Exceptional Home Care Ltd

Exceptional Home Care

Inspection report

Manor House
14 Market Street
Lutterworth
LE17 4EH

Tel: 01455207890
Website: www.exceptionalhomecareltd.co.uk

Date of inspection visit:
18 August 2022
25 August 2022
11 October 2022
12 October 2022

Date of publication:
20 December 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Exceptional Homecare is a domiciliary care service. The service provides personal care to people living in their own homes or flats.

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. When we commenced the inspection there were 19 people receiving care, 16 of these received personal care. Upon conclusion of the inspection there were 14 people receiving care, 11 of these received personal care.

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 who have a learning disability and or who are autistic.

Right Culture:
Quality assurance systems and processes to monitor the quality and safety of the service had not been implemented in line with the provider's policies and procedures. Therefore, the provider had not identified the concerns we found prior to this inspection. Lessons had not been learned from the findings of previous inspections. This is the third inspection we found failings relating to the quality and safety of the service.

Right Support:
Training was not always provided in line with the provider's training and governance policies. Further improvements were needed to ensure all staff received the training they needed to undertake their role. Not all staff had received safeguarding training prior to this inspection and their competence administering medicines and undertaking moving and handling tasks had not been assessed.

Improvements were made to staffing levels during this inspection. However, the time people received care was inconsistent and they did not always know when care would be provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service had not always supported this practice.

Right Care:
People remained at risk of receiving unsafe care. Systems had not been put in place to monitor and

promote safe care. Risk assessments were not always updated when people's needs changed or they had fallen. Medicines were not always safely managed.

Staff did not always follow government guidance for the use of personal protective equipment (PPE) during the COVID-19 pandemic. This increased the risk of transmission of infection and COVID-19.

People were supported to eat and drink enough by staff that knew their dietary needs. Prompt action was taken to seek medical advice when people's health deteriorated. People told us they were supported by staff that knew them well and were kind and caring. Staff supported people to remain as independent as possible and treated people with dignity and respect.

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 inadequate (published 07 May 2022) and there were breaches of regulation. The provider did not complete required action plans after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been rated inadequate in well-led for two consecutive inspections.

This service has been in Special Measures since 06 May 2022. During this inspection the provider did not demonstrate that the required improvements have been made. Therefore, this service remains in Special Measures.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care, safeguarding and good governance at this inspection.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 always safe. Details are in our safe findings below.	**Requires Improvement**
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**

Exceptional Home Care

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 3 inspectors and an 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 no registered manager in post. There had been no registered manager since 21 October 2021. The provider had employed a manager who told us they intended to register with the Care Quality Commission.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 18 August 2022 and ended on 12 October 2022. We visited the location's office on 18, 25 August and 11 and 12 October 2022. We made phone calls to people, their relatives and staff

during the inspection.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection and used this to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 8 relatives about their experience of the care provided. We spoke with 7 members of staff including the nominated individual, operations manager, service manager and care staff. 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 9 people's care records and where applicable their medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

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 Inadequate. The rating for this key question has changed to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had not operated effective safeguarding systems and processes to protect people from abuse and improper treatment. This was a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● At the beginning of the inspection only 3 out of 7 staff had received safeguarding adults training. There was a risk staff that had not accessed training would not recognise improper treatment and abuse and know how to report this to protect people from harm.
● Prior to this inspection, there was no system in place for reporting and recording concerns raised about the safety and welfare of people who used the service. We found 3 people had pressure ulcers. There were no care plans or risk assessments in place to instruct staff how to care for people's pressure ulcers to reduce the likelihood of them deteriorating further. Furthermore, where a safeguarding referral was required to the local authority's safeguarding team, this had not been made. This is the second inspection we have identified concerns with the provider's safeguarding systems and processes.

Systems had not been established to mitigate risks of avoidable harm and abuse to people using the service. This placed people at risk of harm. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection staff undertook safeguarding training. Upon conclusion of the inspection 6 out of the 7 staff had undertaken safeguarding training. A system was implemented during the inspection to ensure safeguarding concerns would be identified and reported. This needed to be embedded and sustained in practice.

At our last inspection there was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed in relation to infection control, medicines management, assessing risks and safe recruitment. This placed people at significant risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 12

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People's risk assessments and care plans were not always reviewed when their needs changed. One person had a pressure ulcer that needed healthcare professional intervention. Their care plans and risk assessments had not been updated to reflect this information. This meant staff did not have the guidance they needed to reduce the risk of the wound deteriorating and to ensure they were comfortable.
● People's falls risks were not always safely managed. Three people were at risk of falling. Their falls risk assessments did not instruct staff how to support them to reduce the risk of them falling. One person had fallen on 4 occasions in 3 months. Their falls risk assessment and care plan had not been reviewed after each fall to identify measures to reduce the risk of recurrence. This is the third inspection we have identified concerns with risk management.
● Accident and Incident reports showed prompt action was taken when incidents occurred to make people were safe. However, there had been no audit of accident and incident reports since March 2022. This meant the provider had not identified themes and trends in accidents and incidents to learn from these or support staff to improve their practice and promote good care. This is the third inspection we have found these failings. A relative told us in relation to a concern, "It is usually, 'sorry about that, it won't happen again'. However, it happened several times."
● Staff had not received practical moving and handling training, or had their competency assessed to support people with their moving and handling needs. There was a risk therefore, this would not be undertaken safely putting people at risk of harm.

Preventing and controlling infection
● Staff did not always use PPE in line with government guidance for the use of this during the COVID-19 pandemic. We found there was inconsistent use of face masks. A person told us, "They (staff) wear gloves and aprons, but they don't wear masks." A relative told us, "Some staff do [wear full PPE], some don't come with aprons. If they're not wearing masks, I ask them to put one on." Another relative said, "Staff wear gloves, just gloves. They don't wear face masks."
● Staff did not always wear a uniform. One relative said, "They [staff] don't wear a uniform, most don't. Only the regular carer wears a uniform, the others don't." Uniforms act as a first line of defence for infection control and ensure staff are 'bare below the elbow' so they can effectively wash their hands.
● There were no systems and processes in place prior to this inspection to check staff were complying with government guidance for the use of PPE. Therefore, the provider had not identified the concerns we found.

Using medicines safely
● Medicines were not always safely managed. Whilst staff had undertaken medicines awareness training, their competency administering medicines had not been assessed. This meant we could not be assured people received their medicines safely.
● There had been a lapse in medicines audits being undertaken since May 2022. At the beginning of the inspection we found multiple gaps in Medicines Administration Records (MAR). The lack of audits meant we could not be assured people had always received their medicines as prescribed.

The provider had failed to assess and mitigate risks to people's health and safety. This placed people at significant risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the provider took action to address some of the concerns we found and implemented new systems and processes to achieve compliance with the regulations. These newly implemented systems

and processes needed to be embedded and sustained.

Staffing and recruitment

● Since our last inspection, the provider's recruitment checks had improved. However, we found an absence of references for one staff member. This meant we could not be assured people were always supported by suitable staff.

● Systems and processes failed to identify a missed call in October 2022. A relative told us, "No-one turned up at all." They told us as a result they needed to ask another family member to support them to provide care to the person.

● Call times were not scheduled for a consistent time. This meant people did not know when to expect care staff. We received mixed feedback about this. One person said, "Sometimes they are late, but I don't mind." A relative said, "They don't really stick to times. The last couple of days they have been on time... they can turn up whenever." Another relative said call times varied and added, "They are very good and flexible and can move calls [e.g.] make them earlier if we ask."

● There were not enough staff at the beginning of the inspection to meet everyone's care calls at a consistent time. A staff member told us the previous manager had cancelled people's calls as a result and they went without care. Action had been taken to address this during the inspection and improvements had been made. A staff member said, "At the moment there are enough staff to meet care calls."

● We received mixed feedback from people regarding the duration of their care calls. Some people told us staff stayed and supported them for the agreed duration of their care visit, others told us staff left early which meant they did not always receive the agreed support.

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. 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

- The manager told us people's physical, social and wellbeing needs were assessed before receiving care from the service to ensure they could meet their needs. However, no records of these assessments were maintained, therefore we could not be assured people's needs had been comprehensively assessed prior to the provider delivering care.
- Care and support was not always delivered in line with legislation and evidence-based guidance to achieve effective outcomes. Government guidance relating to the use of PPE during COVID-19 pandemic was not applied consistently.
- People's care plans and risk assessments had not always been updated following a change in their needs.

Staff support: induction, training, skills and experience

- Staff had not received training to meet people's individual needs such as catheter care, end of life, learning disabilities and/or autism. During the inspection the provider sourced a new training provider to undertake this training.
- At the beginning of our inspection, the manager was unable to provide evidence of staff training. During the inspection, all but one member of staff had undertaken training the provider deemed as mandatory, and compliance had improved.
- There had been a lapse in staff supervisions and spot checks being undertaken. There was a risk therefore staff performance concerns and development needs would not be identified and addressed. However, staff told us they felt well supported by the manager at the service.
- People told us they felt staff had the skills to meet their needs. One relative said, "As far as I'm aware they've got the necessary skills as things are at present."

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

- Most people who used the service were independent with their meals, or received support from their family. Where required, staff supported people to eat and drink enough. One person told us, "They [staff] make me snacks. They make sure I have enough to drink." Another person said, "If I'm having sandwiches, I do it myself. If it's a cooked meal, they [staff] do it for me. They cook what I want."

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

- Care records evidenced staff escalated concerns about people's health care to the manager, who facilitated referrals to the relevant agencies to ensure people's health and social care needs were met.

However, we found healthcare professional advice was not always reflected in people's care plans and risk assessments. For example, a district nurse was involved in caring for a person's pressure ulcer, the service had not sought their advice to inform the persons care plans and risk assessments. Putting them at risk of health deterioration.

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
● Where people were deemed to have limited capacity to make their own decisions, the provider had not always followed good practice in relation to assessing capacity. Improvements were made during the inspection and upon conclusion we found decision specific mental capacity assessments had been undertaken.
● People told us staff sought consent before they provided care and support to them. One person told us, "They [staff] usually say, 'would you like me to do so and so for you', or 'what would you like me to do for you?'." A relative said, "They are very good, polite and they ask [Name] 'do you want to have your shower now?'. They don't just move [Name] around and assume what they want."
● Care records showed where people had appointed a lasting power of attorney (LPA) for health and welfare or finance this was recorded. An LPA is a person that acts in the persons best interests when making decisions on their behalf. The manager understood the need to seek evidence of LPA, however had not always obtained the appropriate proof of this.

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 requires improvement. At this inspection the rating has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had failed to make the necessary improvements required following the last inspection to improve the quality and safety of the service. This did not reflect a caring approach. Prior to this inspection they had not sought people's feedback to determine how their experience of care could be improved.
- People and staff had developed caring relationships together and enjoyed each other's company. Staff knew people well and provided kind and compassionate care. Some of the comments we received included, "They [staff] are always very sweet and very kind;" "They're marvellous carers; " "The [staff member] is absolutely wonderful, it's fantastic how [staff member] engages with [person].".

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

- Staff involved people and sought their views and contributions when delivering their care. A relative said, "[Staff member] talks to [person] all the time and natters away; I think it's lovely to keep [person] engaged. [Staff member] is very thorough. It's just nice to see somebody caring about their job and caring about their patient."
- Staff understood when people needed the support of an advocate. This is someone that can help a person speak up to ensure their voice is heard on issues important to them.

Respecting and promoting people's privacy, dignity and independence

- Staff knew when people needed their space and privacy and respected this. One relative said, "They [staff] are good at promoting dignity. They shut curtains and doors [when delivering personal care]."
- People told us their interactions with staff were respectful. One person told us, "I would say on a whole, we interact with each other in a good, positive way."
- People were supported to be as independent as they could be. One person told us, "I like to be as independent as possible. I realise that there are things I can't do now. I leave it until the carers come in and I ask them to do it. It helps me to maintain the independence that I do have."

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 inadequate. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people received appropriate person-centred care that met their needs. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst further improvements were required, enough improvement had been made at this inspection with regard to ensuring people received personalised care for the provider to be no longer in breach of regulation 9.

● People did not always receive care at the time they wished and told us they did not always know when staff would arrive. This was because the provider had not planned for care to be delivered at a set time. The provider had planned improvements to the scheduling of care calls to address this.
● The provider was in the process of implementing new care plans during this inspection. Upon conclusion of the inspection we found everyone's care plans had been transferred to the new format. They included detailed information on people's preferences and wishes relating to the delivery of their care.
● People told us staff knew them well. However, we received mixed feedback from people in relation to whether care was personalised. One person said "They [staff] think they know better than me, what is good for me." They told us they reported these concerns and improvements had been made. A relative said, "[Staff] puts [Name's] beads on, her hair is done, and she is always very happy." A staff member said, "I personally like to read the notes for the past few days." This was so they knew of any changes to people's needs before supporting them.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to establish and operate a system to record, investigate and respond to complaints about the service. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst further improvements were required, enough improvement had been made at this inspection with regard to complaints for the provider to be no longer in breach of regulation 16 for complaints.

● There had been a lapse in systems and processes for recording and monitoring complaints, which meant we could not be assured complaints had always been addressed in line with the provider's policy prior to

this inspection. However, improvements had been made and we found a complaint received during the inspection had been dealt with in line with the provider's policy and to the complainants' satisfaction.

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.
● Staff knew how to communicate with people effectively. However, their preferences and wishes in relation to communication had not always been assessed and detailed in their care plan.
● At the time of our inspection, none of the people who used the service required information in an accessible format. The operations manager told us should people require information in an alternative format such as large text or a different language, they would approach the provider to facilitate this.

End of life care and support
● At the beginning of inspection, the provider was supporting people at the end of their life. We found people's changing needs had not been reflected in their care plans and risk assessments.
● Staff had not received training in end of life care at the time they were delivering this. Upon conclusion of the inspection, there was no one receiving end of life care. The provider had identified training for staff to undertake, prior to providing further end of life care.
● People's care records evidenced staff worked collaboratively with relatives and professionals when people reached the end of their lives.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were not at risk of social isolation. Where required, staff supported people to follow their hobbies and interests and to access their local community.

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 inadequate. The rating for this key question has remained 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 operate systems or processes to assess, monitor and improve the quality and safety of the service provided. They did not maintain accurate, complete and contemporaneous records of people's care. Feedback was not actively encouraged. These issues constituted a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 failed to follow their policies and procedures in relation to monitoring the quality and safety of the service. This included, but was not limited to, a failure to undertake audits in relation to safeguarding, accidents and incidents, medicines and care records and to implement their training programme. This meant the concerns we found had not been identified or addressed by the provider prior to this inspection. This is the third inspection we have found these failings.
- The provider failed to have an oversight of the quality and safety of this service. They failed to return the required action plan following our last inspection to evidence how they would achieve compliance with the regulations. There were no action plans in place for the manager to follow to enable them to make the required improvements identified at our last inspection. The provider also failed to ensure records were securely stored prior to this inspection.
- There had been no registered manager at the service since October 2021. The current manager was previously employed by the service. They told us they intended to register with CQC. At the beginning of the inspection the manager spent a significant amount of time providing care to people. This impacted their ability to undertake their managerial role, contributing to the failings we found.
- A review of records indicated statutory notifications had not always been submitted to CQC, there was also no evidence of the provider displaying their rating of performance from the last inspection at the registered location. We are reviewing this and will report on this at the next inspection.
- The provider could not demonstrate they understood and acted on the requirements of the duty of candour. Duty of candour is a requirement for providers to be open and honest with people when things may/could have gone wrong with the care they received.
- Staff were not always given honest feedback about how they were performing, and where improvement

was needed prior to this inspection.

Continuous learning and improving care

● The provider did not have a culture of learning to improve people's experience of receiving care. There was no evidence of learning, reflective practice and service improvement since the last inspection. This is the third inspection we found failings. Action was not taken to address these failings until during this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The lack of provider oversight contributed to the failings we found during this inspection. They had failed to ensure systems and processes were implemented to drive positive change to enhance people's experience of receiving care.

● People, relatives and staff had not had the opportunity to provide feedback about the care delivery prior to our inspection. During the inspection, surveys were undertaken and whilst positive feedback was provided about the care staff, people said they did not always know when care staff would arrive and were not always informed if changes had been made to their care.

● Prior to this inspection staff meetings, spot checks and supervisions had lapsed. This meant staff did not have the opportunity to formally provide feedback, which could be utilised to drive change and improve people's care experience.

The provider continued to fail to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the operational manager undertook an audit and identified a number of areas for improvement and developed an action plan. We found some improvements had been made during this inspection and some had been planned. These needed to be embedded and sustained in practice.

Working in partnership with others

● Records evidenced the service worked well in partnership with health and social care organisations to ensure people received joined-up care.