Choice Care 4U Services 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?	**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
Choice Care 4U is a domiciliary care agency. The service provides personal care to people living in their own homes in Selsey and Bognor Regis. At the time of the inspection 50 people were receiving the regulated activity of personal care.

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
There was a failure to assess and mitigate risks to people. Care records lacked important detail to guide staff on how to make people safe. Support plans did not contain detailed and person-centred information and therefore these did not always accurately reflect the needs of those who used the service. There were shortfalls in the way people's epilepsy, medicines and mobility were managed. People did not always receive support in line with best practice guidelines.

There was not an adequate process for assessing and monitoring the quality of the services provided and ensuring that records were accurate and complete. There was a lack of provider oversight and governance of the service. Processes were not in place to review accidents and incidents and learn lessons to drive service improvements. The provider had not ensured staff were recruited safely and there was a failure to ensure staff undertook training and were suitably skilled and knowledgeable for the role.

People were happy with the care they received and felt safe with the staff that were supporting them. People told us they received a reliable service and calls were never missed. Staff told us it was a good place to work and the enthusiasm from the team impacted positively on the people using the service. People said they received support from a consistent team who knew them well. There were enough numbers of staff to ensure people did not feel rushed and people received their support on time.

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 autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, Right care, Right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right

support, Right care, Right culture.

Right support: The model of care did not maximise people's choice, control and Independence and measures had not been taken by the provider to mitigate this. The provider was unable to demonstrate how they met the needs of people with a learning disability in line with best practice guidance.
Right care: There was a lack of person-centred care and the support people received did not promote dignity and equality. People's needs and preferences were not always known or respected. Care plans did not clearly identify which aspects of their care people could manage themselves or the type of support people required in order to promote independence and aid communication. People did not always receive safe care.
Right culture: The ethos and values of the service did not ensure people using services lead confident, inclusive and empowered lives. People were not empowered to have choice and control over their lives. Staff had not received training to ensure they had the skills and abilities to meet people's needs.

We sign posted the provider to the Right support, Right care, Right culture information on the guidance for providers page on our website

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

Rating at last inspection
The last rating for this service was good (published16 November 2018).

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to providing safe care and treatment, medicines, protecting people from harm, staffing and the management of the service 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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective section below.

Requires Improvement

Is the service caring?

The service was not always safe.

Details are in our safe section below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive section below.

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our well-led section below.

Inadequate

Choice Care 4 U Services 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service did not have a manager registered with the Care Quality Commission. Like the registered provider a registered manager is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 1 December 2021 and ended on 23 December 2021. We visited the office location on 9 December 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We looked at the information we held about the service. We used all this information to plan our inspection.

During the inspection

We received feedback from eight people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, manager and care staff. We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek feedback about the service. Clarification was sought from the provider about their policies and processes.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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; Learning lessons when things go wrong

- Systems and processes were not robust to protect people from the risk of abuse. The provider had failed to identify and mitigate practice that had the potential to expose people to harm. For example, where people were supported with financial transactions including the use of debit cards and cash, processes were not in place to mitigate the risk of financial abuse.
- Processes were not in place to ensure people were not deprived of their liberty for the purpose of receiving care without lawful consent. For example, a restrictive practice was in place for one person regarding medicines kept within their home. The medicines were kept within a cabinet secured with a combination lock known to staff. The person was not provided with the code for the lock and was therefore unable to access their medicines. Staff also used this secure cabinet to store the person's money. It is acknowledged this action was to keep the person safe however the provider was unable to evidence they had sought lawful consent from the person regarding this decision.
- The providers processes did not ensure a consistent approach to staff reporting injuries. Staff were inconsistent in their understanding of whether they should report injuries with an unknown origin such as bruises or skin tears that may have occurred when the person was not being provided with direct care. This meant people may be exposed to ongoing and preventable harm.
- The providers processes for recording accidents and incidents did not ensure people were protected from harm or that lessons were learnt. Staff told us the need for them to report an injury of accident was very rare and they would call the office with the details. Incident records were placed in people's files held in the office. The provider did not have a system in place to monitor or analyse incident records for trends. Information was not used to mitigate the risk of a repeated incident or accident and there were no processes for learning lessons to drive service improvements.

The provider had failed to establish and operate effective systems and processes to prevent abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safeguarding service users from abuse and improper treatment).

- Where safeguarding concerns had been identified these had been reported in line with the local authorities and providers safeguarding guidance.
- Following the inspection, the provider took action to address our concerns. For example, processes for recording and reporting accidents and incidents were updated. We were provided with an example where staff had used this recently. They had implemented process appropriately to record and identify the source of an injury observed during a care visit. Staff took appropriate action and the person's care plan was updated to reflect and mitigate the risk of a further occurrence.
- People and their families told us they felt the care they received was safe. People said they felt safe with

and trusted the staff who were supporting them. One person said "I get regular calls from the office to see that I am ok. This has been especially welcome during the pandemic as I have not seen many people."

Assessing risk, safety monitoring and management

● Risks to people were not identified and managed. We reviewed the care records of nine people and found there had been a failure to do all that was reasonably possible to reduce risks to people. For example, where it was recorded that people had epilepsy or experienced seizures processes were not in place to identify and mitigate associated risks. Risk management processes were not in place for people with reduced mobility or who were considered as being at risk of falls. Where people had known health conditions such as diabetes or Parkinson's disease there had been a failure to consider or identify risks associated with these conditions. The lack of risk management processes placed people at increased risk of harm.

● Where care plans identified a known risk, records were not always enough to ensure safe care. For example, the care plan for a person with diabetes did not contain enough information to ensure the person's diabetes was managed and monitored safely. It failed to provide guidance to staff to recognise changes in the person's blood sugar levels or the action to take. There was risk that staff could miss the signs that the person needed immediate assistance to prevent a rapid deterioration in their health.

● A person who had epilepsy did not have this reflected within their care plans. Guidance was not provided as to how the person epilepsy presented or the support they needed to manage their epilepsy safely. Information was not available to ensure staff recognised the signs that their person may be experiencing a seizure, or the action staff were required to take. Where a person had a history of seizures this information was not included within their care plan. There was no evidence that people had been impacted negatively by this however guidance was not available to ensure staff provided either person with safe and appropriate seizure care and management.

● People were not supported in a consistently safe way. Where care plans identified people as having reduced mobility or being at risk of falls, falls prevention guidance was not in place. There was an absence of guidance to ensure staff knew how to move people safely and any equipment they required to do this. For example, one person's mobility care plan failed to include guidance and information contained within a moving and positioning assessment undertaken by the local authority in March 2021. This contained important information about how to move the person safely using a hoist. The persons care plan did not reflect the use of a hoist and guidance was not documented to ensure the person received safe support when transferring between their bed and their wheelchair.

The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider acted to address the concerns we had raised. We were provided with evidence of up dated care plans and risk assessment which provided detailed information to help ensure safe care and support.

Using medicines safely

● Medicines were not always managed safety.

● People's medicine records were not always transferred from their homes to the persons file held at the service's office. Therefore, we were not assured that people's medicines records were being audited to identify medicine errors, discrepancies or omissions.

● The administration of medicines was not always accurately recorded. For example, a person's record indicated a medicine was not available to be administered and further supplies had been requested. However, the daily medicines records indicated medicines were administered. There was no evidence of a

negative impact for the person however were not assured as to the accuracy of the information that was being recorded.
● Where medicine administration records (MAR) indicated that a variable dose could be administered, for example one or two tablets, staff did not always record the dose administered. This meant there was a risk that staff would not identify a change in need for a medicine and seek professional advice.
● Medicine risk assessments lacked information about how to mitigate identified risks. Information recorded in risk assessments was not always consistent with people's care plans. For example, the number of times per day a person was supported with their medicines. People's allergies and intolerances were not always recorded. This meant that people could be at risk from receiving a medicine that could cause them harm.
● Medicine care plans were not always in place and failed to provide guidance to staff about people's medicines. There was an absence of information to guide staff about how people preferred to receive their medicines and how staff could support people to maintain their independence. This meant people could not be assured of receiving their medicines safely and in line with their personal preferences and the prescriber's instructions.

The provider had failed to ensure systems and processes were established and operated for the safe management of medicines. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always recruited safely. The service had a new provider in August 2021 and a new manager in October 2021. Recruitment processes undertaken by the previous provider did not always demonstrate safe recruitment processes had been followed. For example, appropriate recruitment checks had not been consistently undertaken to ensure staff were safe to work with people. This included a lack of evidence to demonstrate all staff employed had appropriate and up to date checks with the Disclosure and Baring Service (DBS) and suitable references were obtained. We made the new manager aware of our concerns. They took action to address gaps in the employment checks for staff currently employed. We were assured by the managers actions and the current providers processes for safe recruitment.
● There were enough staff to meet people's needs. People told us they were supported by familiar staff who were reliable. The provider did not have a system to record missed calls, however people told us that calls were never missed and on the rare occasion staff were running late they would receive a phone call and rescheduled time. One person told us "I get a rota every week so I know who is coming each day and if someone can't come I get a phone call but I know most of the girls now so it doesn't really matter but they tell me it's important I should know who is coming".
● People told us they never felt rushed and staff always stayed for their allocated time. A person told us "I am never rushed, and I have never had a missed call at all." Another person said, "I have a rota sent each week and its 99% accurate which is pretty good going if you ask me."

Preventing and controlling infection
● Infection prevention and control processes kept people safe and reflected latest guidance for the COVID-19 pandemic.
● COVID-19 testing was carried out in accordance with government guidance, the manager confirmed staff underwent a regular testing regime.
● The manager had ensured staff understood appropriate use of personal protective equipment (PPE). Staff had been assessed in relation to the correct wearing of PPE; how to safely put PPE on, take it off and dispose of it.
● Staff had received training in infection prevention and control.

● Staff told us they had been kept well informed of changes to guidance and felt well supported by the management team.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing staff and visitors to the office from catching and spreading infections.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff did not receive a robust induction. We reviewed the staff files of staff who had been employed during the last 12 months and none evidenced a formal induction. One staff who commenced in March 2021 had undertaken two online self-assessments. No other training was recorded. They had received one supervision since their employment. No actions were recorded and their lack of mandatory training including safeguarding adults had not been identified.
- 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. It's made up of the 15 minimum standards that should be covered in the first 12 weeks of employment if a person has not worked in care previously. The Care Certificate requires each standard to be completed and assessed before staff can work un-supervised. One staff new to care had completed two of the 15 required standards and had passed their probation period without this being identified. They had been working alone for eight months and their knowledge and competencies of the role had not been assessed.
- Processes were not in place to ensure staff were suitably skilled and knowledgeable. We reviewed the providers training records and found that staff training had not been kept up to date. For example, there were 15 staff without any record of ever having undertaken safeguarding training and there was no record of staff having access to training to meet people's specific needs such as Dementia, diabetes or Parkinson's. The provider has learning disability and autism band on their registration. They are providing support to a least one person with a complex learning disability. Staff have not received any training in autism or needs associated with a learning disability. This meant people could not be assured of receiving care specific to their needs to help them achieve the best quality of life.

The failure to ensure staff had the appropriate training and skills to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People recruited recently had undertaken the full care certificate and the manager provided assurances that failings in people's training needs would be addressed. The manager provided assurances that they are sourcing bespoke training appropriate to people's needs and disabilities.

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

- People's needs were assessed before they started to receive support from the service. The information gathered was not always accurate or robust enough to inform care plans and ensure people's needs could

be met. For example, several care plans identified that people had a high Waterlow score. The Waterlow assessment tool gives an estimated risk for the development of pressure ulcers. We asked to review the completed Waterlow assessments and were told these had not been undertaken. The risk scores had been determined by staff's opinion of weather; they felt the person was at risk of pressure ulcers. The lack of effective assessment meant people could not be assured of receiving consistent and effective care to meet their needs. We made the manager aware of our concerns and they provided assurances that where people had been given a high risk for Waterlow this would be reviewed appropriately.

● People's protected characteristics under the Equality Act (2010), such as disability, ethnicity and religion were considered during the assessment process. People told us they had discussed their needs with staff prior to using the service. One relative told us," From the beginning I have been fully involved with how my husband's care is delivered the manager really values my input and it seems to work very well all around."

● People's backgrounds and life stores were captured as part of the assessment process. Staff we spoke with had a good understanding of people's lives before they needed care. Staff understood how people's past experiences could impact on their current health and well-being and used this knowledge in the planning and delivery of care. One person who shared their experience of accepting they could no longer manager alone said, "I am extremely happy with the carers, they have been all and more than I could have hoped for".

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

● People received appropriate support to ensure their nutritional requirements were met. Where support with nutrition was an assessed need, staff prepared snacks for people such as sandwiches and microwave meals and meals for people. Where people had capacity and had made an informed decision not to follow specialist diets such as diabetes this had not been recorded within peoples care records. This meant staff might not be aware of any increased risks on the persons health and required action.

● People's support plans identified the levels of support needed to ensure a person maintained a healthy fluid intake and balanced diet. This included support with shopping and preparing food. People's food and fluid intake was recorded where this was an assessed need.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 and they were.

● The manager was able to demonstrate knowledge of MCA and an awareness of the need to ensure multi-disciplinary and family input when making decisions on people's behalf. Where decisions had been made in people's best interest these had not always been documented appropriately. The manager provided verbal assurances as to the action they would take to address this.

● Where people' capacity had been assessed prior to receiving a service this was documented with in people's care records. Where people did not have capacity to consent to care and treatment this was known, and information was used to inform care planning.

● Where there was doubt about a person's capacity or there had been a change in people's cognitive

abilities senior staff undertook a capacity assessment and referred the person for a more formal assessment by a medical professional. We were provided with an example where a change in a person's health had led to staff seeking professional guidance about a person's capacity. A capacity assessment was undertaken by the person's GP and the person was assessed at having capacity. The doubt in the persons capacity had occurred due to a change in the person's ability to communicate. Guidance was implemented to support effective communication.

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

● Staff liaised effectively with other organisations and teams and people received support from specialist health care professionals. This included district nurses, GP and palliative care professionals.

● The manager had begun to implement a system to ensure other professionals would have the information they required if the person was admitted to hospital. Hospital passports had been sought specific to people's needs such as those produced for people with Alzheimer's or a learning disability. These were in the process of being completed and were due to be implemented for all people receiving support.

● People told us that if required staff would make medical appointments for them. If people needed support to attend a medical appointment this could be arranged. Staff provided examples of when they had observed a person to be unwell and called for medical help or made a health appointment for them. This ensured people received appropriate and timely access to meet their health care needs.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were not always referred to in a respectful and dignified way. We reviewed the minutes of staff meetings and these showed that negative and derogatory comments had been recorded about people. These included comments about people's behaviour and staff's perceptions of people. We fed this back to the manager who provided verbal assurances this would be addressed, and measures would be put in place to prevent this happening in future.
- People told us they were treated with kindness by caring and dedicated staff. People said they had nothing but praise for staff and described them as kind and caring. People felt staff understood their needs and said did not feel rushed as staff had time to talk with them. One relative told us "I hear the carers chatting to my husband and they treat him with the utmost respect at all times".
- Staff told us it was important to respect people's choices and feelings, and spend time getting to know people. Staff had formed good relationships with people they supported, one staff said, "It's not all about care I genuinely enjoy the company of the people I am supporting". A person told us "If I ring the office I am greeted like a friend and it's so nice to speak to whoever answers". Another person said "I am very happy with the care I receive. The care staff are all very kind, nothing is a trouble".
- People's privacy was respected. Staff told us they fully understood that they were working with in people's own homes and were mindful to respect people's wishes and preferences. People said staff were respectful of their dignity whilst supporting their care needs. A relative told us "The carers are very respectful to me and my relative and because they are regular girls my relative seems to relax with them which is better for his condition".
- People and their relatives told us they felt included in their care and that their views were listened to and respected. A relative told us "From the beginning I have been fully involved with how my husband's care is delivered the manager really values my input and it seems to work very well all around".
- People were very complementary about the service received and the staff providing it. Feedback included "I have only praise for the company.it fits in with my life and what I need and want not the other way around as it is with so many other companies". And "The care staff come in three times a day and they stay as long as they should. I have no complaints it works very well for me and I have no complaints with anything at all".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always receive personalised care.

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

- People did not always receive a person-centred approach to having their needs met. Assessments and risks assessments lacked important details, which impacted on the care plans developed for them and meant that staff had limited guidance to support consistent and safe care. For example, there was a lack of information on how to support a person with a complex learning disability. Important information had been omitted from their care plan such as how they communicate and how their independence could be maintained. This meant people could not be assured of receiving care in line with best practice guidance.

There was a failure to maintain an accurate, complete and contemporaneous records. This was a breach of This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had been involved in the planning of their care. When people's care needs changed this was communicated to staff by telephone or in person. Care records did not always reflect updated information however people told us that staff were responsive when their needs or health changed and provided appropriate support.
- Although there was a lack of detail in peoples care records staff demonstrated that they knew people well. Staff were familiar with people's individual preferences of how they wished to receive their support, their personal life stories and interests.
- People and their relatives felt staff provided a personalised service. One relative told us how important it was for their loved one to have continuity of carers. They said the service had been great an providing a core team of familiar staff. Several people told us how much they had appreciated receiving welfare calls from the office staff during the pandemic. A person said "I couldn't be happier with everything they do for me sometimes the carer is the only person I see all day. I really look forward to them coming in in a morning".

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Where people had a significant communication impairment guidance was not always provided to staff on people's communication methods.
- People's communication needs were not always identified or recorded in their support plans. Where a person had a severe communication impairment due to their learning disability this information had not been shared appropriately with others. Guidance on how the person communicated was not included

within their care plan. We addressed this with the manager who took appropriate action to record how the peons communicated including by understanding what is happening next. For example, if the table is being laid then the person would understand that its dinner time.

● We were told that information was available to people in large print if they needed it and although no one currently needed written information in an alternative language or format the provider understood the requirement to make this available if the need arose in the future.

● Staff told us they did things to aid people's communication such as cleaning people's glasses every day and ensuring hearing aids were switched on and batteries working.

Improving care quality in response to complaints or concerns

● There was a complaints policy and process for responding to complaints. The complaints process was given to people when they began using the service. People told us they knew how to raise a complaint and felt they would be listened to. There was a process for responding to complaints and concerns. This ensured concerns were responded to in an open, honest and timely way.

● Staff and the management team treated people with compassion and encouraged people to speak about any matters that maybe of concern to them. People said they were confident to make a complaint about the quality of care and support they received. A person told us "I have never had a reason to complain but I would if I needed to". Another person said, "I have no complaints with anything at all".

End of life care and support

● At the time of the inspection no one required end of life care. There was evidence the staff had sought advice from the local hospice and End of life care hub (ECHO) when people had required support at the end of their life.

● Staff understood which health and social care professionals would need to be involved to support people who were living with a life limiting illness. People's support plans would be updated to reflect people's end of life wishes and care needs.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not well-led. Governance arrangements were not effective in identifying shortfalls in the quality of the service. The service had new provider from August 2021, and this was their first experience of operating a care service. There was no registered manager however the provider had recently appointed a new manager who planned to be registered with CQC to be the registered manager for the service.
- Service and care records viewed showed that concerns found at inspection had been present when the provider took over the service. When the new provider commenced, they had failed to undertake any audits or quality assurance checks. This meant they had failed to identify significant shortfalls in practices including managing risk, accuracy of information, medicines and staffing that were already present in the service.
- Systems and processes for quality monitoring were not in place. There was a failure by the provider to implement any quality assurance checks and monitoring to improve the quality and safety of support provided. The provider did not have oversight of governance and was unable to demonstrate how improvements could be made. Processes were not in place to ensure the service followed best practice guidance. For example, there was failure to follow best practice guidance for Right Support, Right care, Right culture when supporting people with learning disabilities. This meant the provider was unable to ensure learning, reflective practice and service improvement was adopted.
- There was no evidence presented that showed a structured approach to monitoring the quality of care plans. There was a failure to identify care plans did not always contain enough information and guidance to ensure safe care and support. There were inconsistencies in people's medicine records and a failure to ensure care records and information relating to people's care were contemporaneous. This meant records could not be relied upon as an accurate record of people's care.
- Systems were not in place to identify that risks to people's health and wellbeing were being assessed and documented to ensure that all reasonably practicable actions were considered and taken to mitigate the risk. Processes were not robust to protect people from harm. This meant the provider could not be assured people were safe.
- People's needs were not always documented in a way that supported a person-centred approach. Care plans did not always reflect people's individual preferences for how they wished their care and support to be delivered. Care plans did not clearly identify which aspects of their care people could manage themselves or the type of support people required in order to promote independence.
- The provider had not ensured a process for assessing staff learning, areas for development or if further

additional training or support was required. The evidence made available to us demonstrated a lack of processes to ensure staff had undertaken mandatory training or the provider's refresher training. The provider had failed to ensure staff were skilled to work with people with specific needs such as learning disabilities, dementia and Parkinson's' disease. This meant the provider could not be assured that staff were updating their training at appropriate intervals and that their knowledge and understanding was current and relevant to their role.

● Provider led processes were not in place to review accidents and incidents. There was no effective process to identify concerns so any learning would be taken from them and the service would continue to develop.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to the inspection a new manager had been appointed. They had taken immediate action to address our concerns. They demonstrated an understanding of the work that was required to meet compliance and how this could be achieved.

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

● Staff told us they did not receive formal recorded supervision on a regular basis or an annual appraisal. They said there was good access to the management team each day which they welcomed as it enabled them to discuss matters as they arose. The manager told us that they were in the process of planning staff appraisals and a more formal approach to 1-1 supervision and support.

● Records showed that when things had gone wrong the provider had notified the appropriate authorities. Outcomes were not always shared to ensure lessons were learnt

● The manager promoted transparency and honesty. Staff told us that communication was good, they were kept up to date. One staff said they trusted the management team to be honest with them. They described the management team as approachable, positive and genuinely caring.

● People had the opportunity to provide feedback about the service they received. Satisfaction surveys were provided to people and stakeholders and this gave people an opportunity to be involved in the running and development of the service. Staff said they had the opportunity to be involved in the service and were encouraged to share feedback and ideas.

Working in partnership with others

● The service contacted relevant healthcare professionals if needed.

● The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Staff were aware of the importance of working with other agencies and sought their input and advice.

● Feedback received from health and social care professional was positive. We were told that communication with the service was good and they responded to changes in peoples care packages and needs.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to establish and operate effective systems and processes to prevent abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staff had the appropriate training and skills to ensure people's needs were met

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 The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated.

The enforcement action we took:

The provider was issued with a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were established and operated for the safe management of medicines. The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. Accurate and contemporaneous records in respect of each service user were not kept.

The enforcement action we took:

The provider was issued with a warning notice