Live-In-Care4U Ltd

LIVE IN CARE4U LTD

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Live in Care 4 U Ltd is a care at home service that provides live-in care staff for people living in their own homes. The provider is based in Rudgwick, West Sussex and people receiving care at home services were based in other areas of the country. At the time of the inspection there were two older people using the service, one of whom was living with dementia and another who experienced difficulties with their cognition.

People's experience of using this service and what we found
There were wide spread and significant concerns about the lack of oversight and regard for people's care. Risks to people's safety had not been identified, assessed or managed effectively and lessons had not always been learned. This included, falls management, hydration and nutrition, medicines management, safeguarding adults at risk and environmental risks. People were not always protected from the risk of abuse and improper treatment. Following the inspection, we made a safeguarding referral to the local authority about one person's care.

There was insufficient oversight and systems and processes were not operated effectively to provide assurances of staff's practice or the care people were receiving. Quality assurance processes were not used to monitor people's day-to-day care to ensure they were receiving safe care and treatment. The registered manager had failed to continually improve the service. People and relatives had not been asked for their feedback about the service they received. Policies and procedures were not implemented in practice.

Staff had not been supported to undertake robust and thorough inductions and had not received training before providing live-in care and support to vulnerable people who lived alone. Staff's competence had not been assessed and the registered manager had not always observed staff supporting people to assure themselves staff had appropriate skills and abilities. People's needs had not always been identified or assessed. 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.

One person did not always receive dignified care that respected their rights. Staff were provided with insufficient guidance to inform their practice and ensure people received support that met their needs. People had not been supported to plan for care at the end of their lives.

We recommended the registered manager sought advice and guidance from a reputable source to ensure there were effective systems to assess, plan and meet people's needs.

There were enough staff to meet people's needs. Relatives told us they had confidence in staff's skills. Staff worked in partnership with external healthcare professionals to support people to maintain their health or seek assistance if they were unwell. Infection prevention and control was maintained.

Relatives praised staff's caring approach and attentiveness. People were supported with their social needs and had access to the local community as well as pass times they enjoyed.

Rating at last inspection
The last rating for this home was Good (Published 9 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified seven breaches in relation to oversight of risks and safety, risk of abuse and avoidable harm, dignity and respect, consent, staff skills and competence, failure to notify CQC of incidents and the leadership and management of the service. Please see the action we have told the provider to take at the end of this report.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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 of 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 is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow-up
We will continue to monitor the intelligence we receive about this service. We will request an action plan from the provider to understand what they will do to improve the standards of safety and governance. We plan to inspect in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

You can read the report from our last inspection, by selecting the 'all reports' link for Live In Care 4U Ltd on our website at www.cqc.org.uk.

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?

Inadequate

The service was not 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.

LIVE IN CARE4U LTD

Detailed findings

Background to this inspection

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

Inspection team
The inspection was undertaken by one Inspector.

Service and service type
Live in Care 4U Ltd is a care at home service and provides live-in care to people in their own homes. The service had a manager registered with the Care Quality Commission. They were also the provider. This means they are legally responsible for how the service is run and the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was to ensure that the registered manager was in the office to support the inspection and so that people and their relatives were informed of our inspection and would be at home to receive our calls.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We had not asked the provider to submit a provider information return (PIR) since the last inspection. A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. A discussion took place with the registered manager to enable them to share this information with us. We took this into account when making our judgements in this report.

During the inspection
We were advised by the registered manager and people's relatives that people would be unable to speak to us. We spoke with two relatives, two members of staff and the registered manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care and

medicine administration records for three people. We looked at four staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, which included policies and procedures, were also reviewed.

After the inspection
We sought assurances from the registered manager in relation to the care people received and staffs' skills. We made a safeguarding adults' at risk referral to the local authority for them to consider as part of their safeguarding responsibilities.

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 always safe and there was a potential risk of avoidable harm. This was because the registered manager did not have systems in place to assure themselves that people were receiving safe care and treatment.

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

- Not all risks had been identified, assessed or managed effectively to ensure people's safety. The registered manager told us there had been no accidents or incidents since the last inspection. Staff told us that one person had two unwitnessed falls and on one occasion had sustained a minor injury. When we raised this with the registered manager, they told us they had offered advice and guidance to staff advising them to contact external health professionals for assistance. Whilst immediate action was taken to ensure the person received appropriate support, as the falls had not been documented there was a risk that trends or patterns would not be identified, and appropriate action taken to reduce further risks. Before and following the falls, there was no assessment of risk in relation to the person's risk of falls and staff were not provided with guidance about how to support the person in a safe way.
- People's needs had not been adequately assessed to identify risk and staff were not provided with clear guidance to support people according to their physical and mental health needs. We were told that one person was reluctant to drink and had regularly experienced urinary tract infections (UTI). Consideration of the risk of dehydration and infection had not been made or assessed and staff had not been advised how to support the person to maintain their hydration and health. For example, staff were not advised of a recommended fluid intake for the person, so staff knew what to aim for when supporting the person and what action to take if the person had less to drink. As the registered manager did not monitor any records associated to the person's care, they were unable to know how much fluid the person had consumed each day and how often the person had contracted a UTI, to assure themselves that the person was receiving appropriate care to meet their needs and minimise further risk.
- Records showed, and the registered manager confirmed that one person had a low weight and needed encouragement to eat. Although this was known, assessments and consideration had not been made as to how the person could be supported to increase their weight and calorie intake. For example, it had not been considered that the person's meals could be fortified with items such as cream, butter or cheese to increase the calories they consumed. There was no process for regularly monitoring the person's weight or food intake to enable oversight and assurance that the person was being supported effectively and in accordance with their needs.
- Environmental risk assessments had been undertaken when people first started to use the service to ensure their home was safe for both the person and staff. There was insufficient oversight and action taken to ensure risks continued to be managed. One person's home had not been assessed for risks since 2017, and the other since 2018. The registered manager explained at one person's home they had tested the smoke alarms to ensure they worked correctly and assure themselves of the person's and staff's safety

should there be a fire. They found one smoke alarm was not working correctly and had asked the person's relative to rectify this. This had not been considered as part of the risk assessment of the person's home and staff had not been provided with guidance advising them to regularly check the smoke alarms to ensure they worked correctly. These practises placed people and staff at increased risk of harm.

Medicines management

● A person was not being supported to have their medicines administered safely. The National Institute for Health and Clinical Excellence (NICE); Managing medicines for adults receiving social care in the community, state care workers should use a medicines administration record (MAR) to record any medicines support they give to a person. They advise this should ideally be a printed record provided by the supplying pharmacist, dispensing doctor or social care provider. Staff were not always recording their actions and records of medicines administration for one person were not available. Therefore, it could not be ascertained that medicines administration was safe, and the person was receiving their medicines according to prescribing guidance.

● Staff told us one person was administered some of their medicines covertly. Covert medicines are when medicines are provided in a disguised way and can sometimes be hidden in people's food or drink without their knowledge or consent. Whilst the reasons for staff administering the person's medicines in this way were to ensure they received their prescribed medicines. Staff had made the decision to administer the person's medicines covertly without consulting others involved in the person's care or informing the registered manager. NICE guidance states that the decision to administer medicines covertly should be made in consultation with the person prescribing the medicines as well as the pharmacist to ensure that the medicines would not be altered by administering them in certain types of food or drink.

● Staff administering medicines to one person had not ensured they followed NICE guidance. Staff had entered details about the person's prescribed medicines onto a MAR. This was not completed accurately. NICE guidance advises that there should be robust processes to ensure that medicines administration records are accurate and up to date. For example, changes should only be made and checked by people who are trained and assessed as competent to do so. The provider had not ensured staff complied with this guidance as one member of staff had manually entered information about the person's medicines onto the MAR without receiving training or having their competence assessed.

The registered manager was not doing all that was reasonably practicable to ensure care and treatment was provided in a safe way. This contributed to a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, once our concerns were shared with the registered manager, they acted to ensure that known risks were reassessed. Staff were provided with up-to-date and clear guidance to inform their practice and ensure people received care that minimised risk and met their needs.

● One person was supported by staff in a responsive way. Staff identified that the person was sometimes not taking their medicines and were hiding them in their mouth or hands. Staff monitored this over a period of days and acted to ensure advice was sought from the person's GP. The person's medicines were changed to liquid form so they could be supported to have their medicines in an effective way.

● Staff had considered one person's safety when accessing the local community. Although the person was supported by staff to help ensure their safety, the person had been supported to wear a Global Positioning System (GPS) watch in case they were separated from staff whilst out. This would enable staff to identify the location of the person to ensure their safety.

● Infection prevention and control was considered and maintained. Staff had been provided with guidance about how to minimise risk when disposing of waste.

Systems and processes to safeguard people from the risk of abuse;

● People were not always protected from abuse and improper treatment. Staff had not received safeguarding adults at risk training and therefore the registered manager had not assured themselves that staff would know what to do if they had concerns about people's well-being and safety. Staff demonstrated limited understanding about the signs and symptoms that might indicate someone was at increased risk of harm or abuse.

● Staff had provided information to the registered manager about one person. Staff's language and description of how the person was to be supported raised concerns about how the person was treated. It was not evident that the registered manager had identified this potentially discriminatory treatment or taken appropriate action. This was immediately fed back to the registered manager for them to consider as part of their safeguarding policy.

● There were no processes to monitor the daily care people received or the number of incidents and accidents which had occurred. Due to the lack of documentation and monitoring, it was not evident if there had been any incidences which should have been considered as part of the registered manager's safeguarding responsibilities. The registered manager had not assured themselves that people were being appropriately protected from abuse and improper treatment. This was of relevance as people who used the service were vulnerable and staff who cared for them, lived with them and worked alone.

● The registered manager had not acted when one person was found to have an unexplained injury. Records showed that during a hospital admission the person had been found to have an old, unexplained pelvic fracture. It was not evident if this was a historic injury or one sustained whilst the person was using the service. No consideration had been made about how the person had sustained the unexplained injury and the registered manager had not considered this alongside their safeguarding adult's policy to determine if this needed to be referred to the local authority for them to consider as part of their safeguarding responsibilities.

Systems and processes were not operated effectively to protect people from abuse and improper treatment. This contributed to 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.

Following the inspection, we made a safeguarding referral to the local authority for them to consider as part of their safeguarding duties.

● Relatives told us they had confidence their relatives were well-treated and if they had any concerns, they would contact the registered manager to raise these with them.

Staffing and recruitment

● It was not evident the registered manager had assured themselves that staff were safe to work with people they supported. Their recruitment policy stated that two written references were to be obtained as well as a verbal discussion with the member of staff's last employer before staff started work. Only one written reference had been obtained for two members of staff. One member of staff did not have a written reference and instead a verbal discussion had taken place with the member of staff's former employer. This was not in accordance with the provider's policy and the lack of robust processes to assure the registered manager of staff's suitability, placed people at increased risk of harm.

When this was fed back to the registered manager, they explained they would have received the correct number of references for staff at the time to ensure they complied with their policy but had not ensured these were saved to provide evidence that the processes were followed.

● Relatives told us they had no concerns about the suitability of staff and told us their relatives were safe.
● Relatives told us there were enough staff to support their relatives. When the person's main member of staff took leave, they were provided with another member of staff to continue providing care and support. Staff were supported to work alongside the main member of staff to understand the person's requirements, preferences and needs. This ensured there was a smooth transition with the least amount of disruption caused to people and their relatives.

Inadequate

Is the service effective?

Our findings

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

At the last inspection, this key question was rated as Good. At this inspection, this key question has deteriorated to Inadequate. This meant there were wide-spread and significant shortfalls in people's care, support and outcomes. This was because the registered manager had not ensured staff were appropriately trained and had not implemented their own systems to assure themselves of staff's competence.

Staff support: induction, training, skills and experience

- The service's website advised that staff were provided with an induction programme, ongoing training and had the skills, qualifications, experience and aptitude to care for people. However, this was not implemented in practice. This meant that people were not always supported by staff that held appropriate skills, experience or abilities to meet their assessed needs. New staff had not been supported to have a robust induction to ensure they were aware of how to support people appropriately and safely. Staff had not undertaken training in relation to safeguarding people from abuse and improper treatment, medicines management, fire safety and safe manual movement. One person who no longer received the service, had previously been supported by staff with their wound care, yet the member of staff providing their care had not been trained or supported to understand how to do this safely. Another person was supported to use a slide sheet to assist them when mobilising in and out of bed. Staff had not undertaken manual movement training and were not provided with guidance to ensure they were safely supporting the person to use the equipment. This means that the registered manager had not assured themselves that staff were competent to support people before delegating tasks and responsibilities to staff who worked alone.
- There was no process to enable the registered manager to assure themselves of staff's skills and competence. The registered manager had not visited one person or observed the member of staff who supported them, to assure themselves the care provided was safe, appropriate and met the person's needs, since 2017.
- There were no systems to regularly meet staff or provide them with supervisions or appraisals to enable them to reflect on their practice and the support they provided, or to identify learning and development needs. We found one member of staff's practice did not always demonstrate they provided care to one person in a dignified and respectful way. We asked the registered manager if this had been raised with the member of staff. They explained that it had, but this had not been documented as part of staff monitoring and supervision. Therefore, it was not evident if this issue had been addressed and future actions and behaviours agreed with the staff member.
- One relative told us, "I don't want to be negative, but I do wonder how much of the care is down to luck with the carer we have rather than the care from the company. If [staff member] went I would be quite concerned."

The registered manager had not ensured staff were suitably qualified, competent, skilled and experienced. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager acted to ensure that staff were booked on training to receive learning and development opportunities. They observed one member of staff supporting a person to assure themselves of the staff member's competence and made arrangements to observe the other.

● Staff had sometimes independently accessed on-line courses to help increase their knowledge and understanding.
● Staff told us they felt well-supported by the registered manager and they could contact them if they had any concerns or needed assistance.
● Relatives told us they had confidence in staff's skills and abilities and their relatives were well-cared for

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet;
● People's needs were not assessed in accordance with best practice guidance. The registered manager had failed to ensure systems were implemented in practice and it had not been identified that people's needs had not been assessed or that appropriate guidance had not been provided to staff. Staff had not always been provided with accurate and up-to-date information about people's needs and this increased the risk that people's needs would not be well-managed, and they would be provided with care that did not meet their needs.
● People's oral hygiene needs had not been assessed and staff had not been provided with guidance which informed them of the type of support people required. Staff had documented that one person required a soft diet. The person's needs had not been assessed and it was not evident how this decision had been made. The registered manager explained they understood it was because the person had some teeth missing and therefore could not chew their food sufficiently. As the person's oral health had not been assessed, it had not been identified if the person would benefit from dental treatment.

We recommend the registered manager seeks advice and guidance from a reputable source to ensure there are effective systems to assess, plan and meet people's needs.

Following the inspection, the registered manager took immediate action to visit one person and assess their needs. They sent us updated care plans, risk assessments and guidance they had implemented to ensure staff were provided with accurate and up-to-date information about the person's needs. They also planned to conduct assessments and implement guidance to another person that used the service.

● As people were supported by consistent staff, staff had developed their own understanding about the way the person should be supported. They had provided the registered manager with an overview of the support the person received.
● Relatives told us that staff supported their relatives in a way that met their needs and if there were ever concerns about people's health staff contacted external health care professionals in a prompt way to ensure people received timely support and intervention to maintain their health.
● Technology was used so that people were able to call for staff's assistance. One person had a sensor mat so that when they got out of bed during the night, staff were alerted and able to go to the person's aid.
● People were supported to have food and drinks they enjoyed. Staff had considered people's preferences and ensured they continued to offer items that people would previously have chosen before their cognition deteriorated. One member of staff told us they involved the person as much as possible to ensure they chose the food they liked to eat and were supported to continue to prepare food of their choice. A relative told us, "The food is absolutely exceptional."

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● Staff had not received training on MCA and demonstrated a limited understanding of how people should be supported to make decisions as well as how a person's capacity should be assessed before others made decisions on their behalves. Staff told us they would involve the person's relatives in decisions that related to people's care. Neither the registered manager nor the staff providing care, had assessed the person's capacity to consent to specific-decisions relating to their care before asking others to make decisions on their behalves. For example, one person had their medicines administered covertly. Staff told us they were 'hiding' medicines in the person's food or drinks as if they did not do this the person would refuse to take them. Staff had not assessed the person's capacity in relation to this decision. The same person had been supported to have an influenza injection, the person's capacity had not been assessed in relation to consenting to this decision before enabling others to decide on the person's behalf.

The registered manager had not ensured care and treatment was provided to people with the consent of the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the Deprivation of Liberty Safeguards (DoLS) cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

● One person was living with dementia. Staff had used restrictive practices to provide care to the person as well as to protect their safety. For example, staff were administering the person's medicines covertly. Staff were also locking the front door to the home as well as another door that led to a steep staircase. Whilst they were supporting the person in this way to ensure their safety and well-being, consideration had not been made about the restrictions placed on the person. It was not apparent that discussions and agreements had taken place with a person who had a Lasting Power of Attorney (LPA) to legally make decisions on the person's behalf, or if an application to the Court of Protection had been considered to ensure any restrictive practices were in the person's best interests.

Systems and processes were not operated effectively to protect people from abuse and improper treatment. This contributed to the breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One member of staff told us how they continued to support and encourage a person to make decisions about their day-to-day care such as what clothes they wanted to wear or how they wanted to spend their time.

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 were not always 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; Supporting people to express their views and be involved in making decisions about their care

● Respect for people's differences had not always been considered. One person who had a cognitive impairment, had not been treated in a respectful way that acknowledged their diversity or ensured they were treated equally with others. The registered manager and staff told us the person's memory had deteriorated and they often experienced periods of confusion. Records showed staff had not always supported the person in an appropriate way that respected their preferences or their right to make choices and decisions. Staff had set the person's watch and all clocks in their house 30 minutes fast, without the person's knowledge. When the registered manager and the member of staff were asked why the person was supported in this way, they explained that before the person's cognition started to deteriorate, they often chose to stay up late and wake early and this did not enable staff to have enough break-times.

● Staff had provided an overview of the person's support needs. Discussions with the registered manager, staff and the person's relative raised concerns that the support provided was not always in accordance with the person's own previously expressed preferences. Records stated, 'Bedtime routine, 20:30 (they think it is 21:00) Go in and say it is time for bed. Every night they give me a hard time, even tells me they are not going to bed. Just be firm with them, don't let them give you a hard time.' The person's relative told us, "My relative is at a point where they do as they're asked by staff. The member of staff has their way of doing things and does put my relative to bed a bit earlier than they would want to go. The staff member likes to keep good routines and rules." These approaches did not respect the person's right to make choices and the person was subjected to control and restrictions placed upon their care that were undignified, not proportionate to their needs or in accordance with their preferences.

This contributed to a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager and member of staff, told us due to the person's deteriorating health, they tired more easily and if they stayed up later their mobility was affected and therefore the person was supported to go to bed earlier than their previously expressed wishes. It was not apparent that the person had been involved or consulted when this decision had been made and this did not provide assurances they were always treated in a respectful or dignified way.

● The nature of the service people received enabled them to remain in their own homes. This helped respect

people's right to privacy. A relative told us their loved one was cared for in a way that maintained their privacy and was respectful of their needs. A member of staff told us how they aimed to create a relaxing and restful atmosphere for the person they supported as they found this supported the person to remain calm and free from anxiety.

● People were encouraged to retain their skills. One member of staff told us how they involved the person in their care. They explained the person liked to help with chores around the home such as cooking and loading the dishwasher.

● Consideration had been made about relationships that were important to people and staff had been provided with guidance about how to support the person to care for their pets. Records showed the person had been supported to continue to enjoy walks with their animals around the local area as this was something the person had always enjoyed.

● People were supported to maintain contact with their family and friends and staff had been provided with information about people who were important to the person so that staff had an understanding about the person's social network. People had been supported to receive visits from their family or spend time with friends in the local community.

● Relatives praised the caring attitudes and attentiveness of staff. They told us they were assured their loved ones were well-cared for and staff were kind and caring. A relative told us, "[Staff member] is awesome. We have seen a great improvement in our relative." Another relative told us, "[Staff member] is very, very caring. They put a lot of effort into making sure my relative is looked after."

● A member of staff told us how they continued to support one person who was living with dementia to be involved in day-to-day decisions. The member of staff told us they offered the person choice about how they wanted to spend their time, what food and drink they consumed and what clothes they wanted to wear.

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 deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People's physical and mental health needs had not always been identified, assessed or considered. Staff had not always been provided with current guidance about people's needs when they had experienced changes in their condition. Reviews of people's care had not been completed and when changes in their health had occurred, the registered manager had not ensured their needs were assessed and staff were provided with clear, accurate and up-to-date guidance so they could support people safely and according to their needs.
- It was not evident how the registered manager had involved people or their relatives in planning their care or ongoing decisions relating to it.
- People had not been supported to plan for care at the end of their lives.

We recommend the registered manager seeks advice and guidance from a reputable source to ensure there are effective systems to assess, plan and meet people's needs.

Following the inspection, the registered manager acted to ensure improvements were made. They visited one person and assessed their needs and devised care plans to ensure staff were provided with up-to-date guidance that reflected the person's current needs. There were plans to ensure another person receiving the service was also assessed to ensure up-to-date guidance was provided to staff.

- Staff had been provided with guidance about one person's needs and how they could be supported and communicated with. Staff had been advised to face the person directly when communicating with them and display patience as the person was living with dementia. This would enable the person to process the information and support them to understand the information staff were communicating to them.

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 able to continue with their interests and hobbies. One person preferred their own company and their relative and the member of staff supporting the person, told us the person's preferences were respected.
- One person had enjoyed an active life and staff supported them to continue to be actively involved in the community. Staff supported them to enjoy walks with their animals, visit places of interests and enjoy outings to cafes. Staff told us they supported one person to attend a memory café. The Alzheimer's Memory Cafés are designed to provide an environment for people living with dementia and their carers, to meet others experiencing the same challenges and joys and to share experiences as well as to obtain information

and guidance. The member of staff told us the person enjoyed going to the café and having drinks with people they met there.

● Staff told us one person who was living with dementia, was sometimes reluctant to be supported with their personal hygiene. The member of staff explained how they encouraged the person to view this as a pleasant experience and how they adapted their approach to support the person. They told us. "I turn it into a spa day, put on some music, have warm water and have the towels on the radiator." They told us this supported the person in a way that was more pleasurable and least disruptive to them, whilst also ensuring their personal hygiene needs were met.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy. They told us they had not received any complaints since the last inspection as queries and concerns had been addressed on an informal basis if they had occurred.

● Relatives told us they felt comfortable raising issues of concern to the staff that supported people as well as to the registered manager, whom they could contact when needed.

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 this inspection, this key question was rated as Requires Improvement. There were ineffective quality assurance processes to ensure oversight of people's care. At this inspection, this key question has deteriorated to Inadequate. This meant there were wide-spread and significant shortfalls in service leadership. The leader 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; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider's philosophy of providing individualised care that respected people's rights had not always been implemented in practice. The registered manager ran the service from West Sussex. People who used the service were spread over a wide geographical area which had proved problematic for the registered manager to overcome. The registered manager had not visited one person in their home and therefore had not seen the member of staff providing support, since 2017. The other person had not been visited since 2018 and the registered manager had not observed the member of staff to ensure they held appropriate skills to support the person appropriately. There were no alternative arrangements made to be able to monitor standards of care considering the geographical distance between people using the service and the registered manager.
- The registered manager had a range of policies that provided guidance to themselves and to staff but were not ensuring these were implemented in practice. There was a lack of oversight of people's care and staff's practices. Systems and processes were not operated or implemented to provide the registered manager with assurances that people were receiving safe, effective and good-quality care. The quality of the service had significantly deteriorated since the last inspection.
- Staff were required to document the care they provided people in diaries within people's homes. This did not enable sufficient oversight of people's day-to-day care to monitor any changes in their needs or any apparent risk in relation to their care. One member of staff had sent diaries and medicine records documenting one person's care up until November 2019. The registered manager had not requested records for one other person's care and had therefore not had oversight of their day-to-day care since visiting the person in 2017. There was a lack of oversight which increased the possibility that risks to people's care and changes to their needs would not be identified. The registered manager was not assuring themselves that people's care was safe, and risks were being identified and managed.
- There was a lack of records to document the registered managers actions when operating the service. For example, they had not documented when they had spoken to staff or people's relatives to demonstrate how they were involved in the person's care and able to contribute to it. This also did not enable us to have confidence that issues relating to people's care had been dealt with and managed effectively.
- There was a lack of oversight of people's care and the registered manager was sometimes unaware of changes in people's needs. For example, one member of staff told us one person had experienced two

unwitnessed falls. When we asked the registered manager if there had been any accidents or incidents at the service since the last inspection, they told us there had not.

● The registered manager had not undertaken any reviews or audits of people's care since the last inspection and therefore could not be assured of the quality of care and support people were receiving. After our findings were fed back to the registered manager, they visited one person and viewed documents related to their care. When doing this the registered manager was able to identify they were not sufficient and did not meet the person's current needs.

● The lack of quality assurance systems and oversight meant the registered manager was not always aware of the issues identified as part of our inspection and until our feedback, they lacked an understanding of the severity their lack of oversight had caused. They had not appreciated or considered that staff were working alone, in vulnerable people's homes, yet had not been supported to receive a thorough and robust induction and training. Neither had they ensured that staff had their competence assessed to ensure they had appropriate skills to support people in a safe and effective way. They had not identified there were potentially unsafe practices in relation to falls management, hydration, nutrition, medicines management, safeguarding adults at risk, dignity and respect, and ensuring people's consent was effectively assessed and decisions were made in the person's best interests by those with appropriate legal authorisation. This lack of oversight increased the risk that people were exposed to significant risk of harm.

● Staff had provided an overview of people's needs which showed the support they provided to people throughout the day and night. It was not evident the registered manager had monitored these to assure themselves people were being supported appropriately. In one person's overview, staff had documented that during a visit to hospital, for which the registered manager had no documented evidence, the person was found to have an unexplained fracture. The member of staff had also used undignified and controlling language about the person which did not demonstrate respect for the person's preferences or their right to make decisions. It was not evident what action the registered manager had taken in response to these concerns and this increased our concerns about the oversight of people's care.

● Due to the lack of documented evidence about the care one person had received, the registered manager was unable to determine if the person was being supported in a safe and appropriate way and was unable to ensure risks were being effectively managed. The lack of information also meant we were unable to have enough oversight of the person's care to assure ourselves the care they had received was safe. There were concerns regarding the person's unexplained fracture, their unwitnessed falls and the way they were not always supported in a respectful or dignified way. We made a referral to the local authority for them to consider as part of their safeguarding responsibilities.

● People and relatives had not been asked for their feedback about the service they received. The registered manager had sent surveys to gain feedback in 2017, but had not continued with this to assure themselves people and their relatives were happy with the service they were receiving.

The registered manager had not ensured that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided and had not ensured that risks were mitigated, and people were provided with safe care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt well-supported by the registered manager, who supported them remotely via telephone communications and email. They told us they could seek support and receive advice from the registered manager at any time.

The registered manager was receptive to our feedback and took immediate actions and provided assurances that the concerns found as part of the inspection would be acted upon and people's care would be improved. New care plans were devised for one person in response to our findings and these provided

assurances that systems were being implemented to improve the quality of care people received.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong: Working in partnership with others;
● The registered manager had not always notified us of incidents that had occurred to people using the service, to enable us to ensure appropriate actions had been taken in relation to people's care. For example, the registered manager had not informed us that one person was found to have a serious injury of an unexplained fracture.

The registered manager had not notified the us when it was discovered there were changes to the structure of one person's body. This was a breach of Regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

● Relatives told us they were kept informed if there were any changes to people's care.
● Staff told us they worked in partnership with external healthcare professionals such as GPs and community nurses, to ensure people's healthcare needs were met.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) of the Care Quality Commission (Registration) Regulations 2009 The registered person had not notified the Commission of incidents that occurred whilst services were being provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect. The registered person had not ensured that service users were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of

the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. The registered person had not ensured that service users were protected from abuse and improper treatment. Systems and processes were not established or operated effectively to prevent abuse of service users, investigate, immediately on becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

	The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were: Sufficient numbers of suitably qualified, competent, skilled and experienced people That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.