Lim Independent Living & Community Care Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

LIM Independent Living and Community Care Services Limited is domiciliary care agency providing personal care to people in their own houses and flats. The service provides support to older people, people living with a learning disability and/or autism and children. At the time of our inspection there were 38 people using the service.

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

Right support
The provider did not plan people's care in a personalised and person-centred way or plan for when people experienced periods of distress. There were no specific risk assessments in place for people. This meant there was not sufficiently detailed information for staff about the risks to people and how to safely manage them. People's medicines were not administered safely. We found no evidence anyone had been harmed. However, the lack of specific and detailed risk assessment information for staff and the provider's failure to follow guidance for medicines management put some people at increased risk of potential harm.

The provider enabled people to access specialist health and social care support in the community. Staff supported people to play an active role in maintaining their own health and wellbeing. Staff supported people to have the maximum possible choice, control and independence.

Right Care
Not all staff understood how to protect people from poor care and abuse and the provider lacked knowledge of how to work with other agencies to do so. The provider did not deploy enough appropriately skilled staff to meet people's needs and keep them safe. People's care, treatment and support plans did not reflect their range of needs. The provider did not assess risks people might face. We found no evidence anyone had been harmed. However, the lack of safeguarding knowledge, detailed information about people's needs and risk assessments put some people at risk of potential harm.

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. People could communicate with staff and understand information given to them because staff supported them consistently and understood their

individual communication needs.

Right culture
People were not supported by a registered manager and staff with a good understanding of best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. The provider did not sufficiently evaluate the quality of support provided to people. The service did not have a person-centred culture or a culture of learning and improvement.

Staff knew and understood people well and were responsive. Staff turnover was very low, which supported people to receive consistent care from staff who knew them well. Staff placed people's wishes and needs at the heart of everything they did. People and those important to them, were involved in planning their care. Staff valued and acted upon people's views.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 4 September 2019) and there were breaches of regulation. This service was rated requires improvement for the last 3 consecutive inspections. At this inspection we found the provider remained in breach of regulations and the rating for this service has changed to inadequate.

Why we inspected
We carried out an announced comprehensive inspection of this service on 11 July 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the effectiveness and governance of the service.

We undertook a focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We inspected and found there were concerns with the safety, effectiveness, responsiveness and governance of the service, so we widened the scope of the inspection to become a comprehensive inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for LIM Independent Living and Community Care Services Limited on our website at www.cqc.org.uk

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

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, staffing, safeguarding, recruitment, registered manager requirements and governance at this inspection.

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 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 time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Notice of inspection
We gave the service 12 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 28 March 2023 and ended on 21 April 2023. We visited the location's office on 28 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last 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 also spoke with a local authority that commissions services with the provider. We used all this information to plan our inspection.

During the inspection
We spoke with 5 service users and 1 relative. We also spoke with 4 staff, including the nominated individual, registered manager, care workers and the administrator. The nominated individual is responsible for supervising the management of the service on behalf of the provider. At LIM Independent Living and Community Services Ltd the nominated individual is also the provider and the registered manager. The service was run by the registered manager, a care co-ordinator and an administrator. We reviewed a range of records. This included 7 people's care records and 4 staff records. A variety of records relating to the management of the service were also reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure staff received appropriate training, supervision and appraisal to enable them to carry out their duties. That meant the provider had not deployed a sufficient number of suitably competent and skilled staff. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider did not deploy a sufficient number of staff
• The provider's care call monitoring data showed a high number of calls where staff were late to arrive. It also showed for care calls requiring 2 carers at the same time, there was a high number of calls where the 2 care workers were not with the person at the same time. This meant people who needed 2 care workers to hoist them or move them, for example, were at risk of potential harm.
• The provider's care call monitoring data showed a number of care calls where staff had not stayed for the full duration of the call. It also showed a high number of calls where staff were not given any time to travel between calls. The issues with late calls, calls being cut short, a lack of staff travel time between calls and calls where two staff did not overlap with each other when needed, meant there was not a sufficient number of staff to safely cover all the care calls.
• The registered manager said the issues with lateness and two staff not overlapping with each other when required, was due to geography and public transport. They said care packages were spread out over a wide area and issues with public transport often made it difficult for staff to get to care calls on time. Some staff told us they were not always given enough time to travel between care calls and care calls often took longer than they were supposed to, which made them late to their next care call.
• The provider did not have a strategy or plan in place to improve the punctuality issues with care calls and this put some people at potential risk of harm.

The provider's failure to deploy a sufficient number of staff was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider's recruitment processes did not always ensure safer recruitment.
• At the time of our inspection the service was providing care to a child. The Disclosure and Barring Service (DBS) check carried out by the provider for the member of staff supporting the child did not include checking they were eligible to work with children. The provider had not carried out any DBS checks for any staff to work with children. This meant their recruitment process was not always safe and put the child at risk of potential harm. DBS checks provide information held on the Police National Computer, including

details about convictions and cautions, and helps employers make safer recruitment decisions.
• The provider had not always obtained a sufficient work history for new staff and had not always obtained suitable references for new staff. The provider had not carried out risk assessments for staff they did not have sufficient recruitment information about. This meant their recruitment process was not always safe and put people at risk of potential harm.
• The provider's recruitment practice did not follow the recruitment policy and procedures the provider had in place.

The provider's failure to ensure safer recruitment processes was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had carried out DBS checks for all staff to work with vulnerable adults.

Systems and processes to safeguard people from the risk of abuse
• The provider's systems and processes to safeguard people from the risk of abuse were not always effective.
• At the time of our inspection the service was providing support to a child. However, the service was not registered with CQC to provide services to children. In addition, the DBS check carried out by the provider for the member of staff supporting the child did not include checking they were eligible to work with children. This put the child at risk of potential abuse.
• The provider had not identified this issue and only became aware of it when we raised it with them. This had put the child at risk of potential abuse.
• We asked the provider to raise a safeguarding concern with the local council regarding the issues we found with the service supporting a child. The provider initially notified the council's quality assurance team instead of their safeguarding team. The provider did not have any care packages with the local council, so their quality assurance team had no knowledge or oversight of the service.
• The provider's mistake in notifying the local council's quality assurance team instead of their safeguarding team displayed a lack of knowledge and competence by the provider in raising safeguarding concerns. This put people at risk of potential abuse.
• Staff had received safeguarding training, but some staff told us they had not done safeguarding refresher training. Some staff lacked knowledge and understanding regarding the types of abuse people could experience and the signs of abuse they should be aware of. This put people at potential risk of abuse.
• Some staff told us they had not done whistleblowing training. Some staff lacked knowledge and understanding of whistleblowing and did not know how to raise whistleblowing concerns. The provider's whistleblowing policy and procedures did not include all the necessary contact details for staff to be able to raise whistleblowing concerns outside of the organisation, for example they did not contain the contact details for the local council.
• The provider's safeguarding policy and procedures only covered financial abuse. They did not include the other types of abuse people could experience.

The provider's failure to identify safeguarding concerns, report safeguarding concerns correctly and ensure safeguarding systems and processes worked effectively was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During our inspection we spoke with the provider about how to correctly raise the safeguarding concern we had identified and the provider then notified the local council's safeguarding team.
• One person told us, "I feel safe with them, if I didn't, I would speak to them" and another person said, "Yes, I'm safe, there's no problem, it's adequate enough".

Assessing risk, safety monitoring and management

• 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, choking risks, a risk of pressure sores, a risk of falls, a risk of displaying distressed behaviour and a risk of self-harm. There were no instructions for staff about how to manage these risks to people. This put people at risk of potential harm.
• One person's falls risk assessment was general, contained no specific information about what the risks to the person of falling were and contained contradictory information. It stated the person was at risk of trips and falls but also stated there were no apparent risks or hazards.
• The person's falls risk assessment also stated a general risk assessment should not be used where a specific risk assessment was available. There was no specific information for how staff should support the person to avoid falls other than to use a walking aid. This put the person at an increased risk of falls and at risk of potential harm.

The provider's failure to carry out risk assessments and ensure risk assessments were effective was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were not always used safely.
• The provider did not use a Medicines Administration Record (MAR) chart when staff applied creams to people's skin. This was not in line with The National Institute for Health and Care Excellence's (NICE) guidance for 'Managing medicines for adults receiving social care in the community'. This put the person at potential risk of harm.
• One person's medicines assessment had not been completed and did not contain a list of the medicines the person was taking. This was not in line with NICE guidance for 'Managing medicines for adults receiving social care in the community'. The registered manager said the person's family administered their medicines.
• However, this meant staff did not have information about why the person was taking medicines, what effect the medicines could have on the person, what signs to look for if the person had an adverse reaction to the medicines or what action to take in the event of an adverse reaction. This put the person at potential risk of harm.
• One person receiving 'when required' medicines did not have a protocol in place for one of their 'when required' medicines. This was not in line with NICE guidance for 'Managing medicines for adults receiving social care in the community'. It meant staff did not have information about when to give the person the medicine, how much medicine to give the person, what signs to look for if the person had an adverse reaction to the medicine or what action to take in the event of an adverse reaction. This put the person at risk of potential harm.
• The provider was not always clear about who staff supported with their medicines. The provider told us a person was not supported by staff with their medicines, however, the person's care file stated staff applied the person's topical cream. The administration of the person's topical cream was not recorded on a MAR chart. This displayed a lack of understanding by the provider about medicines administration.
•The provider did not carry out medicines audits. This meant the provider was less likely to be able to identify patterns and trends in medicines administration and identify learning to improve medicines administration. This made the provider's medicines administration practice less robust and potentially less safe.
• One person's MAR chart contained conflicting information for staff. It said one of their medicines should be given to them once a day at night but also stated it should be given in the morning. This was mitigated by the fact the person's medicines were grouped in daily packs by the pharmacy. However, the provider had not identified this discrepancy and that meant there was potential for confusion among staff. This put the person at potential risk of harm.

The provider's failure to use and administrate medicines safely was further evidence of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using PPE effectively and safely.
• We were assured the provider was responding effectively to risks and signs of infection.
• We were assured the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
• There were systems and processes to identify learning and share lessons when things went wrong.
• There was an up-to-date accidents and incidents policy and procedures in place and staff knew the procedure for reporting accidents and incidents.
• Accident and incident audits included an analysis of accidents and incidents, and learning and updates were shared with staff. The provider had taken action to resolve issues identified.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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
• Some people's needs assessments were not always effective because they were not always sufficiently specific, detailed and person-centred.
• One person's assessment stated they needed 2 carers, should be hoisted at all times and staff should carry out personal care and domestic tasks. There was no specific or detailed information for staff in the person's assessment or care records about what personal care or domestic tasks needed to be done and no person-centred information about how the person wanted these tasks to be carried out. This meant the person's needs and choices had not been effectively assessed.
• Another person's assessment stated they were at risk of self-harm. The registered manager explained to us how the person may self-harm. However, the person's assessment and care records contained no information for staff about how the person might harm themselves or any person-centred information about what to do if the person attempted to harm themselves or did harm themselves. This meant the person's needs and choices had not been effectively assessed.
• Some people's needs assessments and care plans were not effectively joined up. One person's care plan did not contain any information about what was outlined in their needs assessment about how to support their personal care. This meant staff did not have quick and easy access to person-centred information about how the person needed their personal care carried out.
• People's assessments did not include an assessment of their equality or protected characteristics or contain any person-centred information about their diversity.
• At the time of our inspection, the service was also supporting people living with a learning disability and/or autism. However, the provider, who is also the registered manger, was unaware of the Care Quality Commission's guidance 'Right support, right care, right culture' (RSRCRC). This is guidance providers should follow when supporting people living with a learning disability and/or autism. This meant the provider was not meeting the requirements set out in RSRCRC guidance.
• One person said, "The care is a bit erratic".

The provider's failure to carry out effective assessments of people's needs and preferences and plan people's care in a way that met their needs and choices was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

• Staff training did not always meet regulatory requirements.
• Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. Staff had not received training in learning disability and autism. The provider had not assessed or checked staff members' competency in working with people living with a learning disability and/or autism. At the time of our inspection, the service also supported people living with a learning disability and/or autism.
• Some staff told us they had not done any safeguarding refresher training. Some staff said they had not done infection prevention and control training or whistleblowing training. A member of staff told us they had only done health and safety training.
• There was an induction training programme in place for new staff and a programme of compulsory core training for all staff. However, these training programmes did not include learning disability and autism training.

The provider's failure to provide staff with appropriate training necessary to enable them to carry out their duties was further evidence of a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had carried out spot checks on staff to observe their practice and staff had received supervision and appraisals.
• A person told us, "They're quite good, the moving and handling is okay, they seem to know what to do" and another person said, "They understand me and my needs for moving".

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.

• At the time of our inspection the provider, who is also the registered manager, told us 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.

The provider's failure to maintain accurate, complete and current records in respect of each person, including documentation necessary to decisions taken in relation to the care and treatment provided was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink enough.
• People and their families decided for themselves what they wanted to eat and staff helped prepare people's meals and drinks.
• People's food and fluid intake was recorded.
• One person told us, "They [staff] help me prepare my lunch, they spend more than 30 minutes on me, they're very good" and another person said, "I choose what I want for a meal and they [staff] help me and put it in the microwave".

Staff working with other agencies to provide consistent, effective, timely care
• Staff worked with other agencies when necessary to provide effective care.
• Staff worked with GPs, specialist healthcare teams, district nurses, hospital staff, social workers and local authorities to ensure people received the care and support they needed.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare services when necessary.
• Most people and their families arranged their own access to healthcare services and support.
• The provider supported people and their families if it became necessary to liaise with healthcare services, doctors, nurses, local councils, occupational therapists and/or dentists, for example.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to requires improvement.

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

Ensuring people are well treated and supported; respecting equality and diversity
• The provider had not assessed people's equality or protected characteristics and people's care records did not contain personalised information about their social or individual diversity. People frequently received late care calls and the provider did not always contact people to let them know their care call would be late.
• However, people were well treated and supported by care workers and staff respected people's diversity and individuality. People told us staff knew them and their likes and dislikes well. There was a consistent staff team, so people received continuity of service and did not have many different care workers providing their care. This helped people feel more secure and more comfortable.
• One person told us, "They [staff] are kind, caring and friendly. They treat me well; they listen to me". Another person said, "They're very good, kind and caring". A person's relative told us, "They [a care worker] have great interaction with my relative, they make her laugh, it's like a friendship. They are friendly and caring, there is lots of banter between them".

Supporting people to express their views and be involved in making decisions about their care
• People and their families were involved in making decisions about their care and were supported to express their views.
• The provider included people and their families and consulted with them when carrying out people's needs assessments and planning their care.
• One person told us, "They [staff] ask for my agreement before they do anything. They are caring and kind. I think they are doing a good job". A person's relative said, "They do listen to us" and "We have a care plan; I drew it up with them".

Respecting and promoting people's privacy, dignity and independence
• Staff respected and promoted people's privacy and dignity and supported people to be as independent as possible.
• People told us care workers treated them with dignity and respect and supported them in ways which helped them retain as much independence as possible. One person said they thought their health and ability had improved since having regular input from their care worker.
• People's confidential information was stored securely and used in line with data protection laws.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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
• People's care was not planned in a personalised or person-centred way.
• People's needs assessments and care plans did not contain sufficient personalised or person-centred information. The information for staff in people's assessments and care plans was mainly about what tasks staff needed to carry out. There was insufficient information about people's preferences and choices and how they wanted things done.
• Not all people were sure about the care they could expect and should be getting. Not all people knew whether they had a care plan in place. Some people said they received inconsistent care.
• One person said, "I'm not sure about what I should be getting. I get a different service on different days". Another person said, "I don't know if I have a care plan. My [son/daughter] lives with me, so they might know".

The provider's failure to plan people's care in a personalised and person-centred way was further evidence of a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some people told us the provider had asked them whether they preferred to have a male or female carer. They said they had been given the choice to have either a male or female member staff support them. People told us they had appreciated being given this choice.

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 (AIS). The AIS 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 did not follow the five steps of the AIS.
• The provider had not assessed people's individual communication needs. People's care records did not contain personalised information for staff about their communication needs. This meant people were at risk of potential miscommunication and misunderstanding.
• One person told us they struggled to hear what care workers were saying. They said when they spoke to care workers the care workers would tell them they could not hear what they were saying because they have

a very quiet voice. They said care workers would then start talking to each other in their own language. The person made it clear this was not a satisfactory exchange for them.
• People relied on care workers getting to know their communication needs well over time. A person's relative said, "Communication would be harder if we had a different carer". This meant people were at risk of potential miscommunication and misunderstanding until staff got to know them well or if there was a change of staff.

The provider's failure to follow the AIS was further evidence of a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 and their families arranged their own activities and social contact.
• The provider liaised when necessary with the community centres some people attended.
• Care workers spent time talking with people. This helped people feel less isolated at times. One person said, "It's a reasonable service, it gets me moving, it's not bad. If there's time, they [staff] will walk with me to the common".

Improving care quality in response to complaints or concerns
• There were systems and processes in place to deal with complaints in order to improve the care provided.
• The provider had a complaint policy and procedure and people and their families knew how to make a complaint. People and their families told us they had the information and understood who to speak to if there were any problems or concerns. They said they felt confident to raise concerns or make a complaint.
• The provider recorded complaints, responded to them appropriately and took action to resolve issues.
• One person told us they had raised a concern with the registered manager early on in their care and it had been promptly addressed and resolved. Another person said, "I would call LIM care direct if I had a problem". A person's relative told us, "I have all the information about raising concerns. I did complain once because we were getting different people all the time and that has got better".

End of life care and support
• At the time of our inspection no one was receiving end of life care.
• However, staff had received end of life care training and the provider had systems and processes in place to be able to plan and deliver end of life care if it became necessary.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to establish and operate effectively systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to establish and operate effectively systems and processes to assess, monitor and improve the quality and safety of the service. The provider had also failed to establish and operate effectively systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.
- The provider had not carried out any audits of the service other than accident and incident audits. This meant the provider was less likely to identify issues and be able to improve them. The provider had not identified any of the issues we found during our inspection.
- The provider had not carried out any risk assessments for people.
- The provider told us they went to people's homes and collected their daily care note logbooks every three months. The provider was unable to provide us with the full and consistent evidence we requested showing staff completed people's daily care notes every day, they were only able to show us samples of periodic evidence of people's completed daily care notes. This meant the provider did not have effective oversight of the care provided to people daily.

The provider's failure to establish and operate effectively systems and processes to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks relating to the health, safety and welfare of people was further evidence of a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager did not know how many people the service was supporting. They told us the service was providing care to 25 people. However, the provider's care call monitoring data showed at least 52 people received care from the service during the beginning of January 2023 to the end of March 2023. In

addition, one of the councils that had care packages with the provider told us they currently had 38 people receiving care from the service.
• The registered manager did not have a clear understanding of the correct DBS checks to carry out for new staff or safeguarding procedures. During our inspection we had to direct the registered manager about how to correctly raise a safeguarding concern with the local council.
• The registered manager did not have a clear understanding of how to notify CQC about incidents. The registered manager had submitted a notification for an event that stops the service instead of a notification of alleged abuse for a person that experienced an incident with their catheter care, for example. During our inspection we showed the registered manager where to find the information about how to submit CQC notifications correctly.
• The registered manager did not have sufficient knowledge and understanding of guidance and staff training requirements. The registered manager was unaware of the CQC guidance 'Right support, right care, right culture' (RSRCRC) for providers supporting people with a learning disability and/or autism. During our inspection we showed the provider the RSRCRC guidance and where to find it.
• The registered manager was unaware that since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism.
• The registered manager displayed a lack of knowledge and understanding about what audits were and how to carry out audits. During our inspection we suggested the registered manager seek professional support to learn about and carry out audits of their service.
• The registered manager displayed a lack of understanding about the electronic call monitoring system they used to monitor care calls. The registered manager told us the system was unable to show whether a member of staff was at a person's home or not when they were providing a person with care. However, when we spoke to the software provider, they said the system did show a staff member's location when they were at a person's home.

The registered manager's failure to demonstrate the knowledge and competency required to manage the regulated activity was a breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had job descriptions and new staff were given a staff handbook and did induction training. Staff did core training and received supervision and the provider carried out spot checks to observe and monitor staff practice. The provider had a written set of aims and values and they were given to staff.
• Staff attended staff meetings and were debriefed when there was an accident or incident.
• This meant staff were supported to understand their role and what was required and expected of them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The culture of the service was not person-centred.
• People regularly received late care calls and were not always contacted in advance to tell them their care call would be late.
• People's care records and information were not sufficiently personalised.
• Most of the people we spoke with said carer workers were often late and care visits did not take place on time. Most of them said they did not receive a call warning them their care visit would be late. Most of them told us they would like staff punctuality to improve.
• One service user told us their care call was due at 08:00 and they often had to wait until after 10:00 before the care worker arrived.

The provider's failure to promote a positive culture that is person centred was further evidence of a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Continuous learning and improving care
• The systems and processes in place to promote and support continuous learning and improve the care provided were not effective.
• The provider told us they mainly dealt with issues in isolation, on an individual basis. This meant there was no systematic way for the provider to monitor the service, maintain oversight of the service and plan a strategy for learning and improving the care provided.
• The provider, who was also the registered manager, had not tried to join council support networks for registered managers. This meant they were not sufficiently linked in with the learning and support available to them.
• Staff training had not always ensured staff had the required level of knowledge and understanding in some areas of care.
• The level of care provided since our last inspection had not improved and had deteriorated.

The provider's failure to establish and operate effectively systems and processes to continuously learn, improve and ensure sustainability was further evidence of a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider received communication from local authorities, the NHS and CQC about guidance. They attended an annual residential care home show and had attended local authority provider forums when invited.
• During our inspection the registered manager said they would contact two local authorities and try to join their registered manager support networks.
• During our inspection the provider told us they may seek external professional help to support them with their learning and improving the care provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People's assessments and care plans did not include sufficient information about their equality characteristics and individual diversity. The provider had not considered all people's protected characteristics and individuality when planning people's care and support.
• The provider did not have a method in place for staff to provide anonymous feedback about the service.
• The provider engaged and involved people, their relatives and staff in the development of the service. The provider used questionnaires to obtain people's and their families' feedback about the service. The provider also carried out regular telephone calls to people and their families to get updates and feedback.
• Staff were given the opportunity to share their views and suggestions in staff meetings and supervision and could informally talk about anything at any time.
• One person said, "They [the provider] call me to ask about the service" and another person told us, "We have filled in a questionnaire". One other person said, "I could speak to the manager if necessary" and another person told us, "I have got a questionnaire".
• Some people said they had spoken with the provider and told us they had been approachable and had helped to sort out any issues.

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 understood their responsibilities in relation to the duty of candour.
• The provider and staff communicated openly and honestly with people and their families and other organisations when there was an incident.

Working in partnership with others

- The provider and staff worked in partnership with other organisations to meet people's needs.
- They worked with a range of healthcare services and professionals, local authorities and day centres.

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 failed to carry out effective assessments of people's needs and plan their care in a personalised and person-centred way.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to carry out risk assessments, ensure risk assessments were effective and use medicines safely.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to identify safeguarding concerns, report safeguarding concerns correctly and ensure safeguarding systems and processes worked effectively.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effectively systems and processes to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks

	relating to the health, safety and welfare of people.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure safer recruitment processes.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy a sufficient number of suitably qualified and competent staff.

The enforcement action we took:

We issued the provider with a Warning Notice.