MK Executive Care Services LTD

MK Executive Care

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

MK Executive Care is a domiciliary care service, which provides personal care to children and older adults. At the time of the inspection 69 people were receiving care from the service.

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 failed to have adequate systems in place to assess, monitor, mitigate and review the risks to people's health, safety and welfare. The provider did not demonstrate how they consistently investigated and learned from safeguarding incidents, complaints, accident or incidents and used these experiences to improve safe care delivery. People were at risk of receiving unsafe care that did not meet their needs and placed them at heightened risk of harm or abuse.

A lack of robust governance and quality assurance systems meant the provider did not have effective management oversight of key areas of the service. They could not assure themselves of the quality and safety of care provision to people receiving care and support. Improvements were required to the timeliness of responses for requests for information from external agencies such as safeguarding teams and commissioners.

Training in key areas, including safeguarding children, mental health and meeting people's oral health was not provided to all care staff. This meant all care staff were not fully trained for their roles, placing people at heightened risk of receiving unsafe care or care that did not meet their needs.

People did not always receive their personal care calls punctually or which lasted for the full duration. People did not always have access to staff on time to provide support with personal care, administering medicines as prescribed and support with eating and drinking.

People's care records did not always contain specific details relating to their holistic care needs and equality characteristics including their physical and mental health needs. The care planning processes did not always ensure people received person-centred care.

The provider was not fully meeting the requirements of the Accessible Information Standard for people with sensory impairments.

We received mixed comments from people using the service and relatives on how staff preserved their privacy and dignity when providing personal care.

Further improvement was needed to ensure statutory CQC notifications were submitted to the Care Quality

Commission (CQC) as required by law, without delay, and contain sufficient detail.

People were not always supported to have maximum choice and control of their lives. Staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

We have made a recommendation about the Mental Capacity Act.

Staff knew how to recognise the signs of abuse. People were involved in decisions about their care and positive feedback was received about their preferences being supported. The management team undertook visits to people's homes and spot checks of staff practice to monitor practice and provide any support needed. Recent questionnaires received from people and their representatives indicated many people were satisfied with the care they received.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 3 February 2021) and there were multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had not been made. We have found evidence that the provider needs to make improvements. Please see the relevant key question sections of this full report.

Why we inspected
This inspection was carried out to follow up on actions we told the provider to take at the last inspection. It was also prompted in part due to increased concerns received by CQC from other stakeholders. These included, concerns of people using the service experiencing missed care calls. The providers lack of managerial oversight and slow response to requests for further information in connection with safeguarding and complaint investigations. Based on these concerns a decision was made for us to inspect and examine those risks.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for MK Executive Care 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.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led findings below.

MK Executive Care

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors and 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.

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

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. The registered manager was also the provider / nominated individual and is responsible for supervising the management of the service.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider / registered manager would be in the office to support the inspection.

Inspection activity started on 27 August 2021 and ended on 07 September 2021. We visited the office location on 06 and 07 September 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioners who work with the service. The provider was requested to complete the Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. The provider did not complete or

return the PIR to us, we took this into account in making our judgements in this report.

During the inspection
We spoke with 16 people who used the service and 16 relatives about their experience of the care provided. We spoke with 15 members of staff including the provider / registered manager, deputy manager, office staff including the Human Resources Manager and care staff.

We reviewed a range of records. This included 10 people's care records and 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 further training data, policies and procedures and care records. We spoke with local authority commissioners and quality monitoring officer who also visit 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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to have effective safeguarding systems in place to ensure all people using the service were prevented from receiving unsafe care and treatment and avoidable harm or risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- The service provided care to children as well as adults. The safeguarding policy provided to us during the inspection did not refer to the safeguarding processes where a concern arose about a child. Following the inspection, the provider supplied a safeguarding children and young people policy. However, on review of the policy there were several anomalies, which made the policy ineffective.
- The safeguarding children and young people policy stated that adequate and appropriate induction and training would be provided for all staff, volunteers, trainees and management committee members on child safeguarding matters. Following the inspection, the provider confirmed that seven staff, from a total of 30 staff, had received safeguarding children training. This placed children at heightened risk of potential abuse or harm as all staff had not been provided with the guidance or knowledge on what to do should potential safeguarding children issues arise.
- Although we found some improvements, safeguarding records remained inconsistent and lacked detail to evidence actions taken by the provider when safeguarding concerns arose. There was very limited evidence to show robust investigations took place. Effective safeguarding systems were not in place to fully protect people from the risks of abuse and harm.

We found no evidence that people had been seriously harmed. However, the safeguarding systems had not been sufficiently improved to ensure all people using the service were prevented from the risk of abuse and improper treatment. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people's safety were not adequately identified, mitigated or monitored. Risk assessments were not always in place to cover all known risks to people's care. For example, risks of malnutrition, swallowing and choking and the use of specialist moving and handling equipment, such as ceiling hoists. Carer staff did not always have sufficient information and guidance on how to mitigate the risks to provide safe support to

people.
● Risk assessments were not always reviewed and updated when people's needs changed, or new risks emerged. For example, a person with advancing dementia expressed emotional distress which placed them and care staff at risk of harm. Incident records confirmed this. There was no risk support plan to provide guidance to staff on how to safely support the person whilst keeping themselves safe. Another person had two falls since their falls risk assessment was written This placed them at higher risk of further falls. Their risk assessment had not been updated to reflect this.
● Systems to report, record, investigate, follow up and review incidents and accidents were ineffective. We received contradictory information from staff on how they reported and recorded accidents and incidents. Records in the office were scant and inconsistent. Appropriate follow up did not always take place when an accident or incident occurred. This placed people at higher risk of harm from repeat incidents taking place as lessons were not learned when things went wrong.
● The provider told us they had set up weekly management meetings, during which safeguarding concerns and complaints were discussed. We reviewed the minutes which were brief and did not give assurances areas identified for further action were completed.
● Systems to ensure people received their care on time and calls lasted for the full duration were ineffective. Local authorities who commissioned packages of care had significant concerns about call times and duration, and calls being missed. At the time of inspection, the provider was in the process of moving to an electronic call monitoring system and there were ongoing teething difficulties. For example, staff could not always record the times they arrived and left people's homes. This meant information on call monitoring was not reliable.
● We received mixed feedback from people using the service, relatives and staff about the punctuality and duration of care calls. One person said, "They come whenever they like, I don't think there is an agreed time." Several people told us staff were often late. Other feedback confirmed people were satisfied with the service they received. Feedback was mixed on whether staff informed people when they were running late. Staff told us they usually had enough time to support people and get from one call to the next. Reasons for running late were usually traffic or if they needed to spend longer with a person due to an emergency or increased care needs that day.
● We received mixed feedback from people and relatives about the continuity of staffing. One person said, "I've had the same carers for several years now and they know what to do." A relative told us of their opposite experience, "We get lots of different carers and I have to tell each one what to do, and how to do it, it's exhausting."
● The provider did not have robust records in place to evidence the staff disciplinary process was followed when required. Records of disciplinary processes were disorganised and did not clearly evidence the actions the provider had taken. We could not evidence appropriate action was taken when there were concerns of poor practice or misconduct by staff.
● The care staff files we reviewed contained information of pre-employment checks taking place, such as obtaining references and Disclosure and Barring Service (DBS) checks. The DBS confirm if individuals have any criminal or barring record which helps employers make safer recruitment decisions. However, we found some gaps in records intended to explore the staff employment history.

The provider did not have effective systems in place to assess, monitor and mitigate the risks to the health and safety of people using the service. People did not always receive timely and consistent care. Accident and incident processes were not effective. There was limited evidence of staff disciplinary processes and actions. This was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Many people and relatives told us staff provided safe care. One person said, "I feel perfectly safe. The

carers have become part of the family." One relative said, "The staff are very careful with [relative]."

● Some staff confirmed they had seen some improvements to the service, such as call times being reviewed in response to individual requests from people using the service and travel time being factored into their call schedules.

● The provider was aware of the issues identified in this inspection, and was committed to making improvements to ensure people received good quality, safe care.

Using medicines safely

● The medication administration records (MAR) were reviewed by management staff during spot check visits and audited monthly. There was limited information on follow up action if any shortfalls were identified. These processes required strengthening to improve the medicines administration practice.

● Where the provider took on the responsibility, people were supported to take their medicines as prescribed. However, some people had experienced missed calls and late calls, which had resulted in them not being supported to receive their medicines on time.

● Records showed care staff received medicines training to support people to take their medicines in line with their preferences.

Preventing and controlling infection

● People confirmed staff followed infection control procedures and used personal protective equipment (PPE), such as gloves, aprons and face masks. One person said, "There is good PPE practice, I am completely confident with the staff." Another said, "The carers are very conscientious, and they have come through COVID-19 and no one in our household has had it."

● Staff said they received training on infection prevention and control, including COVID-19 during the pandemic. They were able to explain the procedures they would follow to help control and prevent the spread of infection when providing care to people.

● Staff said they were provided with sufficient supplies of personal protective equipment (PPE).

● The provider accessed regular COVID-19 testing for staff to prevent and manage the transmission of COVID-19. They encouraged vaccinations for all eligible staff.

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.

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

- People's needs were not fully assessed before packages of care commenced. Pre-assessment documentation was not included in all the care files we reviewed to demonstrate the service could meet people's needs. In addition, not all care plans reflected people's known care needs. This meant people were at risk of not receiving care in line with standards, guidance and the law.
- Some care plans contained limited information and had not been regularly updated. This meant staff did not have consistent records available on people's current needs in order to provide optimal care and support for them in the way they preferred. The provider confirmed they were working to update and improve all care plans.

Staff support: induction, training, skills and experience

- Staff had not received training in key areas including safeguarding children, mental health and meeting people's oral health. This meant they were not fully trained for their roles, which placed people at heightened risk of receiving care which was unsafe or did not meet their needs. One relative told us, "They [staff] do not seem to understand mental health." The provider recognised supporting people with mental health needs was an area staff needed training in.
- There were no records available on specialist training received by staff, for example to support people who required catheter or stoma care or people who used specialist equipment. Staff told us they received training from community nurses and occupational therapists, however there were no training records to evidence this.
- Staff told us they received moving and handling training and new staff worked shadow shifts with more experienced staff to gain practical experience. One person said, "The staff are very good, they speak to me, are friendly and do whatever I want. They use a special lift to transfer me and are well trained to do it. I am happy with the care."
- Regular spot checks took place to check staff were providing care for people according to their needs. The checks provided opportunities for staff to discuss any arising issues and for support to staff to be provided

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

- People's care plans contained a 'nutritional requirement' section with relevant information. For example, one care plan said, 'I have a good appetite, but I am unable to cook. The carers help me with my breakfast, tea and dinner and I get a hot meal delivered by [company name] for my lunch.' Another said, 'I would like carers to support me with preparing my food, encouraging me to eat and ensure that I have enough fluid to drink. If carers notice anything, I will like them to report to my family.' However, one person was unhappy

with support provided and said, "The carers can't cook simple snacks such as scrambled eggs."
● When people had dietary needs due to health conditions, this was recorded in the care plans to ensure staff supported people to follow healthy diets. It was also recorded when people required physical assistance and support from staff to eat and drink.

Staff working with other agencies to provide consistent, effective, timely care
● The staff team worked with other agencies to ensure people received health care support when needed. Staff confirmed they called the family and if necessary, the medical emergency services if a person had suffered a serious deterioration in health or another emergency, such as a fall. A relative said, "The carers do call the doctor regularly for [relative]."

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.
● MCA assessments had not been carried out for people with fluctuating mental capacity, or where there was uncertainty about their ability to make certain decisions. This placed people at potential risk of decisions about their care and welfare being made which were not in their best interests.
● Staff received MCA training during their induction, through the Care Certificate training module. They told us they understood the principles of the MCA and gave examples of how they supported people to make choices.
● People, or their relatives / representatives, where appropriate, had signed and consented to the care being provided.

We recommend the provider consider current guidance on the principles of the Mental Capacity Act (2005) and take action to update their practice accordingly.

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People's privacy and dignity was not always promoted during personal care. We received mixed feedback from people and relatives. One person said, "They [staff] actually pulled my catheter out when they were hoisting me, and the urine went everywhere. One of the carers just used a tissue to clean it up rather than wash the floor." A relative told us, "Some staff will leave [relative] without a towel in the bathroom and [relative] comes outside of the bathroom door without any clothing on. They [staff] also shave [relative] without [relative] having any clothes on." Positive comments from people included staff offering privacy when a person was showering, "The carers stand outside the shower to make sure I am okay."
- People were not always well treated and supported. Mixed feedback was received. A relative said, "The evening carers could be gentler when undressing [relative], pulling clothes over [relatives] head, sometimes they are too rigorous." Another relative said the staff relationship with [relative] was very good. They said, "Every Friday they wash [relative's] hair and they do it without any distress to [relative]." One person said, "The staff will support me to have a shower if I want one. They are a bit anxious that I don't do too much, and I think they should encourage me to do what I can myself I suppose."
- Communication between staff and people receiving care was not always fully effective, and people had mixed experiences of this. Some people said that spoken communication with some staff was difficult. One person said, "They [staff] don't talk with me, I don't think they speak English?" One relative said, "Some staff can't speak English, we did have problems when they first started, but things are better now." Another relative said, "[Relative] is non-verbal, but there is some communication and the carers can get [relative] to laugh."
- People often received care from staff who knew them well. Most people said they thought the staff knew them well enough. Staff we spoke with were knowledgeable of the people they provided care for and knew their individual needs and preferences.
- The management team aimed to ensure people received a caring and supportive service. One relative said, "I was impressed at the initial interview. [Manager] seemed more concerned about the person than anything else. It is a real relief for me that I don't have to worry, and I can get extra help from the agency if I need it. They are really lovely, caring staff."
- Information about people using the service was stored securely within the office and electronic records were password protected. Staff were aware of maintaining confidentiality and keeping records and personal information secure.

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

● People were involved in decisions about their care and their preferences were respected. One person said, "I requested females and the agency has complied." Another person said, "I can always have a shower when I want one." One relative said, "[relative] cannot be involved in decisions about their care, but the carers make sure [relative] gets up and will ask him what he wants for breakfast."

● People using the service and relatives confirmed their views were sought about the care they received. One relative said, "The office phones once a month to check how things are going, and if I'm not happy they sort it out." Another relative said, "The manager visits every three months to see how the care is going."

Requires Improvement

Is the service responsive?

Our findings

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

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

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure complaints were processed, investigated and resolved effectively. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 16.

- The provider kept a log of complaints, which gave a brief summary of the complaint. Some complaints raised concerns of abuse, which the provider had escalated through the safeguarding procedures. But the lack of detailed records did not demonstrate that complaints were investigated thoroughly or the management team had effective oversight of the process
- The provider did not have robust records available to evidence how complaints were processed, investigated, actioned and followed up in accordance with the complaint procedures. One person said, "Every two or three months there is a meeting and I complain, but nothing happens."

The provider did not have robust records available to evidence complaints were investigated thoroughly, in accordance with the complaint procedures. This was a continued breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The care plans we reviewed gave brief information and were not consistently personalised to ensure people had choice and control or received care that met their needs and preferences. Further information was required about people's equality characteristics or diversity needs which could include religious or cultural needs. Significant information about people and their care needs was not always mentioned in the care plans. For example, mental health support or support due to sensory impairments.
- People's care records had limited information about their life histories so staff could provide sufficient support in meeting people's individual preferences.
- People's oral care needs were mentioned in care plans, but the plans gave no personalised details as to what individualised support people needed to maintain good oral care.
- We received mixed comments from people using the service and relatives as to the care planning processes. Some people did not think they had a care plan. One person told us, "There is a care plan, but I don't have a copy. It's on their [staff] phones so I can't read it." Another person said, "My care plan is up to date. The manager visits every three months to see how the care is going."

Care planning processes did not always ensure people received personalised care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The management team confirmed information could be made available to people in other formats, such as easy read or large format, as required. We found opportunities had been missed to support people receive information accessibly, for example one person had a visual impairment and their care plan had not been adapted in any way to meet their needs.

End of life care and support

- The provider confirmed end of life care was not included in the care planning or review process. This was an area which could be strengthened so people and their relatives/friends could be supported to discuss any wishes or preferences in this area. At the time of inspection, no people using the service required end of life care support.
- People that had a DNACPR (Do not attempt cardiopulmonary resuscitation) decision in place had this recorded in their care plan. Staff confirmed the DNACPR document was kept at the person's home, in the event of a medical emergency requiring the decision to be followed.
- Staff had received training in end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to ensure effective systems were in place to ensure good governance of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider failed to have systems in place to continuously monitor, evaluate and drive improvements at the service. Processes to maintain oversight of people's care including call time monitoring, safeguarding processes, accident and incident follow up, reviewing care records regularly, complaints investigations, staff disciplinary processes and effective working with partner agencies were ineffective. This meant people were at risk of receiving unsafe care and of this not being identified and remedied.
●Management oversight had not identified there was an absence of detailed records to demonstrate the actions taken by the provider in response to safeguarding concerns and complaints. There was a significant absence of meaningful analysis of monitoring the care call systems to ensure people received their care as planned. There was also an absence of regular reviewing of people's care needs and risks assessments.
● The provider had failed to identify significant shortfalls in training delivery to staff which led to staff not being sufficiently trained for their roles. They did not have effective oversight of training records and had failed to identify specialist training was not recorded.
● The provider at times worked alongside care staff in attending to people's personal care calls. Some managerial tasks were delegated within the management team. This contributed to delays in responding to requests for information and impacted on the confidence placed in the provider to effectively manage the service, and continuously achieve good outcomes for people using the service. One relative said, "The agency is not well organised. Their intentions are good, but it does not translate into improvements. I wouldn't use them for the further care that was offered, as I cannot trust the care."
● The provider did not prioritise the importance of working effectively with external agencies. Commissioners and safeguarding authorities said they continually had to chase the provider for further information in response to complaints and safeguarding investigations, and the provider did not always respond in a timely manner to action plan deadlines.
● The provider failed to have effective systems in place to ensure regulatory requirements were met. They did not submit their Provider Information Return (PIR) within the timescale, which is a CQC requirement. The provider did not respond promptly to a CQC request to ensure their inspection rating was on display on their

website and in their office, as required by law, and required several reminders to complete the requests.
● The provider is required by law to notify CQC without delay, of all deaths, serious injuries, incidents of abuse and alleged abuse. We found concerns this was not consistently done. Immediately following the inspection, the provider submitted some notifications retrospectively. They told us they would strengthen this process for future notifications.

The provider failed to implement and embed effective systems and processes to assess, monitor and improve the quality and safety of the service. They did not have systems in place to assure themselves they met regulatory requirements. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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;
● Processes to ensure people and their representatives were informed and kept up to date when things went wrong were inconsistent. Within one of the safeguarding files were reviewed there were some letters of apology (under the duty of candour) that had been sent to people in response to concerns that had been raised. However, this had not been consistently applied in all the safeguarding files we reviewed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Spot checks and phone calls were completed to review the care people received and offer people the opportunity to discuss their experience of using the service. One person said, "I get visits from the manager from time to time and he asks me how I am." Another said, "Someone rings up from the office to ask how the care is going." Another said, "We have regular phone calls asking for our views." Another said, "One member of the office staff doesn't pass messages on, so now I have the manager's direct number."
● The provider recently sent out satisfaction questionnaires to people using the service and relatives. The responses indicated people were generally satisfied with the care they received.
● Staff told us they received regular spot checks and they felt well supported by the management team. One staff member said, "[Provider] is always available to contact if you need them." The provider used a private social media group chat to share information with staff on any changes to people's care as face to face meetings were limited during the pandemic period.

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 Care planning processes did not always ensure people received personalised care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The safeguarding systems had not been sufficiently improved to ensure all people using the service were prevented from receiving unsafe care and treatment and avoidable harm or risk of harm. This was a continued breach of Regulation 13: (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have robust records available to evidence complaints were investigated thoroughly, in accordance with the complaint procedures. This was a continued breach of Regulation 16:(Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider did not have effective systems in place to continually assess the risks to the health and safety of people using the service and doing all that is reasonably practicable to mitigate any such risks. This was a breach of Regulation 12: (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a warning notice and gave the provider a short timescale to make improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and embed effective systems and processes to assess, monitor and improve the quality and safety of the service, and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of Regulation 17:(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a warning notice and gave the provider a short timescale to make improvements.