Copper Beech Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The service is a domiciliary care agency which provides personal care to people living in their own homes throughout Northumberland. At the time of this inspection there were 60 people using the service.

People's experience of using this service: There were significant shortfalls in the leadership and management of the service which impacted on the quality of care people received. The provider and registered manager failed to adhere to registration regulatory requirements. Robust governance was not in place and subsequently audits and checks had been ineffective in driving the necessary improvements.

Policies and procedures were not properly implemented or followed by staff. Consequently, there were many aspects of the service which were non-compliant with regulations and exposed people to the risk of harm. Most relatives raised concerns about the care their family members received and several whistleblowing allegations were made by staff.

The service was not safe. Systems to identify, monitor, record and report matters which could be a safeguarding issue were not followed properly. Safeguarding incidents and allegations of abuse had not always been properly managed or reported as necessary to the relevant authorities which meant people were at risk of a reoccurrence.

Risks to people's health, safety and welfare had not been adequately assessed. Specific risks were not recorded, meaning people were not protected as much as possible from harm. Medicines were not managed properly which led to multiple errors.

Recruitment processes were not robust. Recruitment checks were not always followed up. There were not enough staff employed to meet people's needs and wishes. Staff were not properly inducted or suitably trained to ensure they had the skills and competence to carry out their role.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice .

Formal consent to care and treatment was not always sought. Relatives who did not hold the legal right to make decisions were instructing staff on how to deliver care to their family member. Assessments of people's needs and the care arranged did not always meet best practice guidance. Staff were not always proactive with referring people for additional help from external professionals.

Complaints were not always managed in line with the company policy and procedure. Relatives told us they had frequently complained about the service and expressed dissatisfaction with the service their family members received.

Person-centred care planning was not embedded into the service. Care records were often generic and not related specifically to each individual. Records were not always accurate or completed.

People supported by regular, experienced care workers experienced better outcomes than those who were not. Although there had been allegations of neglect and ill-treatment of people, there were other people who told us their privacy and dignity was respected and their care workers were caring and kind.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, safeguarding, complaints, good governance, staffing, recruitment and consent. We also identified one breach of the Care Quality Commission (Registration) Regulations 2009, entitled, Notification of other incidents.

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

Rating at last inspection: This was our first inspection of this service since it's registration in March 2018.

Why we inspected: This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: At this inspection the service has been rated 'Inadequate'. Therefore, the service is now in 'Special Measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months to check for significant improvements.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If enough improvement is not made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-led findings below.

Inadequate

Copper Beech Homecare Ltd

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two inspectors and one Expert by Experience conducted the inspection. 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 homes up to 24 hours per day. It predominantly provides a service to older adults. Not everyone using Copper Beech Homecare receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection: This inspection was announced. We gave the provider short notice of the inspection to ensure that staff were available in the office to assist us to access records.

What we did: Prior to the inspection, we reviewed information we already held about the service, this included information from whistle blowers. We asked for feedback from the local authority who commission services and from the local authority safeguarding team. We also checked the records held by Companies House.

We asked the provider to complete a Provider Information Return, which we received in January 2019. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

One inspector visited the office on 28 February 2019 and two inspectors visited on 8 March 2019 to review care records, policies and procedures. We spoke with the registered manager, the care manager, two care coordinators and an HR consultant. The Expert by Experience conducted telephone calls with two people and eight relatives between 1 and 4 March 2019. During and after the inspection we spoke with eight care staff via telephone and email.

We reviewed six people's care records, five staff personnel files and records related to the safety and quality of the service.

After our site visit, we requested some additional evidence to be sent to us. This was not sent to us in line with the agreed deadline. We gave the provider a short extension and this information was then received and included as part of our inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were exposed to the risk of harm because the systems in place to safeguard people from harm and abuse were not followed properly by staff.
- When incidents occurred, they were not well managed which increased the risk of a reoccurrence. Incidents were not always reported to the local authority safeguarding team or to the Commission in line with procedures. Therefore external agencies did not have oversight of resolutions and further preventative measures.
- Incidents which involved allegations of neglect or the ill-treatment of people had not always been thoroughly investigated, managed properly or responded to, which exposed other people to a risk of similar ill-treatment.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- People were unnecessarily exposed to the risk of harm because the risks to their health, safety and welfare had not been adequately assessed. Specific risks which individuals faced were not recorded. The registered manager had not assured themselves that staff were doing everything possible to mitigate such risks. For example, people with skin integrity, personal care, bathing, mobility (high risk falls), weight loss and incontinence needs did not have risk assessments or specific care plans in place to ensure staff delivered appropriate care and any risk of harm was reduced.
- Detailed records were not kept which meant staff did not have information available to them about risks to help them care for people safely. This was confirmed by relatives and staff who told us there was not always a care plan or risk assessments in people's homes for staff to refer to. This had impacted on some people who had received poor and unsafe care because staff did not know what to do in certain situations.
- Equipment, such as bath lifts and mobile hoists which people needed to receive care safely was not risk assessed. Information was not available to staff to instruct them on how to safely use equipment in line with people's abilities. This increased the risk of an accident and exposed people to avoidable harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

Using medicines safely

- Medicines were not managed properly or safely. This had affected the service people received because there had been multiple medicine errors. The provider could not evidence that there had been no adverse effect on people's health and wellbeing.

● There were no 'PRN' (as required) protocols in place for people with high risk medicines which had exposed people to the risk of avoidable harm.
● Medicine support plans were not in place and insufficient information was recorded in the medicine risk assessments. Not everyone had a medicine care plan or risk assessment in place (where needed).
● Relatives told us their family members went without their pain relief medicine for prolonged periods of time and the provider was not able to evidence that this had not had an adverse impact on people.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

Staffing and recruitment
● There were not enough care staff employed to meet people's needs. Staff rotas showed visits were scheduled at the same time, were overlapping or were without sufficient time for staff to travel from one person's home to the next. This meant some people did not get their visits at the time they needed or expected.
● People were at risk of receiving support from staff who were not properly trained or competent in their role. The registered manager had not made sure that administrative staff only assigned new staff to care visits once the necessary checks were completed, training was completed and their competence was assessed.
● People and relatives told us about inconsistencies with staff, poor time keeping and inexperienced staff working without supervision which had caused them to receive an unsatisfactory service.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Staffing.

● Recruitment processes were not entirely safe. The registered manager had failed to ensure that sufficient recruitment checks were carried out on the staff they inherited from a previous provider and with staff they had employed themselves.
● People were at risk of receiving support from staff who were not of good character. The management team had not assured themselves that all staff were fit and proper due to a failure to audit staff recruitment files properly.
● There was a failure to ensure action was taken where staff with positive disclosures on their DBS checks needed to receive a higher level of supervision following a risk assessment.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Fit and proper persons employed.

Learning lessons when things go wrong
● The registered manager failed to make sure that staff were fully supported to learn from past mistakes.
● Whilst records weren't always completed, there were some records indicating that lessons learned following disciplinary meetings and after complaints were received had been shared with staff in team meetings to improve working practices.
● Following our visits, the provider told us that substantial lessons had been learned from the findings of this inspection. Internal investigations had commenced into staff misconduct and the poor service identified during our visit. They assured us that further lessons would be learned to improve the service people received in future.

Preventing and controlling infection

● The risk of staff spreading bacteria and viruses was reduced. The provider supplied disposable gloves and aprons for staff to use when assisting people with personal care. People and relatives told us staff used the protective equipment as required.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Some regulations were not met.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

● Formal consent to the care people received was not always sought in line with the law and best practice guidance.
● Staff lacked an understanding of MCA principles. They did not know how many people they supported lacked capacity and if any person did lack capacity, who had the legal right to make decisions about their care and welfare. Where a court order was in place, staff were not made aware of what was included in the order or knew whether they were complying with any conditions within it. One relative said, "I don't think they know about mental health, I think they need mental health training."
● There were no mental capacity assessments in people's care records. Staff followed instructions from some people's relatives about how their care should be delivered and in some cases these relatives did not have a lasting power of attorney in place to make these decisions lawfully on their family member's behalf.
● The registered manager told us they would review people's needs and collect the necessary information about people's capacity to make decisions and any legal agreements in place.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Need for consent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Care and support was not always arranged or delivered in line with legislation or nationally recognised guidance. People's physical, mental and social care needs had not been fully assessed. As a result, people did not always receive care which met their needs.
● People did not always experience positive outcomes. Poor assessments and care planning meant that care was not always provided as needed. We received feedback from relatives which reflected that people had received a poor service. Some relatives told us people were considering changing to a different provider

because of this.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

Staff support: induction, training, skills and experience

● Staff were not always properly inducted, trained or supervised to ensure they were skilled and competent. Some new staff told us they had not completed a proper induction or sufficient training which left them feeling unprepared for the role.

● The management team had not realised that staff who transferred to Copper Beech from a previous provider may have required a robust induction into care work. Those staff who became a care worker after 1 April 2015 (without care experience or a qualification) should have been enrolled onto the Care Certificate (or similar). This was not embedded into their induction arrangements. The care manager arranged for staff to be enrolled onto the Care Certificate by the end of our inspection.

● The provider's record of training was misleading in terms of staff compliance with training modules. We identified that some staff had not attended the training as described on the matrix and therefore staff training was not completed or overdue as per the provider's training policy. The management team had not realised this shortfall.

● The provider had not obtained proof of the internal training officer's skills and qualifications to assure themselves that they were appropriately skilled to train the staff team. The provider told us following the inspection that whilst they await confirmation of this person's qualifications, all staff training will be delivered by an external training provider and refreshers courses by e-learning.

● Additionally, the internal training officer had been assessing the competence of staff with clinical and non-clinical tasks. Until the provider is assured of this staff member's qualifications and competence, arrangements were made for other senior staff and a district nurse to conduct competency checks on care workers.

● Supervision meetings were scheduled for staff and some had taken place. Spot checks were also carried out to check on staff conduct and practices. However, we considered these had been ineffective due to the failings identified at this inspection which had not been fully identified by senior staff. For example, spot checks had not identified that important paperwork was not present in people's homes. Staff told us of errors had that occurred and that they felt ill-equipped to meet some people's needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Staffing.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

● Staff did not always actively support people to live healthy lives or access healthcare services.

● For one person, who could become agitated and hostile towards care staff, a referral had not been made to the behavioural intervention team. Staff should have had access to expert advice and guidance on strategies to manage situations better to reduce the need to administer sedative style medicine.

● Staff monitored people's healthcare needs but did not act consistently. Some relatives told us they rang social services themselves to get additional help, whereas two relatives told us the office staff had helped them to access a dietician and a speech and language therapist.

● Relatives said inexperienced staff did not understand people's needs or how to relate to older people in terms of encouraging them to eat well.

● A relative told us, "(Family member) was poorly last week. A carer ended up getting the paramedics as

blood sugar had dropped so low due to not eating properly. I cook all meals and put them in the freezer, they only have to warm them. No-one had called a doctor all weekend. That carer said to me, 'That need not have happened. A good carer, one who knows about dementia, would have turned that around'."

● Another relative said, "One carer cooked fish fingers in the microwave, I think she needs food hygiene training."

● However, some people spoke positively of the help staff provided. One person said, "If I'm poorly (staff) would ring the doctor." A relative said, "If (family member) has been poorly they've rang me or an ambulance."

● The management team provided some examples of the positive outcomes people had experienced. This included one person whose quality of life of greatly improved because staff identified a need for an occupational therapy assessment. The person was provided with essential equipment to help them mobilise safely.

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.

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

- During this inspection, we identified a large amount of concerns and a failure to ensure the service was compliant with regulations. Therefore, we cannot be assured that the provider and registered manager acted in a wholly caring manner by ensuring people always received good quality, safe and effective support that met all their needs. The provider has assured us that all staff are fully committed to making the necessary improvements to the service.
- Equality and diversity training was not featured in the provider's training policy as a key topic, although this was covered when new staff completed the Care Certificate induction.
- The management team had received a small amount of allegations of neglect, disrespect and staff not understanding people's diverse needs. Following internal investigations and disciplinary meetings, some allegations were upheld and disciplinary action was taken.
- Staff could not always spend time with people to provide meaningful social interaction. People and relatives told us staff sometimes rushed their duties and couldn't always stay the allocated time due to poorly coordinated visit schedules.
- People who had regular and experienced staff were very positive about their support. They told us the staff were caring and kind. A relative told us, "When I'm there, I can hear how they do things. They are caring, kind and compassionate. They know what (family member) needs and they are very respectful." Another relative said, "(Staff member) is excellent. A lot more confident, more experienced and seems very knowledgeable."

Respecting and promoting people's privacy, dignity and independence

- We received mixed feedback from people and relatives as to whether privacy and dignity was always upheld. Where investigations had taken place into claims that privacy and dignity had not been promoted, care workers had been prevented from providing any further support and the disciplinary process commenced.
- Training around privacy, dignity, respect and promoting independence was not part of the provider's mandatory training plan. However new staff covered these topics during the Care Certificate induction.
- People and relatives told us staff were often focussed on tasks and did not have time to encourage independence or give people time to manage some tasks on their own.
- People with regular staff were comfortable being assisted with intimate personal care. One person said, "They keep me covered when they are helping me shower and always talk to me and ask permission."

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

- People did not always have access to their care records. Senior staff visited people to complete assessments and gather basic person-centred information to help staff get to know people better, however relatives and staff all confirmed that the paperwork holding this information was not left in the person's

home for staff to read and refer to when delivering care.

● People were asked for their views, but these were not always reflected in the service they received. People had shared their views and made decisions about how they would prefer their care to be delivered. However, due to poorly coordinated visits, people did not always receive their preferred times, their routine was disrupted because staff were not on time, or staff who people weren't expecting turned up to deliver care at short notice.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Some regulations were not met.

Improving care quality in response to complaints or concerns
● The quality of care people received did not always improve after a complaint was made. Some relatives told us they had complained numerous times and seen little improvement made to the service their family member received. Comments included, "(Family member) is very unhappy. Social services are involved now"; "There are lots of problems" and, "I've complained about consistency. If this doesn't change, we are thinking of changing providers."
● Complaints were not always treated as such by staff. Relatives told us of complaints they had made about the service which we could not find documented in the records. Staff were aware of most of the issues we raised with them but records had not always been made and actions were not always followed up.
● A consistent approach to managing complaints had not been taken. At times, the complaints policy and procedure was followed by staff but this was not consistently implemented.
● There was very little evidence to demonstrate that people received a written response following an investigation into their complaint, which (if necessary) should have included an apology.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Receiving and acting on complaints.

● People and relatives knew how to make a complaint and told us they had spoken with the office staff. Two relatives told us that certain staff had been stopped from delivering care to their family members after raising a complaint.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People did not always receive the personalised care they had expected because person-centred care planning was not fully embedded into the service. Basic information was contained within records but a person-centred approach to assessment, planning and reviews had not taken place.
● Records contained generic information that was not person specific. Information was repetitive and at times inaccurate and not completed.
● Some people were supported to access the community and enjoy pastimes of their choice. However, specific details about what people might be interested in or like to do, was not recorded. For example, there was a section in the care plan for achievements, likes, dislikes, values, beliefs, important events, hobbies, education and work life, but this information was not completed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled good governance.

● People's choices were not always respected. Relatives told us that their family members did not always

get their visits at the times they would like. Some relatives told us that care staff had arrived to deliver care who people would prefer not to have assist them.

End of life care and support

- The provider was not currently delivering an end of life care service to anyone.
- End of life care training was not routinely provided to staff but was available as an online training course.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The provider failed to ensure they complied with the requirements of their registration. Allegations of abuse and other incidents which the provider is legally required to inform us of, had not been notified to the Commission. The registered manager and the provider have a responsibility to ensure a system is set up and effectively managed to ensure notifications are sent to us promptly. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, entitled Notification of other incidents.

- The management and leadership of the service was not adequate. Robust governance was not in place which meant that the service failed to comply with multiple regulations of the Health and Social Care Act 2008 and other regulatory requirements. Although checks were conducted by the registered manager and an action plan had been drawn up, we found that progress had not been made as expected towards the necessary improvements.
- Provider audits had failed to identify the extent of the shortfalls within the service which we have highlighted at this inspection.
- The registered manager did not demonstrate that they were clear about their role. An inexperienced care manager was in post to support the registered manager to operate the service on a daily basis but they themselves required support and guidance from a more experienced manager. The arrangements in place to manage the service had not been suitable and because of this, many failings had occurred due to a lack of suitable management oversight.
- The provider and registered manager had not ensured that staff followed systems and processes to effectively identify, assess and reduce all risks to people.
- Records of the care people should and had received were not always accurate and completed. They were also not always accessible to the care staff who required clear instructions to care for people safely.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The service people received did not display high quality or person-centred care. Most relatives and the

external professionals we spoke with did not speak highly of the service.
● Relatives told us of their dissatisfaction and expressed concerns about the care people received. They told us this was due to poor leadership, a high staff turnover, inexperienced or untrained staff and disorganised visit schedules.
● Immediately prior to, during and after the inspection, several whistle blowers raised concerns about how the service was being operated and the poor care people had received.
● Policies and procedures were not embedded throughout the service. Frequently, staff failed to follow policies and procedures which led to people receiving poor standards of care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

● The provider has worked with us since the inspection and been open and honest about the failings at the service. They have accepted responsibility for the shortfalls and assured us that robust action would be taken to address and rectify the matters immediately. They have worked proactively and in a timely manner to implement the necessary changes.

Continuous learning and improving care; Working in partnership with others
● A culture of poor working practices and non-compliance with regulations had continued to be adopted by staff who transferred to Copper Beech Homecare Ltd from the previous provider. The registered manager and provider had not taken into account that those staff would need extra support and guidance on how to effectively operate a domiciliary care service and what the necessary requirements were in terms of best practice and compliance.
● The local authority commissioning team told us they visited the service in November 2018 and had identified many concerns. At our inspection, we reviewed an action plan which was developed following that visit and found those concerns had not been fully addressed. This resulted in our judgements that there were multiple failings to comply with relevant regulations and demonstrated that the provider had not been effective in driving the necessary improvements in the service, through continuous learning and effective joint working with the local authority.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager told us people and relatives telephoned the office to resolve any problems. However, some relatives told us this was not an effective means of engagement. One relative said, "I can't always get through to the office. They sometimes ring back." Another said, "I don't trust the management. When I ring, it's always on answer phone."
● There was no information in care plans to indicate that staff had explored people's preferred communication methods. This demonstrated that staff may not be aware of the most effective ways to engage with the people or their families to gather feedback.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

● A 'family' survey had been conducted in January 2019. There had been only five responses, however they were positive.

● Staff meetings were in place and we reviewed the minutes. We saw information was communicated between managers and staff about the service and staff were reminded of company policies and codes of conduct.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager failed to ensure that the Care Quality Commission were notified of multiple incidents as required by law.

The enforcement action we took:

We issued the provider with a fixed penalty notice, for the sum of £1250 which they paid in full as an alternative to prosecution.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure that the service provided to people was always lawful and with the appropriate consent. Assessments of people's mental capacity had not been carried out, therefore staff were unaware if people could make specific decisions. Staff demonstrated little understanding of the Mental Capacity Act 2005 (MCA) and the associated principles in relation to people receiving care in their own homes. Where relatives were making decisions for people, they had not ensured that relatives had the legal right to do so.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to adequately assess the risks to the health, safety and welfare of people receiving personal care.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager failed to ensure staff effectively operated systems and processes in place to always prevent people from abuse and improper treatment.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider and registered manager failed to ensure that all complaints made about the service were responded to and acted upon. The complaints records did not show that a consistent and comprehensive process was being followed by staff to receive, respond to and manage complaints.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to assess and monitor risks to people's health, safety and welfare and failed to maintain complete, accurate and contemporaneous records of the care and support people received. The amount of breaches found at the inspection indicated that governance of the service is inadequate.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They

must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager failed to ensure that adequate pre-employment recruitment checks and processes were carried out. They had not taken all reasonable steps to ensure new employees were suitable to work with vulnerable people. They also failed to ensure staff were properly assessed as competent before working unsupervised in their role.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to assure themselves that staff were suitable for the roles they were appointed to. They also failed to ensure that staff training was kept up to date and that all staff had completed a robust induction into the care industry where required.

The enforcement action we took:

We imposed a condition on the provider's registration that they undertake specific monthly audits. They must also provide CQC with a detailed monthly report of the actions taken as a result of the findings from those audits.