Agincare UK Limited

# Agincare Oxford

## Inspection report

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Website: www.agincare.com

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

Agincare is a domiciliary care service providing the regulated activity of personal care. The service provides support to people living in their own homes. At the time of our inspection there were 53 people using the service.

The service also supports people who are discharged from hospital and require support with rehabilitation for an initial proposed period of six weeks. People receiving this rehabilitation care are referred to by the service as 'reablement care clients'. At the time of inspection 15 people out of 53 were receiving a reablement care package.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not operate effective quality assurance systems to oversee the service. These systems did not identify shortfalls in the quality and safety of the service or ensure that expected standards were met.

The provider did not ensure consistent actions were taken to reduce risks to people and plans were not in place to minimise those risks. The management of medicines was not always safe. Staff did not always follow correct infection prevention and control processes when carrying out personal care. Records indicated that not all staff had completed mandatory training. Following the inspection, we were informed by the managing director that staff receive a minimum of one supervision and team meeting a year as per their policy. We did not feel that staff received regular supervisions and team meetings.

When incidents or accidents occurred, it was not always clear these were investigated, and if any lessons were learnt. The provider did not follow and accurately record and keep a copy of incidents and the actions taken as required in the duty of candour regulation when a notifiable safety incident occurred.

The registered manager did not ensure clear and consistent records were kept for people who used the service and the service management and did not always inform us about notifiable incidents. Staffing levels did not always support people to stay safe and well.

People, their families and other people that mattered gave mixed feedback about being involved in the planning of their care. Care plans did not always contain information specific to people's needs or contain information on how to support people to manage any conditions they had. Staff were not provided with detailed guidance to follow when supporting people with complex needs.

The provider did not ensure their safeguarding systems were operated effectively to investigate and follow the provider's procedure after becoming aware of an allegation of abuse. Records indicated that not all staff

were trained in this.

People and relatives gave good feedback about staff being kind, caring and respectful. The majority of staff members felt staffing levels were sufficient to do their job safely and effectively, we heard from people using the service that often staff were late and felt turnover was high.

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; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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

Rating at last inspection
This service was registered with us on 10 March 2022 and this is the first inspection.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified six breaches in relation to quality assurance; risk management, safeguarding, record keeping, responding and acting upon complaints, effective and person-centred care planning, management of medicine and staff training and competence 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
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?

**Inadequate**

The service was not safe.

Details are in our safe findings below

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# Agincare Oxford

**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 one inspector and an Expert by Experience. An Expert by Experience made phone calls to people who use the service and/or relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post, they have since left the organisation.

Notice of inspection
This inspection was announced.

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 available in the office to support the inspection.

Inspection activity started on 24 August 2022 and ended on 05 September 2022. We visited the location's office on 24 August 2022.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the local authority. 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 looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern. We used all of this information to plan our inspection.

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During the inspection
We spoke with five people who used the service and five relatives of those using the service. We spoke with five staff including the registered manager, and we contacted the funding local authority for feedback about the service.

We reviewed a range of records. This included six people's care records. We reviewed care records remotely through the provider's secure portal. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and policies and procedures, were reviewed.

Following our visits to the office, we continued to seek clarification from the provider to validate evidence found. We looked at training data, electronic monitoring data and quality assurance records off site.

Inadequate

# Is the service safe?

## Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

● Records held did not include all safeguarding concerns identified or investigated. CQC were made aware of four additional safeguarding concerns raised by external professionals. These were not included within the service records and the service had not acted upon these. A further three safeguarding concerns were identified during inspection which had not been raised by the service. This meant the registered manager did not have a full accessible record of safeguarding concerns and therefore would have been unable to fully consider any themes, trends or learning for the service.

● The registered manager had failed to identify and report safeguarding concerns to the local authority. For example, one person using the service had disclosed concerns in August 2022 regarding how a staff member had allegedly assaulted them. The service did not offer additional assistance, investigate this or report this to the local authority. Not acting on this incident led to a further occurrence of harm with another person using the service. We saw that this had not been investigated or reported to the local authority as there were no records or confirmation available. We contacted the local authority who confirmed they had not received this information. This incident is being reviewed under our specific incident guidance.

● Records indicated that not all staff had received training in relation to safeguarding adults from abuse during induction. Staff we spoke to understood signs of abuse and their responsibility to raise safeguarding concerns to the management of the service, however had limited knowledge about how they would report concerns to the authorities.

The service had failed to implement effective systems to identify, investigate and appropriately respond to allegations of abuse. 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.

●The service had a detailed safeguarding policy in place, which clearly outlined types and signs of abuse. The policy was accessible to staff electronically. The service operated in Oxfordshire, yet the policy included references to Leeds City Council local safeguarding guidance.

●Most people told us they felt safe. Peoples comments included, "I feel very safe, they are all very good, I can't fault them" and "I feel safe, all very nice." One relative when asked if they felt their family member felt safe with staff commented, "I think so, they are a mixed bag, some rush him a bit. Others put a lot of input in."

Assessing risk, safety monitoring and management

●Risk assessments were either not present, had not been updated in a timely manner, or lacked sufficient detail to help staff understand and respond to risks. We reviewed three reablement client's documentation and noted an absence of risk assessments. This included areas such as moving and handling, risks of skin

breakdown and surgery complications. Records lacked sufficient detail to help staff understand risks in relation to medical needs, such as stoma care, diabetes and skin integrity.

● Care records were not always complete. This meant there was not always evidence to demonstrate how risks to people's health and safety was being effectively assessed, monitored and mitigated. For example, one person's referral stated they had an ulcer on the heel of their foot and required support with application of cream and monitoring. This risk was not detailed within their care plan, there was no instruction or indication that staff needed to support this person with their medicines, and the creams were not listed on their medicines chart. Upon reviewing the daily notes, we could see staff had not been monitoring or applying cream to the persons heel.

●We saw four people were at risk of developing or worsening pressure damage to their skin. Appropriate care plans, body maps and risk assessments were not in place. Care plans lacked important detail such as, current pressure sores or skin integrity concerns, the location of the wound, guidance, position changes and applications of creams. There was limited evidence that staff were supporting people with position changes, monitoring of pressure sores or applications of creams.

●Care plans did not reflect what staff told us. For example, staff informed us that a person had an identified risk around developing pressure sores and had sustained pressure damage to their sacrum. Staff told us they were currently applying cream but not all staff were doing so. Due to ineffective efforts by a staff member to ensure application of cream was carried out by the staff team, they asked the service user to inform visiting staff to monitor and apply cream to the area. The person's care plan did not reflect what action to take if changes of skin integrity occurred, and there was no information available about the concerns documented.

●Where staff were required to support people with stoma wound care, there was no guidance available on how to best support them. We saw one person's front-page mention they had a knee stoma and staff were to support them to drain this. This was not specified within their care plan and there was no risk assessment available. Guidance for staff on how to prevent complications associated with stoma care, or who to contact if there were any concerns was not made available and staff had not received training in stoma care management.

● We saw staff were supporting someone with their nutrition, this person had type 2 diabetes. Information about the risk associated with their diabetes was not available to staff and their diabetes was not mentioned within their nutritional risks or risk assessment tool. There was no diabetic risk assessment in place or guidance for staff on how to best support this person.

●Some people using the service were prescribed emollient creams. Emollient creams can be easily transferred from skin on to clothing and bedding, and testing has shown increased fire risks when fabrics are contaminated. Therefore, a risk assessment should be in place. There were no risk assessments for this in place.

The failure to ensure people received a safe service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe Care and Treatment.

●Although risk assessments lacked detail, staff were able to explain how they monitored and responded to identified risks. Staff provided feedback regarding maintaining people's skin integrity, safe moving and handling, monitoring people at risk of falls, and assisting people who were reluctant to accept support with personal care, nutrition and hydration. Staff understood the importance of monitoring and reporting any concerns for people's welfare to the office. Some staff told us they felt they had to report to the management team several times in order for further support to be implemented or care plans updated.

Using medicines safely

● Some people using the service were supported to apply prescribed creams. Some medicine

administration records (MARs) did not include information of where to apply prescribed creams, meaning MARs did not contain an accurate record of their administration. For example, one person had three creams prescribed, the MAR chart and care plan did not include adequate information. The care plan stated "uses Medicare on sacrum" but did not specify the use of the other creams including where they should be applied, the recommended thickness and frequency of application.

● We reviewed a care plan in which staff were supporting with the administering of medicines. We found conflicting information about the support required with individual medicines. For example, the persons front page stated 'to administer all medicines' within the same information it stated 'do not administer' one specific medicine. There was no risk assessment in place for this medicine, there was no detail within their medicine cabinet or tracker and no MAR chart available.

● Medicine audits were carried out; however, they did not provide a picture of the whole service. For example, medicine audits did not include reablement clients as there was no MAR charts available for these clients on the electronic system. We also saw in one audit that all medicine information was ticked as being available, however we saw that for one of these people, not all medicine information was available.

●Outcomes from medicine audits in August 2022 identified staff were not signing for medicines correctly. The service development plan identified this has been an issue since April 2022. Actions to improve this included spot checks; however, these were not documented, we could not see how improvements were being made and where the correct action had been taken.

●The service did not always follow their medication management policy and procedure and it was not always specific to the service. We saw stoma care was listed as something staff could do if relevant training has been provided. Stoma care was being carried out by staff despite staff having not been trained. Information about application of creams mentioned staff could apply this with appropriate assessments in place, and 'staff will not assist people to take medication, prescribed or non-prescribed, unless it is part of a comprehensive care plan'. We did not see appropriate assessments or accurate information around medicines in the form of a comprehensive care plan in place.

The service had not ensured the proper and safe management of medicines, including record keeping of the administration of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

●We spoke to people using the service about the use of personal protective equipment (PPE). The majority of people we spoke to confirmed staff wore PPE however we heard from one person that newer staff didn't always wear gloves when applying creams.

● At the time of our inspection staff were required to carry out two asymptomatic tests weekly as per government guidance. Records did not evidence staff uptake of COVID-19 tests. Staff we spoke to told us they had not been informed that this was the current guidance and had not been asked to carry out asymptomatic testing.

●We were not assured that staff had been made aware of changing government guidance. We did not receive any evidence to support how changes in relation to COVID-19 testing were communicated to staff.

The provider did not have processes and systems in place to ensure that all staff met their responsibilities in relation to preventing and controlling infection. This 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

● Staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff. Disclosure and

Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● We asked people about their experience with staffing. We heard, "They have a high turnover of staff; they don't last long with them", "lots of lateness. I like to have my breakfast at 9am, sometimes they don't come until 11.30am" and "The times seem to depend on when they book the calls for. What happens is mum then gets her own breakfast, it hurts her due to an injury."

● At the time of inspection, we were informed that office staff were covering calls due to being short staffed. We also heard from professionals working with the service that one person had recently been asked if their calls could be cancelled and if their family could support due to low staffing numbers.

●We spoke to staff about the current staffing. One member of staff said they were currently working 7am until 11pm and their schedule changes often meaning they have limited time to get from one call to the next and thus overrun on their call times.

The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● We reviewed the accidents and incidents record log. Records identified the degree of harm; however, the records did not include further investigation, analysis, action or outcome to consider how incidents occurred and steps taken to try to prevent a reoccurrence.

● We saw evidence that not all accidents and incidents were being recorded and there was no overall analysis identifying any patterns or trends which could be addressed, and subsequently reduce any apparent risks.

● The registered manager was unable to demonstrate adequate systems were in place to ensure sufficient action was taken to identify and respond to 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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

●We observed care assessments had been carried out with varying levels of detail, meaning some assessments did not present a holistic view of people's physical, mental health and social needs. We also observed where risks had been identified, in some cases the service had not documented relevant risk assessments as part of the care assessment process. For example, we saw one person had recently had a fall, this was not included within their falls risk assessment which was completed following this fall.

● We saw people's preference for a female or male carer was not requested as part of the assessment process.

●Staff we spoke to expressed that often there is not enough detail within peoples care plans, for example one member of staff told us "There isn't a lot of focus on what you're supposed to be doing. No steps for you to focus on visit by visit. Some people have four visits a day and there no guidance, sometimes you have to guess in a way."

The lack of complete information within care records put people at risk of receiving care and support which was not always safe. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People indicated they had been involved in the assessment of their care needs and made some decisions about their support. Some people and families indicated they did not know the contents of their care plan. People's comments included, "I don't think I have a care plan" and "I have never gone through the care plan."

Staff support: induction, training, skills and experience

● Following the inspection, the managing director informed us that supervisions are to be carried out yearly as per the company's supervision policy. This did not reflect the registered managements understanding or comply with the requirements of the local authority regarding supervisions. Staff members were not supported to reflect on their working practices through regular supervisions. Staff were not always given opportunities to discuss their progress or discuss issues.

●During the inspection we reviewed the training record for staff. The existing information indicated that not all staff had received adequate training. For example, staff had not received training in; fluid and nutrition, MCA, dementia, food hygiene, safeguarding and infection prevention. We saw staff had not received training in diabetes awareness or stoma care in which they were providing care to people with these conditions.

Effective systems were not operated to ensure staff were suitably competent and had the support required for their roles, including access to supervision in line with the provider's policy. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●New staff received an induction and a period of shadowing more experienced staff before working alone. The provider undertook observations to ensure, skills, knowledge and competency with medicines and manual handling.
●Staff we spoke to said they felt they received enough training for the role, records viewed did not always evidence this. One member of staff said they did not always have time to access further training due to time constraints of the role.

Supporting people to eat and drink enough to maintain a balanced diet
● People and relatives told us staff provided the necessary support to ensure people ate and drank in line with their preferences. One person told us "At lunch time they make us a sandwich and coffee as we like them" and "No concerns, I tell them what I want, and they do it for me."
● Where people needed support with any dietary needs, like diabetes, this was not always recorded in their care records or within their daily notes. This meant we were not sure if dietary people's needs were always being met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●We saw some evidence of interagency working between the service and other agencies such as the home first team (a collaborative team of professionals involving local health and social care providers, who support people to return to their home following a period of illness or injury). We were informed that weekly meetings were held in order to discuss people's physical progress with healthcare professionals as part of the reablement packages, however, these meetings were not documented, and peoples care plans did not reflect their progress.
● It was not always clear if the registered manager understood their responsibilities when working with other agencies. We saw concerns and safeguarding's were left for other agencies to raise.
● The registered managed provided examples of when the service has had to contact the GP regarding medicines or wellbeing concerns, and we heard staff also supported where necessary with physiotherapy exercises.

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 , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We reviewed a care plan of a person in which their relatives had recently raised concerns around their memory and capacity in July 2022. We could not see any action from this. We saw this person's care plan and welfare assessment was due to be updated in July 2022, but this had not taken place.

● Staff understood their roles and responsibility in line with legislation. Although there wasn't anyone at the time of inspection that staff could identify as having limited capacity, one staff member said, "It's important to know stuff about people, their likes and dislikes, always giving people the option, doing what's in their best interest."

● Records of people's notes showed people's consent to care and treatment was continuously sought prior to care being delivered.

Requires Improvement

# Is the service caring?

## Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity
● People told us they felt cared for. One person using the service told us, "My team are great; we chat about everything."
●A relative of someone using the service said, "They are spot on. They are nice with her; they have a lovely relationship."
● Staff gave examples of thoughtful and flexible approaches to supporting people and understood people's abilities could fluctuate daily.
● Despite staffs understanding of people's needs, the provider was not always caring due to limited support for staff, staffing numbers and overall management of the service.

Supporting people to express their views and be involved in making decisions about their care
●People's views were not always clearly recorded. Care plans did not always correctly document people's preferred communication methods to enable staff to support people to make decisions about their care.
● Despite our findings relatives told us, "They ask me about my wife as I can sometimes understand what she wants, she gets very frustrated and anxious, so they go through me" and "They know how to encourage my husband, even when he is having an off day."
●Staff understood the importance of supporting people to make decisions about their care and gave examples of how they talk to people and offer people choice to support people to make decisions about their care. A member of staff told us, " It's important to take your time, people still have ability, I will take out two different items for dinner and sit down with the person to see what they fancy, you should always make sure people have choice."

Respecting and promoting people's privacy, dignity and independence
●We received mixed reviews about people's privacy and dignity being respected. We identified four people using the service who did not like having male carers and had requested to have female only support. This had not been implemented. However, some people using the service also told us, "Oh yes, they are really good, the fellows are superb they turn their back to give me privacy but are on hand in case I need it. I don't mind having male carers."
● We heard from relatives of those using the service "They are brilliant with her. Her favourite one is the male carer; he is very professional in maintaining her dignity".
● People's independence was promoted. Staff supported people to maintain their skills and abilities to live as independently as possible. One person said, " Long term clients need a little more assistance, but we still support people and promote their independence" and "A lot of the time [client] is independent and likes to

do things for herself, so we offer support around other things".

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

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

● Staff knew people and their interests well, however this knowledge was not always captured within care records. This put people at risk of receiving care which was not always personalised to their needs. For example, staff were able to provide us with detailed information about the way in which someone liked to have their drinks laid out, and how people communicated. There was no information about this within their care records which meant staff did not always have access to this important personalised information when delivering care.

● Care plans were not reviewed regularly to ensure they remained relevant to people's needs, there was no oversight of when these reviews were needed or if they had taken place.

●Staff told us they were made aware of people's changing care needs via WhatsApp communication. It was not clear if peoples care plans were updated to reflect these needs, this posed a risk that important information may not be being recorded or acted upon.

●We received variable feedback regarding whether people were given choice about timings of visits and who supported them. We also saw where female members had specifically been requested, people were told the service was unable to accommodate this with no explanations or attempts to move calls around to accommodate this.

●When preferences of carers was requested, we saw this this was not respected. We heard from one relative, "She will not have a shower if a male carer comes, about every other day we have male carers. I have asked for female carers". A person using the service when asked if there was anything else, they would like to add told us, "Timings of calls and having female carers."

Processes for assessing and reviewing people's needs were not fully effective in ensuring care met people's needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs

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

●Care plans included information about people's ability to communicate verbally, and any conditions affecting the person's hearing or eyesight. Where people had an identified communication need, some

records contained limited guidance for staff. For example, the care assessment for one person who was unable to verbalise stated that they had no sensory deficit which would limit their ability to feel or voice pain or discomfort. Their care plan stated, 'able to use nonverbal communication' and 'Team members to ensure [client] offers nonverbal consent for all tasks'. The care plan offered no further guidance on how to promote effective communication with the person, or what nonverbal consent looks like for this person.

● Staff we spoke to described how they took steps to communicate with this person, such as using visual ques and discussing their needs with their relatives. The individual had capacity, it was unclear if the involvement of family support had been agreed upon as this was not documented within their care plan and their care plan had not been signed.

Improving care quality in response to complaints or concerns

●Feedback from relatives and information from staff identified concerns and complaints which had not always been logged using the service's system for recording complaints. This meant systems had not been effectively operated to identify, record and respond to complaints as records were incomplete or were not accessible at the time of our inspection.

● The service's compliments and complaints management policy, revised June 2021, stated 'All complaints are responded to in writing by the organisation within 28 days of receipt (even if not yet resolved). Records are maintained of all input and output information for review and further improvement'. There was no evidence complaints were reviewed, investigated, responded to or actioned. The inconsistent recording of complaints meant it would have been challenging to reliably review and analyse information.

● A small number of staff felt their concerns and complaints had not been appropriately addressed. One member of staff advised, "I would tell management a service user had made a complaint about a member of staff and they would say 'Oh another complaint'. It was just dismissed, they would say they needed it in writing or it required more staff to complain."

● We heard from relatives and people using the service complaints about staff, and lateness had been raised with the registered manager. During the inspection we found evidence of some of these complaints, however there was no outcome, or action recorded.

Systems were not operated effectively for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had also received a number of compliments about staff which was discussed in team meetings and detailed care workers had been informed.

● The service had a complaints policy in place, and people received information about how to raise a concern, compliment or complaint, as part of the care service guide.

End of life care and support

● At the time of the inspection nobody was receiving end of life support.

●The registered manager told us they had supported people in the past with end of life care. Examples were given of support put in place and training was available to staff. We saw four staff had completed this training.

Inadequate

# Is the service well-led?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People did not receive a service that was well-led. The registered manager did not have an adequate understanding of their role, regulatory requirements and lacked oversight of the service.
- Audit schedules were allocated to staff however they did not contain information of when and if said audits had been completed. During and after the inspection we requested the registered manager submit all audits they had undertaken, however this information was not provided to us. This meant we could not be assured systems were in place to monitor the effectiveness of the service.
- The provider's systems and processes in place to assess, monitor and mitigate risks and to improve the quality and safety of the service were not always effective. We saw monthly quality assurance 'Snapshots' had been completed by the provider. This looked at the service's audits and provided feedback on how to improve. We saw there were consistent comments such as 'auditor has not completed audit, name, date and if any actions', 'no allocation or target dates' and 'Complaints missing from tracker, tracker does not match the audit'. Actions to address these concerns were not clearly documented and we found the same failings during the course of our inspection.
- We reviewed audits relating to incidents. In July 2022 the audit identified five falls, the consideration was; 'as reablement clients, we have no set visit times', and the conclusion was; 'reablement clients having unwitnessed falls which have all had no injuries'. No mitigations appeared to have been made for these individuals, there was no information available regarding these incidents or the action taken to further safeguard these people.
- The registered manager and provider were unaware of the issues identified during the inspection, regarding shortfalls around medicine management, lack of risk assessments, ineffective care plans, poor documentation and inadequate reablement care plans.
- The registered manager did not act upon serious incidents, and did not understand the gravity of our concerns and failed to demonstrate continuous learning and improvement.

The failure to ensure the service was well-led is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Requirements Relating to Registered Managers and Good Governance.

- Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. During our inspection we identified several safeguarding concerns which had not been raised by the service and notifications had not been submitted to CQC in accordance with requirements.

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

●The service did not always promote a positive and inclusive culture which involved people. The majority of care related paperwork was unsigned and undated, the provider was unable to evidence how they included people.

●Staff had mixed views about the management of the service. We heard from several staff that they had not yet met the registered manager, "I think she is a good manager; haven't met her so can only go off what I've heard, never spoken to her" and "There have been an issue like staffing, way too many clients for the staff - they shouldn't have taken this many clients on considering how many staff there is. I get told we are understaffed."

●We also heard from people and their relatives, "My doubts are about the turnover staff. On the whole they are pretty good" and "It is well managed as it can be. You get used to the carers then they leave. The phone always gets answered in the office if you call."

● The registered manager had failed to demonstrate records were maintained to provide staff with robust guidance to ensure positive outcomes.

The failure to ensure the service was well-led is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Requirements Relating to Registered Managers and Good Governance.

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 were supported by a registered manager that did not have adequate understanding of the duty of candour. The registered manager was unable to identify the appropriate steps to follow when things went wrong.

● Staff told us there was good communication with management. However, it was not clear what systems were being used to enable staff to learn from incidents, improve practice and drive improvement in the service through shared learning.

The registered person did not follow and accurately record and keep a copy of all the actions taken as required in the regulation when a notifiable safety incident occurred. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager was unable to evidence how they sought the views of people and relatives or acted on any feedback. People using the service gave mixed feedback about being asked for their views such as, "Yes, they have several times, but there have been no changes" and "Not really, not had any spot checks or surveys." We saw records around 'quality phone calls' however they did not contain a date, the names of people consulted, and the discussion held, thus it is unclear if action was taken and how feedback was used to drive improvement.

● We saw evidence that some staff meetings had taken place, however, the recording of these meetings often lacked detail and it was not always clear what was discussed or who had attended.

●Staff we spoke to provided examples of when their views had been asked for but had not been implemented.

The failure to ensure the service was well-led is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Requirements Relating to Registered Managers and Good Governance

● The provider worked in partnership with others. At the time of the inspection, this was primarily with the local GPs and health professionals from the hospitals who supported people with health conditions requiring specialist reablement care.
● The registered manager and staff gave examples how they had communicated with people and relatives to ensure access to other health care professionals.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Processes for assessing and reviewing people's needs were not fully effective in ensuring care met people's needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The service had failed to implement effective systems to identify, investigate and appropriately respond to allegations of abuse. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Systems were not operated effectively for identifying, receiving, recording, handling and responding to complaints |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was no system in place to identify any trends for accidents and incidents, therefore no lessons were learnt.<br>People's care records were not up to date and did not reflect current care.<br><br>Systems and processes to monitor and improve |

the quality and safety of the service were ineffective.

The provider and registered manager did not understand their duty of candour.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>The registered person had failed to record and keep a copy of actions taken, as required of this regulation, when a notifiable safety incident occurred. |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered manager did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs.<br><br>Effective systems were not operated to ensure staff were suitably competent and had the support required for their roles. |

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered person did not ensure safe care and treatment. The registered person had not assessed the risk to health and safety of service users or done all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe Care and Treatment |

**The enforcement action we took:**

We served a warning notice.