Brisen Company Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Brisen Company Limited is a domiciliary care agency. It provides personal care to people living in their own homes as well as a reablement service. This service provides short term care, normally up to six weeks, and therefore the numbers of people receiving support vary on a weekly basis. At the time of the inspection there were 30 people using the service.

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

People's experience of using this service

We found the provider had failed to ensure appropriate assessments of risks to people were completed. Risk management plans were not always in place to manage these risks, which included distressed behaviour, medicines, nutrition, moving and handling, falls, skin integrity, and where people had health conditions such as a stroke, Parkinson's Disease, or diabetes. People's medicines were not always safely managed. There was not a robust safeguarding process in place to keep people safe.

Staff were not effectively deployed to meet people's needs in a timely manner. Appropriate recruitment checks were not carried out before staff joined the service. There was a system in place to log and investigate accidents and incidents, but these were not analysed, and any learning was not disseminated to staff. People's independence was not always promoted. People's end of life care wishes, were not always recorded in their care files. Staff had not received adequate training. Staff were not always supported through regular supervision. The provider did not have a robust complaints system in place to manage people's complaints effectively.

People or their relatives were not always involved in planning their care and support and their support plans were not reviewed regularly. People's consent to care and support was not always been documented. Regular feedback had not been sought from people. Where feedback had been sought, the provider did not always act to rectify any shortfalls which had been identified. Governance systems were not effective at identifying and reducing risks to people's safety. There was a lack of oversight and effective leadership of the service.

People were protected from the risk of infection.

Rating:
The last rating of the service was Inadequate (published on 06 October 2022) when we carried out a comprehensive inspection.

At our last inspection we found breaches of the regulations in relation to regulations 9(person-centred care),

10 (dignity and respect), 12 (safe care and treatment), 13 (safeguarding service users from abuse and improper treatment), 16 (receiving and acting on complaints), 17 (good governance), 18 (staffing) and 19 (recruitment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had told the provider what action they needed to take to ensure the safety of people who used the service. However, at this inspection, we found the provider remained in breach of regulations. This service has been in Special Measures since October 2022. During this inspection the provider demonstrated that improvements had not been made. The service remains inadequate and continues to be in special measures.

Why we inspected:
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We also identified breaches in relation to lack of risks assessments, risk management plans, detailed support plans, medicines management, staffing, recruitment practice, complaints. There were no robust systems in place to assess and monitor the quality of the service provided. There was a lack of effective oversight and leadership of the service.

Enforcement:
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.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review. 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below

Inadequate

Is the service effective?

The service was not 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

Brisen Company 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

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.

Notice of inspection
We gave the service 48 hours' notice of the inspection as we needed to be sure that the registered manager would be in the office to support the inspection. This inspection site visit took place on 13 April 2023 and was announced.

What we did before the inspection
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. We reviewed information

we had received about the service since the last inspection, we sought from the local authority who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people and 10 relatives to seek their views about the service. We spoke with three members of care staff, the lead care coordinator, the care manager, and the registered manager. We reviewed records, including the care records of six people using the service and recruitment files and training records of five staff members. We also looked at records related to the management of the service such as quality audits, accident and incident, and policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remains inadequate. This meant people were not safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection in August 2022, we found the provider had failed to ensure that risks were not always assessed and safely managed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• People were not always safe and protected from known risks of harm. Risks had either not been assessed or risk management plans did not adequate describe how safety should be maintained in relation to people living with Parkinson's Disease, diabetes, choking, medicines, nutrition, falls, moving and handling, catheter care and pressure sores.
• Risk management plans were either not in place and/or not always detailed to ensure that there was up to date guidance for staff on what to do should if people become ill.
• Some people used mobility aids, such as standing frames, wheelchairs and/or hoists. However, their moving and handling, and falls risk assessments did not always identify the potential risks of using these mobility aids. There was not always guidance in place for staff on how to safely mobilise the person and how to minimise potential risks.
• Risks to some people in relation to their behaviour were not always assessed and they did not always have, risk management plans in place to manage these risks.

We found no evidence that people had been harmed however, we found the provider had failed to ensure systems or processes were in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider sent us some updated risk assessments and risk management plans. We will check that these have been implemented for all people at our next inspection.

Using medicines safely
At our last inspection in August 2022, we found systems and processes were not put in place or robust enough to demonstrate that medicines were safety and effectively managed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• Medicines were not always safely managed. People did not always receive their medicines as prescribed, which meant they were at risk of harm.

• We reviewed Medicine Administration Records (MAR) for three people for October 2022, February 2023 and March 2023 and found a number of gaps on each of the MAR charts where staff had failed to sign. The MARs had no explanation for the gaps. Records did not show that these shortfalls had been followed up and there had been no checks to ensure the medicines were administered. This meant that provider was not able to tell us if this had been a medicines error or a recording oversight.
• Medicine risk assessments did not have guidance in place for staff as what to do should people refused to take their medicines.
• Risk assessments related to medicines administration were not sufficiently detailed to guide staff. For example, in relation to the extent that family, where involved in medicines administration. The registered manager confirmed staff signed MARs when family members administered medicines to people. This meant MARs were not an accurate record as staff were not involved in the actual administering of medicines. Therefore, the provider could not assure us that people were always receiving their medicines as prescribed.

• MARs audits were not effective. MARs audited for October 2022, February 2023 and March 2023, identified shortfalls in staff recording but these had not always been fully investigated and acted upon. We noted, MARs for February 2023 were not audited until April 2023 which meant any issues had not been identified and rectified in a timely manner.
• Where people were prescribed PRN medicines (medicines as and when required) there were no protocols in place to guide staff how and when people should take these medicines. This meant people were at risk of not receiving their medicines as prescribed. One person was given a PRN medicine four times a day. The registered manager told us that the person demanded this medicine whenever other medicines were administered. However, there had not been a GP review of this PRN medicine to determine whether or not it should be administered every day.
• Where people were prescribed topical medicines (creams), the application instructions were not appropriately recorded on their MARs and there were no body maps in place to guide staff on where these topical medicines needed to be applied.

We found medicines were not safely managed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider sent us some updated body maps. We will check that these have been implemented for all people at our next inspection.

Staffing and recruitment
At our last inspection in August 2022, we found the provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were effectively deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• Staff were not effectively deployed to meet people's needs in a timely manner. The provider failed to ensure that they had an effective call monitoring system (ECM) in place to monitor staff attendance and punctuality, and to ensure people received their care as planned. The registered manager told us there was

not a dedicated member of staff to monitor the ECM system throughout the day.
• We analysed three months of care calls on the ECM system prior to the inspection. We identified there were 512 missed calls. Punctuality was poor, with only 60% of calls delivered within 15 minutes of the planned time and 20% of calls were more than 45 minutes late.
• We received mixed feedback from staff in relation to travelling time between calls. One staff member said, "It can be difficult if care calls are booked back-to-back. If my first call is due to finish at 8am and the next is booked for 8.15am, if I am late finishing at 8am this will impact my 8.15am call, I will be late," Another staff member said, "Yes, I have enough travel time."

The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were effectively deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider did not follow safe recruitment practices. The provider had failed to carry out robust checks to ensure that staff were of good character and had the appropriate skills and experience to support vulnerable people.
• The provider had failed to adhere to their own recruitment policy. We found that that application forms were not completed in full. Reasons for gaps in education and employment histories were not always sought, in line with regulatory requirements.
• Employment references were not always obtained from referees on headed paper or did not have an official stamp of the organisation they had worked for to verify them. The provider failed to cross check references against application forms as stated in their recruitment policy.

• The provider employed people without carrying out appropriate Disclosure and Barring Service (DBS) checks. The provider accepted DBS checks from staff members former employers where they had not signed up for the DBS Update Service which enabled them to use existing an DBS.
• The provider had also accepted a basic (not enhanced) DBS check that a staff member had carried out themselves.

Recruitment practices were not safe, although we found no evidence that people had been harmed however, this was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse. Learning lessons when things go wrong

At our last inspection, systems and processes were not established and operated effectively to prevent abuse of service users.

At this inspection, we found the provider remained in breach of this regulation.

• There was no effective system in place to safeguard people appropriately and manage concerns of abuse. There was no safeguarding file or system in place to collate all safeguarding incidents.
• Since the last inspection we were shown an email from the provider showing that they had sent CQC a statutory notification, informing us of one potential safeguarding concern that took place in February 2023. However, we this potential safeguarding had not been reported to CQC until March 2023, a month after the incident and following the demise of the person involved.

• We saw there were a further two incidents that took place in March 2023, for which the provider had not sent statutory notifications to CQC for. There was no clear contemporaneous documentation maintained in

relation to these two incidents. Therefore, the provider could not assure us that they were monitoring safeguarding concerns appropriately.

• There was a system to record, investigate accidents and incidents, however learning from this was not shared with staff.
• The provider, failed to carry out analysis of accidents and incidents to identify trends and where lessons learnt were disseminated to staff, so there could be a positive impact in improving people's experience of the care they received.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Overall infection control was appropriately managed. People and their relatives told us that staff always wore personal protective equipment (PPE).
• The registered manager told us that they dropped PPE off to each person's house to ensure that it was available to staff. However, one relative told us that they provided PPE to staff who supported their family member, rather than the provider. This meant that there was a risk that PPE would not be available to staff when providing care and support.

Inadequate

Is the service effective?

Our findings

Effective – this means 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 requires improvement. At this inspection this key remains requires improvement. This meant that people's outcomes were not consistently good.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection in August 2022, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• Some people's support plans did not show that they had been accurately assessed when there was a change in their care needs. For example, the point at which staff had taken over medicines administration from relatives had not been recorded.

• Support plans failed to address people's emotional and behavioural needs in assessments and support plans. There was a lack of guidance and strategies in place for dealing with people's behaviours to ensure people were kept safe.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The provider had not taken on any new clients since the last inspection, so there were no assessments of needs carried out.

Staff support: induction, training, skills and experience
At our last inspection in August 2022, we found the provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were effectively deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• The provider did not have any records demonstrating that staff members had attended an induction, or staff new to the caring profession had completed an induction in line with the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
• The provider considered safeguarding, medicines administration, infection control, moving and handling, equality and diversity, catheter care, PEG feeding and fire awareness as mandatory training. We reviewed the staff training matrix for six staff members and saw only one staff member had completed all mandatory

training after joining the service.

• Two staff members had not completed any mandatory training since they joined the service. Three staff members had not completed all mandatory training since joining the service, instead the provider had accepted training they had completed prior to them joining the service.

• We reviewed five staff files, we found that three staff members, had not been supported with regular supervisions since our last inspection in August 2022. This meant staff did not have a formal process between staff and managers where staff could review their workload, monitor and review performance, and identify any learning and development opportunities.

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

Supporting people to eat and drink enough with choice in a balanced diet
At our last inspection in August 2022, we found the provider had failed to ensure that people's nutritional and hydration needs were met is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, we found the provider remained in breach of this regulation.

• People's nutritional needs were not always adequately assessed, and guidance was not in place to ensure people were safely supported.
• We saw that that some people care records showed that they had a number of allergies, however, their nutrition risk assessment did not have guidance in place for staff on what food should be avoided and what staff should do if people had an allergic reaction.
• People at risk of choking did not have choking risk assessments in place and there was no guidance in place for staff on how to safely support people when eating and drinking.
• Following the inspection, the provider sent us choking risk assessments, however it was not clear from care records if staff had met with people who were at risk of choking to ensure that they were meeting people's needs effectively.
• There was also no information in care records that a speech and language therapist had been consulted to identify actions/guidance for staff on how to minimise the risk of choking.
• Care records documented when people required a diabetic diet. However, there were no person-centred diabetes risk assessments in place, which documented what a diabetic diet meant and what to do people become unwell.

The failure to ensure people's nutritional and hydration needs were safely being met is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• Following the inspection, the provider sent us updated diabetes risk assessments. We will check that these are in place for all people living with diabetes at our next inspection.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
At the last inspection, the provider needed to make improvements to ensure that people's health care needs were effectively monitored.

At this inspection the provider had failed to make improvements and was now in breach of regulation.

• People were not always supported to live healthier lives as staff did not have detailed information about people's specific health and medical needs
• People's support plans did not always clearly document the support they required. For example, people living with Parkinson's Disease or Chronic Obstructive Pulmonary Disease (COPD) had no detailed guidance in place for staff on how to safely support people living with this condition.
• People's care records did not always document if the provider was working with other care agencies to support their specific health conditions.

This was a breach of regulation 9 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked and saw the service was working within the principles of the MCA

• The registered manager and staff understood the principles of MCA and when it should be applied. People were encouraged to make all decisions for themselves and were provided with information to enable this in a format that met their needs.
• People's rights were protected because staff sought their consent before supporting them.

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

Respecting and promoting people's privacy, dignity and independence
At our last inspection in August 2022, we found the provider had failed to ensure that people were always treated with compassion, dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

At this inspection, we found the provider remained in breach of this regulation.

Respecting and promoting people's privacy, dignity and independence
• Peoples' care records did not detail what people could and could not do for themselves. There was no detailed guidance in place for staff on how to support people to encourage or maintain their independence.

• Late or missed calls meant that people were left waiting for support and meant that people's dignity could be compromised. This was because systems were not effectively used to address late calls or missed calls and consider the potential impact of this on the quality of people's experiences and their dignity and preferences.
• Support plans did not address the different stages of people's dementia and how this affected their daily lives in terms of their wellbeing and independence.

The failure to ensure people were always treated with compassion, dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care. People were not supported to make decisions about their day-to-day support.
• People and/or their relatives were not always supported to be involved in decisions about their care. For example, care records did not always document if people were able to choose what they wanted to wear.

• Care records did not always contain enough detail about people's daily care personal care preferences. For example, some care records stated, 'Personal care: Undressing, washing and dressing'.' Therefore, there was not guidance for staff about whether people preferred to have a bath or shower.

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

• People and their relatives told us that staff were kind and caring.
• Notwithstanding the positive feedback, we were not assured that staff were deployed effectively to ensure people's dignity and respect was not impacted and they received support in line with their needs in a timely manner.
• People's cultural needs had not always been explored and clearly documented in people's support plans. For example, one person's care records documented 'Care Worker to respect my religious and/or cultural needs and beliefs. Which I will communicate if the need arises'. The person's cultural needs and beliefs had not been recorded to help guide staff in the support the person required.

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 requires improvement. At this inspection the rating has remains requires improvement. This meant people did not feel well-supported, cared for, or treated with dignity and respect.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences. End of life care and support
At our last inspection in August 2022, we found the provider had failed to ensure people received person-centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• Some people's care plans were not always person-centred and contained minimal information. Care records did not always have detailed information about people's specific health needs, this included people living with Parkinson's Disease, at risk of choking or strokes. This meant there was no guidance for staff on how to support people with their individual needs effectively.

• People or their relatives had little involvement in the planning or review of their care. There were no records in people's care plans to show when people or their relatives, had been involved. One relative told us, "I don't know if [family member] has a care plan. Social services arranged it all for us."
• Care records were not always regularly reviewed. We saw that support plans were not always signed either by people or their relatives consenting to their care. Staff had not always signed and/or dated support plans.

• Care records did not always contain advance decisions about people's choices about how they wished to be supported at the end of their lives. The registered manager said that this had not been discussed with everyone using the service or their relatives, where appropriate.

The above issues amount to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider sent us some updated support plans. We will check that support plans have been implemented for other people using the service at our next inspection.

Improving care quality in response to complaints or concerns
At our last inspection in August 2022, we found the provider had failed to ensure there was a robust complaints system and process in place. This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• The provider did not have a robust system in place to handle complaints effectively. Although complaints were logged, these were not always investigated and documented in line with the provider's complaints policy.
• The provider's policy stated that an acknowledgement letter would be sent within five working days of receiving a complaint and the complaint would be investigated and within 14 days a full explanation would be to the complainant. If issues were more complex then, the investigation would be completed within 28 days and the complainant would be informed of any delays. However, there were no records to show that the provider complaints policy had been followed.
• We found that people were not always informed of the timescales for responses to their complaint, the action the provider had taken and the action they would take, should the response not be satisfactory to them.
• We found that complaints were discussed with some people via WhatsApp message, instead of adhering to the provider's internal complaints policy.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection, the registered manger told us that they would ensure that the provider's internal complaints policy was followed. We will check this at our next inspection.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The 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.

At the last inspection, the provider needed to make improvements to ensure that people's health care needs were effectively monitored.

At this inspection, although some improvement was made, further improvements were still needed.

• Care records showed that people's communication needs had been recorded in their support plans to guide staff on how to communicate with them effectively.

• However, the provider failed to ensure there was an AIS policy in place, this meant people were still at risk of not having their communication needs met.
• There was no information available in different formats, should people need it, to meet their personal needs. The registered manager was not aware of the AIS.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means 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 inadequate. At this inspection the rating remains inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care
The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At this inspection, we found the provider remained in breach of this regulation.

• People did not receive a service that was well-led. The registered manager did not adequately understand their role, regulatory requirements and lacked leadership and oversight of the service. The provider had not effectively addressed issues that we found at the inspection and people were exposed to unsafe care and treatment.
• The registered manager was unaware of the issues identified during the inspection, regarding the lack of risk assessments, poor medicines administration, poor recruitment processes and staff deployment. Failure to share learning from accident and incident records, lack of staff supervisions, lack of AIS, lack of a robust complaints system and lack of robust governance, leadership and management oversight.

• The registered manager lacked awareness of their statutory responsibilities in relation to safeguarding and legal requirements. The was not a robust system in place to safeguard people appropriately and manage concerns of abuse.
• Monitoring systems had not been put in place to ensure effective oversight of the service. This meant the provider had failed to ensure they operated effective systems to assess and improve the care provided.

• Risks relating to Parkinson's Disease, diabetes, choking, falls, seizures, pressure sores, medicines and moving and handling were not being addressed safely and effectively by the provider.
• Accidents and incidents were logged, however the provider failed to carry out any analysis and disseminate any learning to staff on how to minimise these in the future.

• The provider had failed to carry out regular audits to identify issues. For example, since our last inspection in August 2022, there were no regular medicine audits carried out for all people using the service. The medicine audits we saw for one person for May to June 2022 and July to August 2022, did not identify the shortfalls we found with their medicines at the inspection.
• There were no audits carried out in relation to care plan audits, staff files, and the ECM system.

The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) 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

• The registered manager had held staff meetings since our last inspection in August 2022. We saw the minutes of meetings held in December 2022 and February 2023 however, the minutes did not demonstrate that any learning had been disseminated to all staff.
• Staff were not supported through regular supervisions, which meant that they were not given the opportunity to feedback individually to drive improvements.
• Regular feedback about the service had not consistently been sought from people or their relatives. We reviewed five peoples' feedback that had been sought, which was only once for each person since our last inspection in August 2022. We saw that the provider had failed to act on the feedback received in relation to people not feeling cared for by staff, people not involved in planning their care needs, people not having their support plans reviewed regularly, people not knowing how to make a complaint, or people not feeling listened to when they made a complaint. We saw that no action plans had been drawn up to drive improvements from the feedback received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and understands and acts on duty of candour responsibility when things go wrong

• People did not always receive good outcomes. Since the last inspection in August 2022, the service had failed to embed a culture that looked to achieve positive outcomes for people.

• The registered manager had failed to demonstrate clear and accurate records were maintained to provide staff with robust guidance to ensure positive outcomes.

• Support plans were not comprehensive and failed to detail people's needs and preferences to ensure person-centred care and support was provided.
• People were supported by a service that did not have adequate understanding of the duty of candour. At our last inspection the inspector signposted the registered manager to the Health and Social Care 2008 regulations. However, at this inspection, the registered manager was still unable to identify the appropriate steps to follow when things went wrong.

Working in partnership with others.

• The service worked with the local authority, who had been supporting the service to drive improvements since our last inspection in August 2022. However, at this inspection we found improvements had not been made.

The above issues meant that the provider's systems to assess, monitor and improve the service were not effective. The above issues were a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People's needs were not always assessed and care plans were not person-centred People or their relatives were not involved in planning their care needs

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People dignity and privacy and independence was not always maintained

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment and risk management plans were not always in place Medicines were not always safely managed Recruitment practices were not robust and staff were not supported through regular supervisions and appraisals.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider failed to have effective systems in place to safeguard people appropriately and manage concerns of abuse

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There provider failed to have a robust complaints process in place

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems for governance and management oversight were robust, safe and effective The provider did not have oversight of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have robust recruitment practices in place

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs in a timely manner