Adonai Services Limited

Adonai Healthcare Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Adonai Healthcare Services is a domiciliary care service providing personal care to adults aged 65 and over in the Medway area. At the time of our inspection there were 20 people receiving a 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
A person said, "Yes, I am quite happy. They help me in and out of the shower." A relative said, "We've had the agency since June 2023, and I've had a couple of concerns that I have spoken with the manager about. I do not think that some of the carers are dementia trained, and it's a bit of a haphazard service for Dad. The carers are lovely, but they do miss things." Although people told us they feel safe and comfortable with staff visiting them, we found that people were not always sufficiently protected from the risk of harm because care plans did not always give enough information to support people safely.

People did not have appropriate risk assessments in place and environmental safety assessments had not been completed. Medicines were not managed safely.

Staff had not always been recruited safely to ensure they were suitable to work with people they support. There was no evidence of lessons learned despite accidents occurring.

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 provider failed to follow the principles of the Mental Capacity Act 2005. There was no evidence of people's consent or involvement in care decisions.

Staff knew people well but could not support them effectively because initial assessments were not completed by the provider prior to commencing care packages for people to ensure they could meet people's needs. We made a recommendation about this.

The provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. However, this had not been followed.

The provider did not have systems in place to monitor or audit the quality of the care provided therefore could not drive improvements. Oversight and management of the service was not effective.

Staff training was not effective. People were not supported by staff who were skilled, trained and knowledgeable. Staff had not received all training relevant to meeting people's assessed needs.

Staff followed good infection control practices including wearing personal protective equipment when supporting people.

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

Rating at last inspection
This service was registered with us on 7 July 2022 and this is the first inspection.

Why we inspected
The inspection was prompted due to concerns received about staff deployment, people not receiving care to meet their assessed needs, dignity and respect, infection control and responding to complaints. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to risk management, medicines management, safe recruitment practice, staff deployment, mental capacity, person-centred care, dignity and respect, complaints management and quality monitoring at this inspection. We have made a recommendation on how the provider consider good practice guidance in relation to initial assessment of people's care and support needs.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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 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 of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Adonai Healthcare Services

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 3 inspectors and an Expert by Experience who made telephone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post since January 2023 and had not submitted an application to register with CQC .

Notice of inspection
We gave the provider 24 hours notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 22 August 2023 and ended on 29 August 2023. We visited the location's office on 22 August 2023 and 23 August 2023. We carried out calls with staff and relatives between 25 August 2023

and 29 August 2023.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place in March 2023 to help plan the inspection and inform our judgements. We reviewed information we had received about the service. We sought feedback from the local authority who commission the service. We used all this information to plan our inspection.

During the inspection
We spoke with 9 relatives and 3 people who used the service. We spoke with 6 staff, as well as the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's care records, risk assessments, daily records and health records. We also looked at 3 staff files including their recruitment and training records. We reviewed records relating to the management of the service, quality assurance records and a variety of policies and procedures implemented by the provider. We also looked at other records the provider kept, such as minutes of staff meetings and surveys people completed to share their views.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks to people had not always been assessed.
- There were no risk assessments in place for some people living with dementia, diabetes, epilepsy, Parkinson's disease, risk of pressure sores and a risk of UTI (This is an infection in any part of the urinary system). There were no instructions for staff about how to manage these risks to people. We did not find any direct impact on people, however this put people at risk of potential harm.
- Some people used mobility aids, such as walking frames, sling, slide sheet and/or hoists. However, their moving and handling, and falls risk assessments did not always identify the potential risks of using these mobility aids. There was not always detailed guidance in place for staff on how to safely mobilise people and how to minimise potential risks.
- People were prescribed paraffin based emollient/barrier cream which could act as a fire accelerant; there was no fire risk assessment in place in relation to this. This put people at risk of potential harm.
- No risk assessments were undertaken in relation to the environment risk. This meant that the provider could not be assured that staff were safe when entering/exiting people's homes. A staff member told us some people had dogs. There were no risk assessments where pets were in a person's home, there were no control measures to detail how staff could work safely.
- Some people were prescribed blood thinning medicines which meant that they were at increased risks of excessive bleeding if injured and would need immediate medical attention if they fell or banged their head. No risk assessments were in place to detail safe ways of working with people who were prescribed blood thinning medicines. A staff member did not understand the risks associated with blood thinning medicines when asked.
- Care plans did not always detail risk to people's individual needs and guidance on how staff should support them. For example, one person had the diagnosis of epilepsy noted in their care plan. The manager and staff failed to recognise this and failed to put recognised guidance and risk assessment in place.
- The provider had an inadequate system in place in relation to accidents and incidents, which placed people at risk. The manager told us there was no accident and incident records. However, they told us that a person had fallen out of bed and had been found by staff when they entered the person's home to provide planned care. There was no accident report relating to this. The manager evidenced they had reported it to the person's relative.
- No records were made to record incidents such as staff lateness/missed visits. There had been no learning from accidents and incidents.

Individual risks relating to the health, safety and welfare of people had not been robustly assessed. Accidents and incidents had not always been responded to and reviewed. This placed people at risk. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the manager sent us an action plan which showed what they will do to address these concerns.

Staffing and recruitment

● Staff had not always been recruited safely to ensure they were suitable to work with people. The provider had not always carried out checks to explore staff members' employment history. We reviewed 3 recruitment files for staff who had been employed, 2 of the 3 staff application forms had gaps in the employment history that had not been accounted for. The provider's application forms only asked applicants for 5 years of work history. Interview records did not evidence that this had been identified and discussed. The provider had failed to follow their recruitment policy. The provider could not be assured that all staff were suitable for their roles.

The failure to ensure staff were recruited safely is a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the provider told us they had taken action to address the gaps in employment and had updated their application forms to request a full employment history.

● Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Prior to the inspection and during inspection, we received concerns regarding staff deployment. The deployment of staff was not always adequate to ensure people's needs were met. Relatives told us about issues from erratic call times, staff lateness and care visits being cut short because staff were rushing to get to the next care visit. Relatives reported to us that they had experienced delays in receiving support to get up, washed, dressed, eat, drink and support with continence care.

● Comments from people and relatives was mixed; "Timing might be a bit iffy sometimes, but I am OK with it all, they are absolutely lovely girls, and take their time"; "If they're late, I just go back to bed and wait, it's not a problem"; "They do come more or less on time, but [the manager] does call and let me know if they are going to be late"; "We've never had a problem with their timings, they are not rushed" and "Times are starting to get a bit better (the times they are starting) I still have to say no you should be here an hour or half an hour (if staff try to leave earlier than they should). I have spoken to [the manager] and was going to cancel the care but she asked me not to. It stresses me out, I shouldn't have to watch over them."

● Before the inspection, we received concerns from relatives which stated that there were concerns with early, late and rushed care calls. We discussed these with the manager, they confirmed more people and relatives had complained about the same issues and at one point they had received 6 complaints about this issue in one day. The provider's call monitoring data showed people were still experiencing these issues. This showed people and their relatives had not been respected and listened to effectively.

● The management team told us that travel time between care calls was scheduled, and we saw this was mostly the case when we checked the provider's electronic system. However, the provider's electronic system identified frequent lateness (sometimes as little as a few minutes up to 1 to 2 hours late). The system had flagged a staff member had been 6 hours late on one occasion. During the inspection on day 1 of our inspection, a relative phoned at 10:26am to inform the manager that their carer had not turned up to their 09:30am call. The care staff had not let the person nor the manager know. The manager phoned the staff who confirmed they were running late. Our analysis of call logs between May 2023 and August 2023 showed that in terms of delivery of care 69% of calls are within 15 mins of the planned time, and 10% are more than 45 minutes late. This meant some people had not received their care as scheduled or planned.

The provider had not ensured that staff were deployed sufficiently to meet people's assessed needs. This

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

Using medicines safely

● Medicines were not always well managed.

● On the first day of our inspection, the manager told us that there were no medication administration records (MARs) in place and in use. On the second day of our inspection, the manager told us the provider had showed them where it was on their electronic system. The provider's electronic system in place for staff to record what medication they had administered to people or at what time was not being used. We found only one person out of 3 had MAR chart completed. The provider's policy stated, 'If the MAR is not available, the medication must not be administered.' This meant that the provider failed to follow their medication policy and we were not assured that people received their prescribed medicines safely.

● Staff did not receive medication competency assessment. Assessments seen showed 7 out of 20 staff had these completed by the manager. Further, only 1 staff had signed their assessment record. This left people using the service potentially vulnerable to unsafe medication practices.

● Where staff were not responsible for administering medicines, it was not always clear what medicines people were prescribed as these are not always listed on their care records. The manager failed to follow NICE guidance for those managing medicines for adults receiving social care in the community. Staff did not have information about the possible side effects or contraindications of medicines they needed to be aware of, which could put people at risk.

● Some people were prescribed topical medicines (barrier creams), the application instructions were not appropriately recorded on their MARs and there were no body maps in place to guide staff on where these topical medicines needed to be applied.

The provider had failed to take appropriate action to ensure medicines were managed in a safe way which was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Some people were supported to be independent with their medicines. They did not need physical support with managing their medicines as they were able to do this themselves or with support from relatives. Some people needed a prompt to make sure they had taken their medicine. A relative told us, "They help give the medicines, they stand and watch that he doesn't spit them out."

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Safeguarding concerns had been reported to the local authority in relation to allegations of neglect. However, the provider had not recognised that CQC needed to be informed. This is an area for improvement. After we raised this with the management team this was appropriately reported.

● The provider had safeguarding policies in place and staff told us they had training in safeguarding. People told us they felt safe.

● Staff had an understanding of how to report safeguarding and who to report to outside of the organisation if needed. A staff member said, "I have done abuse training. I would tell the company immediately (about abuse) they would deal with it. I could report it to CQC."

Preventing and controlling infection

● Staff followed safe infection prevention and control (IPC) practices. The provider had an up to date IPC policy. Not all staff had completed IPC training, only 14 out of 22 staff were listed as completed on the provider's training matrix.

●There was no longer a requirement for staff to routinely be tested for COVID-19. The provider had a stock of tests which were used to check when staff had potentially been exposed to COVID-19 or had symptoms.

● Staff were provided with appropriate equipment to carry out their roles safely. There was a stock of personal protective equipment (PPE) kept in the office. A staff member told us, "I wear PPE when providing care, I put it on when entering the house. I wear gloves and a face mask and an apron is used when showering or bathing. I wear a uniform."

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.

This is the first inspection for this newly registered service. This key question has been rated 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

● Initial assessments were not completed by the provider prior to commencing care packages for people to ensure they could meet their needs. The manager explained that they carry out telephone assessment by speaking to relatives over the phone. This meant that aspects of care needs that might be assessed physically such as moving and handling needs had not been properly assessed. Conducting an initial assessment helps identify the specific needs and requirements of each person cared for. For example, moving and handling. The initial assessment also allows for the implementation of appropriate measures to ensure people's safety during transfers or movements, minimising the risk of accidents and injuries.

We recommend that the provider consider good practice guidance in relation to initial assessment of people's care and support needs.

● Records showed that the care plan had people's diversity characteristics. Diversity characteristics include age, disability, gender identity and reassignment, pregnancy and maternity, race (ethnicity, nationality, national origin, skin colour), religion or belief, sex and sexual orientation. This ensured that the service was able to meet people's diverse needs.

Staff support: induction, training, skills and experience

● People were not supported by staff who were skilled, trained and knowledgeable. Staff had not received all training relevant to meeting people's assessed needs. The provider's records of training were not robust. Training records did not evidence that all staff had been appropriately trained. Not all the staff working at the service were listed on the training records. Staff had not been trained in diabetes, catheter care, Parkinson's disease and epilepsy despite providing care and support to people with these conditions. This meant that staff may not have the necessary skills and knowledge to deliver high-quality effective, safe and person centred care. Lack of adequate staff training in the areas above meant care staff might struggle to perform tasks effectively.

● Staff received moving and handling training through an online course, this meant that they did not practice using equipment as part of their training. They did not have their competency checked to make sure they were working safely to protect the person and themselves from harm. We reviewed 6 care records and 3 out of 6 records we looked at showed they required staff to safely move, transfer them and use specialist equipment such as sling and hoist. Under the Manual Handling Regulations employers are legally obliged to ensure all employees are trained and competent in manual handling. Failure to assess to ensure that had the required skills to move people put people at increased risk of harm.

● Some relatives told us they were not always convinced that staff had received adequate training. They gave examples of having to repeatedly remind staff how to provide person centred care.
● Comments included, "I think some of them lack dementia awareness training, and they don't follow instructions that I have asked them to" and "It is most definitely a training issue, especially dementia training. They pull the blanket back from mum in the morning and she's not awake and then they are trying to get her straight up, she hasn't even got her eyes open. She starts to scream. They are trying to yank her out of bed, they don't communicate with her or talk to her." The relative told us they had reported this to the manager. We discussed the lack of dementia training with the manager. The manager told us they were planning 'Dementia Friend' training for staff.
● Staff did not meet with the management team to discuss their personal development or support they needed to carry out their roles. There were no records of supervisions carried out with staff. New staff completed training and the manager told us they completed the Care Certificate. However, when we explored this with the manager, staff were completing online training only, they were not being assessed and checked to make sure they were putting the learning into practice. The Care Certificate guidance document stated, 'The Care Certificate is the shared health and social care training, which must be completed and assessed, before new HCSW/ASCWs can practice without direct supervision (HCSW/ASCW refers to Healthcare Support Workers (HCSW) / Adult Social Care Workers (ASCW)).'

The provider failed to ensure staff had the appropriate training to ensure people's needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● The provider failed to follow the principles of the Mental Capacity Act 2005. Capacity assessments had not always been completed. Some people had fluctuating capacity as a result of living with dementia. This was recorded in their care plans, however it had not been taken into account. For example, in one person's care plan, it was recorded that they lacked capacity in where they live, finance, meal preparation, fluid intake and personal hygiene. This was not followed up with a capacity assessment to ensure decisions made were in their best interests.
● Care plans we reviewed showed that some people's families had Lasting Power of Attorney (LPoA) over their healthcare and finances. LPoA can give someone permanent authority to assist a person with decisions about their health, personal welfare and finances. However, the provider did not have evidence of the legal authorisation giving families the power to make decisions about their relatives' care if you're no longer able to or if you no longer want to make your own decisions. The manager confirmed this and informed us after our inspection that they had contacted all relatives to provide them with required information.

The provider had failed to ensure people's capacity was assessed in line with the Mental Capacity Act (2005). This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff gave examples of how they supported people to make their own decisions. For example, offering a choice of 3 items to wear.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People's care records failed to include guidance for staff to follow, for example, on Alzheimer's and incontinence. There were no recommended guidance, which would have further enabled staff in understanding and meeting people's needs. This is an area for improvement.

● Where people needed support to access healthcare this was in place. Staff called an ambulance and referred people to the GP as needed. Staff were clear about the action they would take when a person presents as unwell. A staff member told us they would report health concerns to a person's next of kin and the office.

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

● People's nutrition and hydration needs were met. People said they were happy with the support they received. A person said, "My [relative] buys my meals and puts them in the fridge or freezer, and I choose what to have and the girls (staff) cook it for me."

● Those people who did need staff assistance chose what food they wanted from their own store of food.

● Staff supported people with their meals when this was required. Daily records showed food was being prepared and provided to people.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People told us staff were kind. A person said, "They are very caring and careful." A relative told us, "The carers know mum well."
- Despite these comments, the wide-ranging concerns identified during our inspection did not demonstrate a caring approach which placed people at the centre of their care. The provider had failed to identify and address the standard of support people received. This showed a lack of care and compassion from the provider.
- People were not always involved in decisions about their care. People had not been involved in developing their care plans. There was little personal information about people in their care records, to enable staff to provide care and support that was individual, taking into account their life choices and history.
- People and relatives we spoke with had not been involved in devising their care plans or seen copies of them. One person told us, "I have not been involved in my care plan. This was handled by social services." One relative said, "There is not a care plan here." Relatives said they had not been able to see the care plan in place in their loved one's homes. A relative said, "There is not a care plan, but I would like to have access to the app that the carers use, and I'll talk to [the manager]. I would like to see what the carers are saying, as I'm not there all the time." Another relative told us they had asked for a copy of the care plan in their relatives home 4-5 times and they still did not have a copy. Involving relative would have ensured better coordination of care and ensured all needs were considered and met.
- People's privacy was not always respected. Relatives gave us examples of when they had addressed issues with staff regarding privacy and dignity. A relative said, "I did have to ask them not to change his catheter in the front room, but in the bathroom." Another relative told us they had repeatedly asked staff to ensure their loved one was given time to use the toilet rather than being placed on a commode and being washed at the same time.

The provider failed to ensure people were treated with dignity and respect is a breach of regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Staff detailed that when they provided people with personal care, they ensured curtains were closed, doors were shut, and that people were supported to cover up. A staff member said, "When providing

personal care, I would close windows and curtains and wrap a towel around the person."

● Most people told us the staff were nice and kind. Comments included, "They are very friendly people, they're very helpful"; "They are brilliant, whatever you need, nothing is too much trouble" and "I can honestly, honestly say that they are lovely. They know exactly how to help me with the shower, and anything else I need doing. This morning, one of them made my bed for me, that was lovely."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; End of life care and support

● People's care had not been consistently planned with them and their relatives to meet their needs and preferences. Detailed guidance had not been provided to staff about the support they should offer people. For example, one person was diagnosed with bipolar disorder (Bipolar disorder is a mental health condition that causes extreme mood swings that include emotional highs and lows), there was no guidance for staff about how to reassure them. This meant that the care plans were not detailed enough to meet individual's needs in a consistent way .

● People's care plans were not always up to date. For example, there was a lack of detailed information regarding people's likes and dislikes. This increased the risk staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life.

● At the time of our inspection 1 person was at end of life. Care plans did not contain information in relation to the care and support people wished to receive at the end of their life. Care plans for 6 people contained no information regarding end-of-life care or reflected any conversations had taken place in relation to this. The manager told us they have not yet developed an end of life care plan. They told us that when requested, they do support people with making referrals to healthcare professionals when needed. We found no evidence of referrals being made.

The provider failed to plan people's care in a personalised and person-centred way which reflected people's needs, preferences and end of life care wishes was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

● The agency had received 9 complaints since it started providing services in January 2023. We found no records/logs of complaints received and how these were responded to. For example, the manager told us they received 6 complaints in 1 day about time keeping in June 2023. The manager told us they visited all complainants and apologised. The manager failed to send an acknowledgement letter to the complainant and respond to the complaint, which was not in line with their complaints policy. We were not assured that lessons had been learned from complaints which would have helped them improve their service provision.

● The provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. However, this had not been followed. This meant that the provider had failed to take necessary action in response to concerns raised.

Failure to act on any complaint received, and proportionate action taken in response to any failure identified by the complaint or investigation was a breach of Regulation 16 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014

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

- The provider followed the five steps of the AIS.
- The provider had identified people's individual communication needs in their care plans. For example, in one person's care plan it stated they use hearing aid, verbal, gestures, touch, facial expression, body movements and posture to communicate. The care plan gave staff instruction to be patient, clear when speaking, use simple sentences or key words. This meant people were not at risk of potential miscommunication and misunderstanding.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not have a system in place to effectively monitor the service. Audits and checks had not been taking place by the provider or the manager. This meant the provider was unaware of the issues in the service relating to risk management, medicines management, accident and incident reporting, staff recruitment, staff deployment, assessment of care, mental capacity, staff training, dignity and respect, care planning and complaints management.
- The provider did not have a contingency plan in place to provide back up when the electronic call system was not working, this meant at times staff were not able to log in and out of care calls and were not able to access people's care records. The provider had failed to follow their own policies and procedures to ensure people's needs were met.
- Records were inconsistent and did not include a complete, accurate and contemporaneous record of care needs. For example, one person had diagnosis of epilepsy, and another had diabetes. These were not recorded in their care plans.
- The service was required to have a registered manager in post. The previous registered manager had left the service in January 2023. No applications to register a new manager had been received by CQC .
- The provider had failed to ensure there was sufficient oversight of staff training and staff competencies. The provider had not ensured staff had completed training to support people with their identified health needs and specific medicines.
- The provider could not demonstrate continuous learning and improvement as they did not have any quality assurance process in place.
- It was not clear that the provider understood duty of candour (DoC) as DoC processes had not been followed, there were no letters of apologies and formal responses made to people and their relatives when things had gone wrong.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had failed to ensure the CQC were notified of significant events within the service in line with

their statutory responsibilities. This included safeguarding concerns, missed calls and serious injuries. This meant the CQC were unable to effectively monitor risk and the actions taken.
● After the inspection the provider gave CQC an action plan which detailed how they planned to address the significant shortfalls found during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had no systems in place to seek feedback on the quality and safety of the service provided to people, which would have enabled them to learn and improve the service. A relative said, "No, I have not been asked to provide feedback, but I would like to have something to feedback." This demonstrated that people's views and experiences had not been gathered and acted on to shape and improve the culture and service.
● Surveys for people they supported, and relatives were completed over the phone or during visits to their homes.

The provider had failed to act on feedback from people, staff and their relatives to continually evaluate and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager was visible to people and relatives. The manager told us they visited people in their homes regularly and people knew who they were. One person said, "Sally is a good manager." A relative said, "Sally is always there and has helped us out a lot. We have a good rapport and she always has good advice for me." Overall, we were told that the manager was easy to contact, and always available.
● Staff felt able to raise concerns with managers without fear of what might happen as a result.
● The manager told us they felt supported by the provider. They had regular meetings to discuss the service and any actions that needed to be addressed. During feedback session, both provider and manager assured us they will be working on all areas of concerns found. They had sent us an action plan based on the initial feedback given to them.

Working in partnership with others
● The service had not always worked in partnership with people, their relatives and health and social care professionals to ensure people had the best outcomes. This is an area for improvement.
● The manager had signed up to well known, reputable websites to find advice and guidance such as Skills for Care. Skills for Care supports adult social care employers to deliver what the people they support need and what commissioners and regulators expect.
● The manager had maintained contact with local authority commissioners.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's capacity was assessed in line with the Mental Capacity Act (2005). Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to act on complaint received and take proportionate action. Regulation 16(1)(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff were recruited safely. Regulation 19(1)

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out an effective assessment of the needs of people to plan their care. The provider failed to plan people's care in a personalised and person-centred way which reflected people's needs, preferences and end of life care wishes. Regulation 9(1)(a)(b)(c)(2)(3)

The enforcement action we took:

We served the provider a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. Failed to manage medicine safely. Regulation 12(1)(2)(a)(b)(c)(g)

The enforcement action we took:

We served the provider a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at

	risk of harm. The provider had failed to act on feedback from people, staff and their relatives to continually evaluate and improve the service. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

We served the provider a warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were deployed sufficiently to meet people's assessed needs. Regulation 18(1)(2)(a)

The enforcement action we took:

We served the provider a warning notice.