Community Care Worker 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Community Care Worker Limited is a domiciliary care service that provides personal care to people living in their own homes. At the time of our inspection, the service was providing personal care support to 101 people.

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
People did not always receive safe care. People were placed at risk because staff did not always stay for the full call duration and risks associated with their care were not always identified and planned for. People's medicines were not managed safely. People were not always protected against the risk of infection.

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

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

Although records showed staff had received training, this had not given them the skills or knowledge needed and this was reflected by what people, relatives and staff told us. Staff did not always feel confident in their role and did not always demonstrate they had learnt from their training. People's care plans did not include all the information staff needed to be able to support them safely or in the way they wanted.

There was a continued lack of provider oversight of the service to ensure it was being managed safely and in line with current good practice. Quality systems had not identified concerns, errors and contradictory information in care records. An open culture was not embedded at the service and people and their relatives did not always feel well treated and listened to.

Lessons were able to be learnt through incidents which had happened, although further improvement was needed to ensure this was reflected across the whole service.

The provider had worked with other health professionals to deliver people's care however, the recording of these contacts needed improvement.

Throughout our inspection we received mixed feedback from people, relatives and staff. When people had regular care staff, they considered the service they received to be good. Some people felt some staff are excellent, however some people gave us negative feedback about staff.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 28 September 2021).

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

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 14 July 2021. Breaches of legal requirements were found. We imposed conditions onto the provider's registration following that inspection to require them to send us monthly report of actions.

We undertook this focused inspection to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people, safe care and treatment, management of medicines, staff training, consent and the oversight of the quality and safety of care to people.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Community Care Worker Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection site visit was carried out by two inspectors. Telephone calls to people and relatives were made by three inspectors and two Expert by Experience. Telephone calls to staff were made by two inspectors. 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.

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 two registered managers in post. One of these registered managers was also the nominated individual and director of the company. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was announced.

We gave the service 24 hours' notice of the inspection. This was because we wanted to make sure the registered managers would be on site to support the inspection.

Inspection activity started on 17 June 2022 and ended on 25 July 2022. We visited the location's office on 7, 12 and 21 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also sought feedback from the local Healthwatch team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 38 people who used the service and relatives over the telephone. We spoke with 16 staff members. This included care staff, office staff, managers, the registered managers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one external consultant the provider had employed to support the service.

We reviewed 18 people's care records including medicine records. We also looked at records relating to the management of the service, including audits, meeting minutes, call timings and nine staff recruitment files.

After the inspection
The provider sent us further documentation about the management of their service which included management reports, training information and clarification on specific questions we asked.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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
At our last inspection the provider had failed to protect people from the risk of abuse. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- The provider had failed to ensure their safeguarding systems reduced risks to people.
- Staff administered one person's medicine without leaving the required time gap between dosages. This posed a risk of harm to the person. We reported this to the local safeguarding team.
- People told us they did not receive a rota of scheduled care calls. They did not know which staff member was due to support them or what time they were due to arrive. They told us this made them feel unsafe and anxious, particularly when staff were able to let themselves into their property. Some staff did not introduce themselves or show their identity card and were not in uniform. The registered manager told us people could have a rota if they requested it however they also told us they did not tell people this.

The provider had failed to ensure people were protected from the risk of avoidable harm and neglect. This is a continued breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider told us, "All people are informed at the time of their initial assessment that a rota will be made available to them in a format that they can access, should they wish to choose this."

Assessing risk, safety monitoring and management
At our last inspection people did not always receive safe care and treatment. They were exposed to risk as medicines were not always managed safely, COVID-19 Government guidance for staff testing was not followed and people's assessed amount of care was not always supplied. This was a breach of regulation 12(1) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were at risk of avoidable harm and neglect due to their care calls not always being on time and staff did not always stay for the planned duration of the call.
● Risks to people's skin were not monitored safely. Some people required daily monitoring of their skin and for staff to document this. The provider had failed to ensure staff completed these checks and records, which put people at risk of skin problems.
● People did not always have risks safely managed. Risk assessments lacked information to help staff provide safe care.
● Some people had catheters with no plans in place to help staff provide safe catheter care or to identify risks such as the catheter being blocked. Some people's care plans did not identify they even had a catheter, but it was evident from daily notes, staff supported them with catheter care. This placed people at risk of receiving unsafe and unplanned care.

Using medicines safely
● The provider had failed to ensure people's medicines were safely managed. Some people's medicines were administered without the correct recording documentation in place. This included prescribed creams and pain relief. This placed people at risk of harm due to staff not having information or authority to administer these medicines.
● People's medicines were not administered as prescribed. Some people were prescribed time sensitive medicines and their medicine administration records (MARs) showed the administration times of their medicines varied greatly. Some people had been left waiting for their medicines due to staff being late for their care call. This placed people at risk of over dosing and under dosing which can impact significantly on their health conditions.
● Although staff were responsible for administering some people's medicines, risk assessments were not always completed to assess what level of support was required or how it should be monitored. This placed people at risk of harm.
● The provider failed to have regard for current national guidance for best practice, including the Health and Care Excellence (NICE) guidance for managing medicines in the community.

Preventing and controlling infection
● The provider had again not followed Government guidance in relation to staff testing of COVID-19. Current Government guidance requires staff to test a minimum of twice weekly using a lateral flow device (LFD) test kit.
● The provider could not evidence staff completed twice weekly testing and staff told us they did not test twice weekly. One staff member told us they tested once per month. Another staff member told us they tested once a week but had not been asked to let the provider know of their results, so they never had. Staff did not out the required twice weekly lateral flow tests to prevent the spread of infection. This placed people at risk of contracting COVID-19
● Some people told us staff did not always follow safe infection control practices. We spoke with eight staff about when they wore face masks and when they changed them. We found six of these staff did not change their mask in accordance with the current Government guidance. This placed people at risk of catching infections, such as COVID-19.

The provider had failed to ensure risks to people's health and safety were managed, which included the prevention and control of infection and the management of medicines. This is a continued breach of regulation 12(1) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection we invited the provider to update us on how they were assured of safe practice. They

told us their staff were, "Fully trained in the administration of medicines. If there are any medication errors, then it is followed up with the correct procedures such as supervisions, spot checks and relevant training. All information required for PRN is updated for the staff to be fully informed." They also told us they had reminded all staff to check and record people's skin integrity. The provider also told us, "All procedures and measures put in place are to keep service users safe." However, our findings did not reflect this.

Staffing and recruitment
At our last inspection the provider had failed to ensure they had enough staff to safely support people. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider had failed to ensure suitable staff were deployed to cover the routine work of the service and provide consistency of care to all people. Staff did not always stay for the duration of agreed care calls.
● We received mixed feedback from people when we asked them about staffing levels. People told us their daytime care calls, Monday to Friday were good with them mostly seeing the same staff at the same time. However, people told us outside of these times they received care from different care staff who were often late and did not stay for the full duration of the care call.
● People told us there were not enough staff to manage the call times safely and effectively. One person told us, "There have been times when the 8pm call is at 11pm, this is far too late." One person's relative told us their family member would start to complete their own care when staff were late which left them at risk of falls. Another relative told us their family member needed routine due to their health condition and became anxious when staff were late.
● One relative told us their family member's care calls were being cut short. We sampled a selection of their calls from April to June 2022 and this was evidenced regularly, with no explanation as to why staff did not stay for the full duration of the care call. Other records we viewed showed people regularly received calls under their planned call duration. Some people received calls lasting just one, three or 13 minutes when they should have 30 minutes. There was no information to state why people did not receive their full amount of time.
● Staff told us there were insufficient numbers of staff to meet people's needs. One staff member told us, "They are taking on too many clients for the staff to cope." Another staff member said, "Call times are not consistent, it's dangerous."
● The provider's staff list, training matrix and LFD Testing spreadsheet did not give a clear picture of staff employed. We found staff who were recorded on the LFD testing spreadsheet but did not appear on the provider's staff list or training matrix. We were therefore not assured staff were safely recruited due to discrepancies with these staff lists.

We found no evidence people had been harmed however, the provider had failed to ensure staff provided care calls as expected. This is a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● We saw evidence of concerns raised by relatives which had been acted upon. One relative was concerned over staff not wearing appropriate PPE when they supported their family member. The provider had completed spot checks on the staff members to ensure they were wearing appropriate PPE.
● However, despite actions taken in response to incidents we were not assured the provider had learnt

lessons to ensure people continually received safe care. We could see specific and individual actions taken but these did not feed into the wider service to help identify themes for improvement.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff were suitably trained and competent to provide effective care. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● We received mixed feedback from people and relatives about the competence and effective skills of staff. People told us when they received care from regular staff, they were happy with their competence. However, when people received care from staff who did not know them well, they did not feel they received effective care. One relative told us they frequently had to tell staff how to provide their family member's care.
● The registered manager told us staff received training and their training matrix showed the dates staff had completed this training. However, some staff told us they had no recollection of completing this training.
● The provider had failed to ensure the training provided to staff gave them the skills and knowledge needed to give safe and effective care to people.
● During staff's induction to the service staff completed 22 care related topics in one day. The registered manager told us staff completed a workbook during this induction training however, retained knowledge was not tested and these workbooks had not always been reviewed. Not all staff we spoke with could recall their training or demonstrate an understanding of what they had learnt.
● Records showed staff also completed the Care Certificate on the same date. 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 is made up of the 15 minimum standards that should form part of a robust induction programme. Guidance is for staff to be supported to complete the care certificate over 12 weeks. However, the provider had recorded staff completed this in one day. Some staff told us they had no recollection of having completed this course.
● Some staff did not feel their training was in-depth enough to ensure they felt confident and competent to carry out their duties. One staff member told us there were too many questions for them to remember during their induction day.
● Some staff supported people with learning difficulties. From 1 July 2022, under the Health and Care Act 2022 providers must ensure staff receive training in how to interact appropriately with people with a learning disability and autism spectrum disorder, at a level appropriate to their role and have assessed

competencies following that training. We found not all staff who supported people with a learning disability had received appropriate training. The registered manager told us they were currently developing a training session for staff.

We found no evidence that people had been harmed however, the provider had failed to ensure staff were suitably trained and competent to provide effective care. This is a continued breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the provider told us Autism awareness training had been created for staff to complete.

After the inspection, the provider told us they were aware their training matrix showed an incorrect reflection of completion of the Care Certificate. They also told us they had made improvement to the way staff completed the Care Certificate.

● Some people were happy with the care they received and told us when they had regular care staff many were, "excellent". One person told us, "I like my regular carer, they go above and beyond. They are supportive and make me feel safe and secure. They support me with walking, and they make sure I am eating and drinking well."
● The area manager acknowledged staff supervision and observation of their practice had not been completed regularly but they were now getting back on track with these. This was reflected in staff we spoke with.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● The provider did not work within the principles of the MCA. Where people lacked capacity or needed support with making decisions, the provider had not ensured these were always shown to be in the person's best interest.
● One person lacked capacity to consent to their care. However, their care records stated their relative had agreed to their care and was to be consulted to make decisions on the persons behalf. Best interest decisions had not been made and the management team did not know whether or not the relative had the lasting power of attorney (LPA) they needed to make care decisions. This lack of knowledge of the MCA placed people at risk of being unlawfully restricted.

We found no evidence that people had been harmed however, the provider had failed to ensure the principles of the MCA were followed. This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's protected characteristics, as identified in the Equality Act 2010 were not always outlined in their care plans. This included gender, age, culture, religion, ethnicity and disability.

● People's needs were assessed. However, due to poor records of daily support and practice there was little evidence of whether these choices were actively promoted.

● One relative told us staff did not document what they had done during the care call. The only record was a tick list to show staff had completed a task. The relative told us, "Nothing has been proactive. It's been care with a box ticking solution."

● National guidance was not implemented to ensure people's support was following best practice. This included the support of people with Parkinson's Disease and the campaign and guidance to ensure they received their medicine, "On time, every time". Also, guidance produced by the National Institute for Health and Care Excellence (NICE) for supporting people with Learning Disabilities as they grow older.

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

● Staff prepared food and drink for people when an agreed part of their care needs. We received mixed feedback from people and their families about the support they received with this. Some people were happy with the support they received, and some told us they felt staff needed more training and experience in this area.

● One person told us staff made them a cup of tea and toast in the mornings, but as soon as they left they made their own. They said, "Sometimes a cold tea and badly cooked toast." However, other people we spoke with were happy with the support they received with food and drink. One relative told us they felt staff would support their family member if they had not eaten.

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

● The provider told us concerns for people's welfare had been raised with other agencies but could not always show us any evidence of this. However, we did see occasions where staff had liaised with other health professionals such as GP, district nurse teams and social workers to support people's 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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure sufficient oversight of the quality and safety of care. This was a breach of regulation 17(1) (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17(1).

Continuous learning and improving care; Working in partnership with others

- Following our previous inspection in July 2022, we placed a condition on the provider's registration to send us a monthly report. This report was to summarise the outcome of monthly reviews and audits including themes of what was found on these audits and their actions taken to improve and resolve concerns. At this inspection, although the provider had submitted these reports, we found they had not been effective in driving improvement throughout the service.
- The provider's monthly report for May 2022 had identified people received care calls short of the agreed call time duration. The provider could not show us evidence of actions taken to mitigate the risks of this continued practice of care calls being cut short by staff.
- The local authority who contracts care from the provider, had shared numerous concerns with the provider. They had also worked closely with the provider to help them identify and drive improvement. The provider had failed to respond to many of actions the local authority had asked them to complete. Most issues the local authority identified were the same as the issues we identified.
- Since the provider registered with us in 2015, we have inspected them nine times. On only one inspection have they been rated as good. The provider has failed to show any sustained improvement since their registration in how the service is run and has continued to provide a poor service to people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not promote a positive and open culture. We found people, relatives and staff had a lot of the same concerns as reported on in our previous inspection in July 2021. This included concerns about not being able to speak to an office staff member when telephoning the provider's office.
- Prior to this inspection, the provider had opened an office overseas in Bangladesh. Telephone calls made

to the provider's Stoke-on-Trent office were diverted to their office in Bangladesh. The registered manager had not informed people or relatives about this or considered the possible challenges this may pose.
● One person told us, "To speak to the (Stoke-on-Trent) office you have to ring Bangladesh. You can't speak to anyone who understands you." Another person said, "I can't ring the office anymore, as I can't get them to understand me." One relative told us, "To make any enquiry you have to go through a call centre type operation. When they answer they do not understand what you are saying."
● We queried if people and relatives were aware staff at the Bangladesh office had access to their personal and sensitive data. The registered manager told us no, they had not been informed.
● We were not given full information about the staff's responsibilities in the provider's new office in Bangladesh, which included the records they had access to and the audits they completed. Furthermore, staff used one staff member's password and log in details to gain access to the provider's electronic records systems. This meant staff accessing these records had no accountability for actions they had taken.
● We were not assured the provider safeguarded people's data in accordance with the Data Protect Act 1998 and their own data protection policy. The provider told us they had assured themselves they were acting in accordance with General Data Protection Regulation (GDPR) laws. We have shared our concerns with the Information Commissioners Office.
● The information we viewed as part of our inspection and received from the provider did not reflect what people, staff and records told us. This included staff testing for COVID-19 and staff training.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider's governance systems did not ensure safe care practices. Although audits were completed on people's care and records, they had not identified the concerns and errors we identified. Where a concern had been noted, there was not always an audit trail to show what actions had been taken to protect the person's health, safety and welfare.
● The provider had not identified their staff had administered and applied prescribed medicines with no direction or legal recording system in place as required. We also found staff who completed the medicine audits had amended administration records, so it showed people had received their medicine. Some of these records were amended over six weeks later. There was no audit trail or evidence of how the staff member knew the medicine had been administered. This failure to recognise the importance of legal records and accountability put people at risk of harm.
● The provider had not identified care records were partially completed and there was inconsistent information throughout people's care records. The provider had not identified a lack of guidance for staff when people had catheters. Also, that people's skin was not monitored as per their care plans.
● The provider's oversight of staff knowledge and competencies was insufficient to ensure staff were skilled and trained to carry out their roles.
● The provider had failed to ensure enough oversight of their own policies and current Government and best practice guidance to ensure their service protected people's health, safety and welfare at all times.
● The provider's monitoring of people's care calls had failed to ensure people received their care at the agreed time and that staff stayed for the designated amount of time. The registered manager told us they were aware staff did not always stay for the full duration of care calls. However, they could only show us one instance where they had taken any action with one staff member.

We found no evidence that people had been harmed however, the provider had failed to ensure they had protected people's health, safety and welfare through the service they provided. This is a continued breach of Regulation 17(1) (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of incidents they are required to.

● At our previous inspection, the provider had failed to notify us of safeguarding concerns they had reported to the local authority safeguarding team. Registered persons are required by law to submit statutory notifications. These ensure we are aware of important events and play a key role in our ongoing monitoring of services.

● At this inspection, we again found the registered persons had not submitted statutory notifications when required to and had not submitted them in a timely manner.

This is a continued breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

● People and their relatives told us their care calls were not always on time and they did not always know what staff were coming to provide their care which resulted in high levels of anxiety, dissatisfaction and frustration.

● Some people were confused about who the registered manager was and named different members of staff as they had more interaction with them.

● We received mixed feedback from people using the service, some people told us they had received surveys, others told us they did not feel engaged within the service.

● In their monthly report the provider told us they had completed telephone surveys with people in February 2022. However, the registered manager told us they could not provide us with evidence of these telephone calls having taken place.

● The registered manager told us they were in the process of completing a feedback survey with people and their relatives. They therefore did not have any analysis of feedback to show us.

● We found the provider did not always demonstrate sensitivity towards people. Staff asked a person over the telephone if they had a 'Do not resuscitate order' (DNACPR) in place. It was evident the person did not know what the staff member was talking about. This type of conversation should not happen over the telephone with a staff member the person has never met.

Following our inspection, the provider told us people were given a guide which outlined who the registered manager was. The provider told us, "There are other managers such as area managers and it is likely that service users and their family members, over time, have interpreted other members of management on who the registered managers are.

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 11 HSCA RA Regulations 2014 Need for consent You have failed to ensure the care and treatment of service users is only provided with the consent of the relevant person.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Your safeguarding systems had not been operated effectively to protect people from abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing You have failed to ensure staff were sufficiently competent and had received appropriate training and support to enable them to carry out their roles.