Royale Care Uk Limited

Royale Care UK Limited

Inspection report

Office 18, The Annexe, Investment House
28 Queens Road
Weybridge
Surrey
KT13 9UT

Tel: 01932481617

Date of inspection visit:
06 June 2019
04 July 2019

Date of publication:
06 July 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Royale Care UK Limited is a domiciliary care agency supporting older people living in their own homes. Not everyone using Royale Care UK Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.
At the time of our inspection the service was supporting 13 people, eight of whom were receiving personal care.

People's experience of using this service and what we found
There was no registered manager in post which impacted on the service people received. This had led to a lack of organisation and responsive action when concerns were raised. Managerial oversight of the service was poor and quality systems were not effective in identifying concerns.

People and their relatives told us they rarely received a rota informing them which staff members would be supporting them. They told us that care calls were often late and they were not informed, and some care calls had been missed. People said that they found it difficult to get a response from the provider regarding this and said their complaints were not responded to. During our inspection we informed the provider of two missed calls which they were unaware of. Audits and systems to check the quality of the service were not always effective and the provider did not always respond to concerns in an open and transparent manner.

Recruitment checks to ensure staff were safe to work at the service had not been fully completed. The provider failed to produce training and supervision records to confirm if staff received on-going support and completed the training required for their role.

Assessments lacked detail which meant there was a risk the service would be unable to meet people's needs. Care plans and risk assessments were not personalised and did not give sufficient guidance to staff on how to provide people's support. This issue had previously been highlighted by the local authority quality assurance team, but had not led to improvements. Records were not securely and accurately maintained. The provider told us they were unable to access a number of records as they had changed IT provider. We have made a recommendation regarding people's communication needs being recorded in detail in line with the Accessible Information Standard.

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; the policies and systems in the service did not support this practice.

Although people expressed concerns regarding the management of the service, they told us that individual staff members treated them with respect and knew their needs well. We observed staff show kindness and

consideration when speaking with people.

There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 June 2018)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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 effective. Details are in our effective findings below.	**Inadequate**
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**

Royale Care UK Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by three inspectors

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

The service did not have a manager registered with the Care Quality Commission in line with the conditions of their registration.

Notice of inspection
We gave the service 48 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 6 June 2019 and ended on 4 July 2019. We visited the office location on 6 July 2019.

What we did before the inspection
Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection-
We visited the office location and spoke with the provider. We checked care records for three people, including their assessments, care plans and risk assessments. We looked at four staff files and checked records including satisfaction surveys, complaints, accident and incident records, quality monitoring checks and audits. We visited two people in their homes. We spoke with them and the staff supporting them about their care. We also spoke with one person and two relatives on the telephone to gain their views of the service provided.

After the inspection –
We continued to seek clarification from the provider regarding information which was unavailable to us during the inspection such as policies and procedures, recruitment checks, training and supervision information and quality assurance processes. After the inspection we requested further information from the provider not all of which has been received.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question had deteriorated to Inadequate. This meant people were not safe and were at risk of harm.

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

- Potential risks to people were not always identified and assessed in order to keep them safe. One person required the use of specific equipment which presented significant risks to the person and staff. This needed to be closely monitored and staff were required to understand the potential risks. The provider told us the local authority quality assurance team had recommended a risk assessment be implemented which provided guidance to staff on how to use the equipment. Although the provider had completed this, it had not been transferred to the person's home file which meant staff were unable to refer to the guidance in order to understand and mitigate the risks. The risk assessment kept in the office was taken from manufacturers guidance and was difficult to navigate and understand.
- Another person's care records identified they were living with dementia. Risk assessments determined the person was at risk of dehydration and fluid charts should be used to monitor how much the person was drinking. The provider told us these were not being completed. They told us, "That's not something we do."
- One person's risk assessment stated they were at high risk of falls and used a specific piece of equipment to transfer between chairs. The provider told us this information was incorrect and was unable to say why this was written as the person had always been able to mobilise using furniture to steady themselves. There was no additional guidance to staff regarding how to keep the person safe when mobilising or what assistance they should provide.
- Accidents and incidents were not recorded in detail and no monitoring was completed to identify trends. The provider told us that on occasions staff were late arriving to some calls as they stayed on to deal with emergency situations at previous calls, such as people being unwell or having fallen. However, we found that no accident or incident forms had been completed in relation to this. The provider told us that prior to February 2019 they used a different IT package which enabled them to record incidents electronically but they no longer had access to this information. The lack of recording and information meant we were unable to fully assess the risks to people's safety and how this was being monitored.
- Contingency plans were not completed to ensure that people would continue to receive safe care in the event of an emergency. The provider showed us a copy of their contingency plan which was a pre-printed form purchased with their policy and procedure information. However, they had failed to complete any of the information specific to the service which would guide staff as to the action required should an emergency situation arise.
- During the month prior to the inspection the provider had needed to take time off.. During this time staff were not paid and found it difficult to contact the provider. There was no contingency plan in place for staff to follow, resulting in them raising a safeguarding concern with the local authority as they believed people may not continue to receive their care.

The failure to ensure risks to people safety were assessed and mitigated, accidents and incidents were

monitored and that effective contingency plans were in place was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was a lack of safe staff deployment and monitoring. People and their relatives told us the timing of their calls was not always consistent, and they were not informed when staff were running late. One person told us, "The morning calls are always late. One time they arrived at past 11 (am) and I was still in my pyjamas. When I asked why it was so late I was told, 'It's a morning call, it's still the morning.'" One relative told us, "They never bother to ring to say when they're running late and it happens a lot. It causes a lot of anxiety." They described the direct impact the late calls had on their loved ones' health.

● One person's records highlighted on two occasions in May 2019 their care call had been missed. Due to the person's needs they were unable to support themselves with getting ready for the day and eating. We spoke to the provider regarding this who told us they were not aware the calls had been missed.

● Staff did not always stay for the full duration of the call. One person told us, "They're supposed to be here for half an hour but some of them stay five or 10 minutes." An electronic rostering system was used which required staff to log-in and out of each care call. We checked 20 call records for the week prior to our inspection. Eight of these had been shorter than planned by at least 10 minutes with no explanation recorded. Two of these calls were cut short by over 30 minutes. The provider told us they had not been aware of the calls being cut short.

The failure to ensure that staff were safely deployed and people received their care in line with their care needs was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. This meant the provider could not assure themselves people were being supported by suitable staff.

● We asked the provider to show us recruitment records for five named staff. The provider told us they were unable to show us records for one staff member who had recently left the service as they were stored at their home address. We asked the provider to forward the information following the inspection but they failed to do so.

● Of the remaining four staff members none had the required Disclosure and Barring Service (DBS) checks in place. DBS checks help employers make safer recruitment decisions and include a criminal record check. Two staff members had no DBS checks on file and two staff had DBS checks from previous employers. The provider told us they had evidence of the checks being completed on email but were unable to access them. We asked for this evidence to be forwarded to us following the inspection, but the provider failed to send this information.

● In addition, the provider had not explored the reasons for gaps in the employment histories of two staff members whilst two others did not have appropriate references. No health checks had been completed for staff employed by the agency to assess their fitness to work in their role.

The failure to ensure safe recruitment processes were followed was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection in May 2018 we found that medicines were not safely managed as records were not

always completed in sufficient detail and audits had not identified these concerns. At this inspection we found improvements had been made.

● People told us they felt safe with staff supporting them with their medicines. One person told us, "They make sure that I have taken my meds. At night I take my medicines when they are with me and I self-medicate in the morning when I choose to. They check my pack to see if I have taken it."
● Medication administration records (MAR) were in place for those people receiving support with their medicines. Charts were fully completed and prescription guidelines fully transcribed.
● Staff files contained evidence that their competency to administer medicines had been assessed.
● MAR charts were regularly audited to ensure they were fully completed and staff were spoken to where minor errors had been identified.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe with staff. One person told us, "I feel safe, they always make sure I get in and out of my wheelchair." Another person said, "Oh yeah (I feel safe), all the carers have been so lovely." We observed another person appeared relaxed in the company of staff and responded well to their conversations.
● Where safeguarding concerns had arisen, these had been reported to the local authority as required. Where additional information had been requested as part of investigations this had been provided.

Preventing and controlling infection
● Staff maintained appropriate standards of infection control. People told us staff helped them to keep their homes clean and we observed staff had access to gloves for use when supporting people with their personal care.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question had deteriorated to Inadequate. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People told us their needs were assessed prior to them receiving care. One person told us, "The manager came around and went through everything with me and we worked out what I needed help with." A second person said, "I had an assessment after I was discharged from hospital and I was able to talk about what sort of support I wanted to have."
- Despite these comments we found people's needs were not always comprehensively assessed prior to their care starting. Records for one person did not contain any assessment information and a second person's assessment contained only basic information.
- The provider told us this had been highlighted as a concern by the local authority quality assurance team. As a result of this the provider had started to use the support plan as a template to complete the assessment information for prospective people. Although this had led to additional information being gathered, this did not give a range of prompts for the assessor regarding the support people may require. This meant there was a continued risk important information regarding people's needs may be missed.
- Call times for one person had not been taken into account when the agency had agreed to provide their care. This had led to the service having to hand back the package of care to the local authority as they were not able to consistently meet the person's needs. Another person's personal care needs had not been assessed in detail, which had led to a delay in them receiving the support they required from other services.

The failure to comprehensively assess people's needs prior to them starting to use the service and to use recognised tools to continually assess people's care needs was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- We received mixed views from people and their relatives regarding the competence of staff. One person told us, "All the staff that have come to my home seem to know what they're doing. It took some of them a bit of time to know what I needed but they all know now." Another person said, "I'd describe them as adequate. I'll leave you to make of that what you want."
- We asked the provider for training records to demonstrate staff were up to date with their training. The provider told us they had not updated the staff training record for some time and would forward this following the inspection. However, despite reminders being given, the provider failed to send this information. This meant we could not be assured staff had received appropriate training relevant to their role.
- We asked the provider to send us contact details for staff members to enable us to discuss areas including

induction, training and supervision systems with them. Again, the provider failed to ensure we received these. This meant we were unable to fully assess staff skills and knowledge in relation to their roles.
● Not all staff had completed the Care Certificate as part of their induction. This is a set of agreed standards that health and social care staff should demonstrate in their daily working lives. The provider told us staff were expected to complete the Care Certificate training online and were given reminders of this. However, the provider said they were unaware of the need to assess staff competence in these areas as part of this process. This meant the provider was unable to assure themselves that staff were working in line with these standards.
● Records failed to demonstrate staff had the opportunity to discuss their role and professional development on a regular basis. Of the four staff files viewed, only one contained evidence of supervision taking place within the last 12 months. Spot checks to assess staff skills in delivering care were not completed at regular intervals. Records showed that only two spot checks had been completed this year.

The failure to ensure that staff received suitable training, induction and supervision to support them in their roles was a breach of regulation 18 (Staffing) 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.
● People's legal rights were not protected as the principles of the MCA were not followed. One person had not signed to give their consent to receive care. The person's risk profile described their capacity as 'Good'. However, the provider told us that, due to the person's health condition, they did not believe they had capacity to sign their care plan and consent to their care. No capacity assessment had been completed to determine if the person had capacity to make this decision.
● The risk profile sheet for the person contained generic guidance which stated, 'If the person lacks capacity then a Best Interest Decision Record would be completed with the support of an Independent Mental Capacity Advocate (IMCA) and would also include involvement of family members where this is applicable'. This information is not in line with the MCA which does not require the involvement of an IMCA for all decisions, particularly where the person has representation from their family members. No reference was made to the person's views also being taken into account. No capacity assessment process was in place to guide staff in completing assessments.
● One person's consent to care record was signed by their relative as the provider told us the person did not have the capacity to do so. No capacity assessment had been completed and the provider had not checked if the relative had the legal authority to sign on their loved one's behalf.

The failure to ensure the principles of the Mental Capacity Act 2005 were followed and that people's legal rights were protected was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People told us they were supported to access healthcare support when required. One person told us, "I have been a bit sore when I am sitting. They have called the nurse to come and see me and they also chase up appointments for me."

● Electronic care records showed that where people had experienced health concerns, the provider had sought advice from healthcare professionals including GPs, district nursing team, continence service and occupational therapy. However, records were only available regarding this since February 2019. Prior to this the provider was using a different electronic system which they were no longer able to access.

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

● People told us that staff supported them in preparing meals of their choice where required. One person told us, "They get me breakfast, they then make me lunch in the afternoon and top up my water. Then at dinner, they make me some food, drinks and help me get into my pyjamas."

● Care plans contained information regarding the food and drinks people liked. Prompts were also included to remind staff to ensure people had a drink with them at the end of each care call.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question had deteriorated to Requires Improvement.

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

- People and their relatives told us individual staff members treated people with kindness. However, as detailed within other areas of the report, we found that people's care was not always provided in accordance with their needs. Until these issues are fully addressed we will be unable to apply a 'Good' rating to the domain of Caring.
- People told us that staff were caring when they completed their calls. One person told us, "The carers are really good and (staff member) is amazing." Another person said, "They provide a very good service. They have a nice chat to me about my family and their family, it gives me someone to talk to and keeps the mind going,"
- We observed positive and caring interactions between people and staff when visiting their homes. People and staff had a good rapport and staff understood people's preferences. Staff talked to people about their families by name.
- Staff spoke about the people they supported in a respectful way. One staff member said, "(Name) is such a lovely lady, it's a pleasure to support her."

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 they felt individual staff listened to them treated their homes with respect. One person told us, "They always listen to me and respect that it's my house they've come in to." We visited one person's home which was cleaned by staff to a high standard. The staff member supporting the person told us the person had always taken great pride in their home and they understood it was important to maintain this for them.
- People told us that staff supported them to remain as independent as possible. One person said, "I can't do much on my own anymore, but they let me do the bits I can do myself. I don't want to feel as though they need to do everything for me." Another person told us, "I can't do a lot now, but they know me now, know what I can do." Care plans reflected that people should be supported to maintain their independence and that staff should always encourage people to take an active part in their care.
- People told us that staff respected their dignity and privacy. One person told us, "They'll shut the doors and that. They don't make me feel uncomfortable, when they're here they do a good job."
- The provider told us that no one currently being supported by the service had any specific cultural or religious needs. They told us that, should this be the case, they would ensure staff were aware and support people in line with their beliefs.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question had deteriorated to Requires Improvement. This meant people's needs were not always met.

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

● People's support was not always provided in line with their needs and preferences. People told us they were asked what time they would like to receive their support and the provider had agreed these times with them. However, we received feedback these times were often not honoured, and people were not informed what time their calls were scheduled. Comments included, "I worry because I don't know what's happening. They don't seem to listen or take my concerns seriously so that's annoying." And, "They know the worry this causes but they don't take any notice. They know the situation and how many problems it causes."

● Care plans varied regarding the amount of information they contained. The local authority quality assurance team had visited the provider in July 2018 and reported, 'Care plans seen lacked personalisation and were written in a very task-orientated way.' The provider acknowledged the quality assurance team had continued to raise this as a concern during subsequent visits. The provider told us they had started to change to another care planning format which they felt provided staff with more details regarding people's needs and life history. Despite being alerted to these shortfalls 10 months ago, only two care plans had been updated to the new format.

● People's care plans were not routinely updated when their needs changed. One person's care needs had changed significantly, and their care package had substantially increased. Despite these changes, their care plan had not been fully updated to ensure staff were aware of how to support the person at all times. The care plan gave guidance to staff on the support the person required at set visit times which was no longer accurate. The staff member supporting the person was able to give a detailed description of the support the person required but this information was not comprehensively documented.

● Care plans regarding the care people wanted at the end of their life had not been completed and there was no evidence these discussions had taken place with people or, where appropriate, their relatives. The provider told us they were aware of this requirement and intended to start discussing this with people. We asked if any format had been developed or training completed in this area. They told us this had not been completed to date.

The failure to ensure people's care was provided in line with their needs and that care plans were comprehensively completed was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although care plans lacked detail regarding people's support needs, people told us that staff had a good understanding of how to provide their care and of the things which were important to them. One person told us, "(Staff member) knows me really well, she knows all about my family and my dog. Would you believe she didn't like dogs before she met my dog and now she loves her?" One relative told us, "There's a lot to know

about his care and equipment and (staff member) understands how to do it."
● We spoke with one staff member who was able to describe the care they provided to the person they were supporting in detail. This included a routine they followed at night which made the person feel safe and in control.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans contained a section regarding people's communication needs although this contained very basic information such as, '[communicates] verbally'. Information was also included in some areas of care records regarding sensory impairments which may affect communication, such as hearing loss. However, consideration was not given to people who may experience difficulty in communicating due to health conditions, such as those living with dementia.

We recommend that communication plans are reviewed to ensure detailed guidance is available for staff to follow in line with the Accessible Information Standard.

Improving care quality in response to complaints or concerns
● People and relatives told us they did not feel their concerns were taken seriously and did not lead to improvements in the service they received. Comments included, "When I have a problem or complaint (provider) just smiles and doesn't seem to take my complaint seriously." And, "You can make constant complaints and requests. It doesn't make any difference, nothing changes." The concerns raised with us centred around late and missed calls, not knowing which staff member would be coming and what time they are due to arrive.
● The provider told us that they had not received any complaints. This meant they had not recognised or responded to people's concerns and ensured the information was used to improve the service they received.
● The provider had listed what they described as informal complaints which had been raised with them during quality assurance checks. These were centred around the conduct or skills of staff such as a staff member not staying the full time and a person commenting on the level of English language skills of one staff member. Issues had been resolved by replacing the care workers with other staff members. The provider told us these concerns were discussed with individual staff members as they arose. However, there was no record of these discussions maintained in order to monitor and support the staff member and minimise the risk of concerns happening again.

The failure to respond to complaints raised regarding people's care was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection we found the provider had failed to demonstrate good governance in the overall management of the service. This was a breach of regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- People and their relatives expressed concerns regarding the leadership of the service. One person told us, "The management isn't very good." One relative said, "The staff are adequate, but the management and organisation are dreadful. You can't get a response about anything. It's so frustrating and it's getting worse."
- The provider did not have effective communication systems in place and did not operate in a transparent manner. A number of staff members had contacted the local authority safeguarding team and CQC as they believed they had a responsibility to raise concerns regarding the sustainability of the service. The CQC received information that a number of staff members had been dismissed shortly after raising a safeguarding concern with the local authority. We asked the provider their reasoning behind this. They told us the dismissal was for other reasons and said they had not followed any disciplinary process as the staff members were self-employed. The provider later told us the staff members had not been dismissed but had left of their own accord. They were unable to provide evidence to confirm this was the case.
- Opportunities to learn from mistakes and concerns had been missed. People and relatives had raised concerns regarding late calls and not having access to a rota on a number of occasions. However, the provider had failed to ensure these concerns led to improvements to ensure people's needs were being met.

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

- There was no registered manager in post. The last registered manager left their post in October 2017. Since this time two applications to register a manager had been submitted but both were withdrawn by the provider prior to the assessment process being completed. One of these applications was from the provider who had taken responsibility for the day-to-day running the service.
- The provider acknowledged the lack of a registered manager was having an impact on the service. They told us, "Not having a registered manager here is definitely a problem. I am following on from what the

previous managers have been doing and that may be wrong." They told us they had advertised the role with two recruitment agencies.

● The provider had failed to securely store and maintain accurate, complete and detailed records. The provider told us they had previously used a different IT package but had changed in February 2019. They told us they were now unable to access electronic records for people prior to this time. They said they were unaware where this information was now stored as they no longer had login details for this account. The provider also told us emails to social care professionals relating to people's care and to staff recruitment were only available via an email account which they no longer had access to.

● Audits were not effective in identifying the shortfalls of the service. Audits had not been completed to monitor the accuracy and effectiveness of care plans, the implementation of the MCA or risk management processes.

● Staff members had been asked to spend time in the office reviewing MAR charts and visit records. However, where shortfalls had been identified, these had not always been acted upon such as records not being completed or missed calls not being fully investigated.

● We asked the provider to forward an overview of their quality assurance processes following our inspection. Despite a number of prompts, they failed to do so.

● As reflected throughout the report, the provider was asked to forward information to the CQC which was not available to us during the inspection. Despite repeated requests, the provider had failed to share some of the information requested and had not responded within timescales set.

Continuous learning and improving care; Working in partnership with others

● The local authority quality assurance team had made regular visits to the service since May 2018 when they received concerns regarding the standard of care people were receiving. The provider told us they had found their support useful. However, despite the quality assurance team providing guidance regarding areas of improvement, this advice had not been effectively implemented by the provider. Prior to our inspection the local authority informed us they would not be referring people to the service until improvements had been noted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Quality monitoring checks were not completed in line with the provider's processes. The provider told us they aimed to contact people or their relatives every six weeks to discuss their care, any changes to their needs and any concerns. However, records showed that checks were not always completed this frequently. One person's records showed they had been contacted on three occasions over the past year.

● The provider told us that staff meetings were held at least monthly although no minutes were available prior to February 2019 to confirm this was the case.

The failure to ensure robust management oversight of the service was a continued breach of regulation 17

● Where minutes of staff meetings were available, they showed each person supported by the service was discussed including any changes to their needs or concerns regarding their care. The provider also used this opportunity to share organisational messages with the staff team.

● Surveys had been distributed to people, relatives and staff in August 2018 to gather their views of the service. This was a tick box form which did not contain comments. Feedback was provided by four people and two staff members, all of whom responded positively.

● The provider had ensured notifications of significant events had been forwarded to CQC in line with their regulatory responsibilities.

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 comprehensively assess people's needs prior to them starting to use the service and to use recognised tools to continually assess people's care needs The provider had failed to ensure people's care was provided in line with their needs and that care plans were comprehensively completed

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure the principles of the Mental Capacity Act 2005 were followed and that people's legal rights were protected

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people safety were assessed and mitigated, accidents and incidents were monitored and that effective contingency plans were in place

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	The provider failed to respond to complaints raised regarding people's care

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure robust management oversight of the service

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

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

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were safely deployed and people received their care in line with their care needs The provider failed to ensure that staff received suitable training, induction and supervision to support them in their roles

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration