are in and out" and "It's the phone business, they talk to their friends in different languages when they are meant to be doing things for me. They spend a couple of minutes with me and then they are on their phone. When I complain they say they are on the phone to the office but I know they are not because they are talking in another language".

• A relative said "I am reasonably happy with the service so far but I am not backward in coming forward and tell them when I am unhappy with them. Just wish they could be gentler with [family member]." One relative commented that when the care workers were providing personal care for their family member, they saw the care workers did not ensure the person was covered to maintain their dignity. The care workers also regularly left the person uncovered for a long period of time which caused the person to become upset. The relative explained they left towels and clothing to be used by the care workers, but they had to keep reminding them to use them and keep the person covered.

• Another relative told us "They treat [family member] with dignity and respect, they are very caring and experienced, they don't say no, but, I do have to point out to them what needs doing. Nothing is done voluntarily, even if the sheets are wet I have to tell them to change them".

• Although some of the comments identified that individual care workers were caring, the service was not always caring because the way care and support was planned and provided to people did not demonstrate they were always supported with empathy and respect. Therefore, people may not have received the support they required in a caring way to meet all their care needs. For example, people's care visits were not always scheduled according to their preferences leaving them to wait or to be seen when they did not expect it, their risk assessments and management plans were not comprehensive to help ensure they were protected from the risk of poor care and their medicines were not always managed appropriately.

• Notwithstanding the above positive comments we received from people included "They help me a lot, they always ask me how I am and how I spent the night, I am quite happy, no complaints", "I have no issues with the way they protect my dignity and they are always respectful asking if I am sure she can't do anything else for me before she goes. She always asks me I am okay and makes sure I have my frame next to me before she leaves and that my front door is locked behind her" and "They are respectful, kind and compassionate. I can talk to them about anything and we have a laugh and a joke. I live on my own and the carers are often

the only person I see all day so it is important they respect my dignity and are kind and compassionate."
• The care plans included information on the person's religious and cultural preferences. The information also indicated the person's preferred language.
• People told us they felt the care workers supported them to maintain their independence when they received support. People's comments included "I do as much as I can for myself, but this can vary from day to day, hour to hour. I am never 100%" and "I am able to wash the bits I can reach, and I always get out the clothes I want to wear that day in advanced to them coming. They then put my dirty washing in my machine for me."

Supporting people to express their views and be involved in making decisions about their care
• People and relatives explained care workers could usually communicate with them but some feedback indicated there were occasions when care workers were unable to communicate as they had difficulty understanding the preferred language of the person they were supporting.
• People were supported in making decisions about their care. People and relatives told us that they feel involved in decisions about their care and that generally care workers do all the tasks they are supposed to do. However, some people said that some care workers needed reminding and prompting. One person told us, "When I needed to change my care plan and have less visits a lady [staff member] came to sort out a new plan with for me. When the council sent me an invoice for more care hours than I had received this same lady sorted it all out for me." A relative commented, "We as a family are very aware of mum's care needs and they do heed our decisions and offered us the option of making any changes and understood when we made the decision to not have carers in during the lockdown and pandemic."
• People we spoke with stated care workers asked for their permission before they started to provide care with one person commenting, "Yes they do. They never do anything before checking it is okay. If I need something different, they will do that for me."

Requires Improvement

Is the service responsive?

Our findings

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

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

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

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.

• The provider did not always ensure people's communication needs were identified and guidance provided for care workers so they could best communicate with the person.
• The care plan for one person indicated they lived with a hearing impairment and used lipreading to understand what staff were saying. Due to COVID-19 care workers were required to wear face masks which meant their mouths were covered. The person's care plan had not been updated to provide care workers with guidance on how they could communicate with the person to reduce the risk of isolation and misunderstanding. Alternative types of face mask had not been considered including those with a see-through panel were not in use. This meant the person was at risk of not receiving information in an appropriate manner and that met their needs.
• The provider did not always ensure care plans provided up to date information in relation to people's care and support needs.
• One person's care plan stated that care workers needed to ensure they were positioned correctly in in their wheelchair chair but there was no guidance provided for care workers on the correct position.
• The moving and handing risk assessment for one person indicated that the care workers needed to support the person with oral healthcare, but this was not reflected in the care plan. Therefore, it was not clear for the care workers that they needed to support this person with oral healthcare.
• The care plans were not always person centred and were focused on the care tasks and did not provide information on how the person wanted their care provided. For example, one person's care plan stated 'Please assist with a strip wash and dressing' but there was no information on the person's preferences as to how they wanted their care provided. Therefore, the care workers were not provided with guidance on how to meet the person's wishes in relation to their care needs being met.
• The daily care records completed by care workers to demonstrate what care and support was provided during each visit were care task focused and did not reflect the experiences of the person.
• People's wishes in relation to their end of life care were not recorded as part of their care plan. The registered manager confirmed that at the time of the inspection the service was not providing any care packages with involved supporting people with end of life care.
• People's care plans did not indicate their wishes in case their health began to deteriorate in relation to

what support they wanted at the end of their lives for example if they wanted to remain at home to be cared for.

The provider had not always ensured people's care plans reflected their support needs and wishes. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The provider did not ensure complaints were always managed according to their policy and procedures. Complaints records showed that outcomes following complaints investigations and measures to prevent similar concerns were not always identified.
• The records for one complaint relating to care workers not carrying out a visit on time indicated the initial action taken was to check to see what time the care workers arrived, and they spoke to the care workers. A list of possible causes, such as traffic or covering other visits, were given but the actual cause for the lateness was not identified. The form included a section on what steps should be taken to avoid a repeat of the issue and the only information recorded was for the care workers to realise the importance of turning up in time but there was no action recorded to show how this would be done or if it had been done.
• Another complaint related to the care workers not changing a person's catheter bags when required which resulted in a negative impact on the person. The relative also called the office three times and did not get a response. The complaint form identified the suspected causes as lack of supplies and no communication with the care coordinator. The next steps stated that there should be a supply of equipment and improved communication but there was no guidance on how this would be done, who was responsible and if these steps had been taken. This meant the provider could not ensure appropriate action had been taken to prevent a reoccurrence of the issues which caused the initial complaint .

The provider did not ensure complaints were appropriately investigated with clear outcomes to resolve the complaints and for lessons to be learned to reduce reoccurrence. This placed people at risk of harm. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider also received complaints via the local authority when people whose care they were funding, complained directly to them. The local authority passed on the complaints to the provider and they sent information from any investigation to the local authority to respond to the complaint.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were supported to maintain relationships with people. People's care plans identified who was important to the person and was involved in their life.
• The care plans also identified the person's interests, any hobbies and social activities they took part in.

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider had a range of quality assurance processes in place, but these were not effectively implemented to identify areas where improvements were required.
• The registered manager explained the care plans' review was used as an audit tool to ensure the care plans reflected people's current care needs. We saw one person had a care plan review carried out in August 2021. Changes to the person's care plan were identified, which included a reduction in the number of visits per day, but the care plan had not been updated and still reflected the person's previous care needs. Therefore, the quality assurance process the provider had in place in relation to care plans was not robust enough to ensure these were accurate.
• The provider did not have a robust process to monitor the rotas and electronic call monitoring system. They had failed to identify where more than one care visit had been scheduled at the same time for a care worker and appropriate travel time had not been allocated as part of the rota to enable care workers to arrive at a person's home on time. As a result people were not always receiving visits as planned for them. The local authority has also shared similar concerns with us.
• The business and quality assurance manager explained a risk rating system had been developed to identify how often a person's care plan and risk assessment should be reviewed whether this was three monthly, six monthly or annually based upon the person's care and support needs. However, this system was not being effectively implemented. The care plan for one person indicated they had very complex care needs and had been receiving support for more than two years, but they were not included on the rating system to indicate the frequency of reviews. This meant the indicator as to the frequency of this person's care plan was not accurate in identifying when it should be monitored. The risk rating for another person indicated their care plan should be reviewed every three months but their care plan had only been reviewed in May 2021.
• The provider carried out an audit of MAR charts when these were submitted to the office. The audits were not robust enough as they indicated there were no issues, but we found a range of concerns with the management of medicines that the audits had not identified. The audit form also had a section for other issues for example where care workers had overwritten or crossed out on the MAR chart and the same issues were identified each month with similar actions, but no improvements had been made as the issues kept happening. Therefore, the medicines checks were not effective in making sure people were always receiving their medicines safely.
• During the inspection the provider informed us they supported eight people with their medicines, but the local authority confirmed that, at the time of the inspection there were 22 people being supported with their medicines. This meant the provider did not have an accurate record of all people being supported with their

medicines and oversight of the support they were receiving with these.
• The provider provided a complaints audit, but this was just a list of the complaints received with no analysis, outcomes or action. Therefore, there was no learning to identify any trends or patterns so action could be taken to prevent similar complaints.
• The provider's systems to manage risks were ineffective. A range of concerns were identified during the inspection including inadequate risk management plans for specific risks. The provider had not identified these issues using their existing processes so they could make the necessary improvements.
• The registered manager provided an organisation chart which showed roles and responsibilities were clearly defined. The provider had recently employed a business and quality assurance manager to review processes. A range of concerns were identified during the inspection which demonstrated that senior staff may not always have had an understanding of key issues, for example, ensuring person centred care was provided and care visits happened as planned and in a timely manner.

The provider did not have effective and robust quality assurance processes to monitor, assess and improve the quality of services people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The business and quality assurance manager explained they were in the process of developing a range of new quality assurance systems. They showed us a blank template for a new audit for care plans and risk assessments they were planning to implement.
• Following the inspection, the business and quality assurance manager provided a revised complaints audit which included the outcomes.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We received mixed feedback from people being supported and relatives in relation if they felt the service was well-led. People told us "I think the service is well led and I have no issues with this agency", and "I think the Agency is well managed. Any issues I have had have been dealt with promptly and satisfactorily." Relatives commented "Things need improvement especially timings of my [family member's] calls. The service is not that well led. It is lucky [family member] has family around to support them", and "The service my [family member] receives is managed reasonably well but we as a family ensure they are well looked after."
• Care workers confirmed they regularly read people's care plans in case there are any changes in the person's support needs. They also confirmed that if they felt the person's care needs had changed, they would inform the office. One care worker told us "I would always start to read the care plan carefully and assess the person's care needs but also report to the agency to evaluate them further."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager explained their understanding of the duty of candour and they told us, "When something goes wrong, we need to tell the CQC and the service user. If an issue happens, we meet with them face to face depending on the service user's needs and ensure we invite all relevant people involved with the service user."
• People and relatives provided mixed feedback when asked if they found it easy to contact the homecare service by telephone. One person stated "The office is good and they are very friendly. Sometimes I have to hang on for a while, if I leave a message they always get back to me" and another person told us "My [relative] tends to deal with the office if she has anything she wants them to know or if she wants to check on why the carer hasn't arrived and I have been waiting over an hour more than expected time for them to call on me." Relatives said "The office is very good and they always get back to us if necessary", and "The office

doesn't always pick up the phone or messages left for them and that means we have to ring again in order to speak to someone."
• There was a range of policies in place which were reviewed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager explained that they received feedback from people and relatives about the quality of the care being provided when they carried out the care plan reviews and when spot checks were carried out.
• Notwithstanding our findings, care workers told us they felt supported by their line manager and that the service was well-led. Their comments included "When I make a complaint, I feel I am listened to and it is resolved", "We always get support from management and the operations manager always helps and gives me good guidance and advice. The registered manager always is ready to listen to my concerns even if it is with the office staff", and "The managers are always understanding and they asked me a few times if there's anything they could do that would support me. I appreciate them."

Working in partnership with others
• The registered manager confirmed they worked closely with the local authority they provided care packages for, the clinical commissioning group and healthcare professionals. The local authority confirmed they had regular meeting with the provider to discuss where improvements to the service should be made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 as they did not ensure care was always provided in line with the principles of the Act. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective complaints process to ensure complaints by service users and others were appropriately managed. Regulation 16 (1)(2)

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 risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1) (2)

The enforcement action we took:

A Warning Notice was issued to the provider requiring then to comply with the Regulation by 28 February 2022.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity The registered person did not have appropriate checks in place to assess, monitor and mitigate the risks relating health, safety and welfare of services. Regulation 17 (1)(2)

The enforcement action we took:

A Warning Notice was issued to the provider requiring then to comply with the Regulation by 28 February 2022.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient suitably

qualified, competent, skilled and experienced staff were deployed to meet people's support needs. The provider could not demonstrate staff had completed training identified as mandatory by the provider to ensure their skills were up to date.

Regulation 18 (1)(2)

The enforcement action we took:

A Warning Notice was issued to the provider requiring then to comply with the Regulation by 28 February 2022.