Forever Homecare Limited

Forever Homecare

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
Forever Homecare is a service providing care and support to people in their own home. At the time of the inspection the service was supporting 36 people, and we were told everyone received support with personal care. The service provided both regular daily visits to people receiving personal care and live-in staff members providing a 24-hour support service. The service supported people in Buckinghamshire and Berkshire.

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 were supported by a service that was not well managed or monitored. Audits were either not in place, or not effective to assess, monitor and drive improvement in the quality and safety of people's support. The provider had failed to ensure everyone using the service had received an assessment of their needs and we found some people did not have a care plan in place. We also found the service had failed to display their CQC rating at their office base and website. Effective systems were not in place to meet the requirements of the duty of candour and the service had failed to inform the Commission of some information they are required to.

A manager had been appointed following our last inspection. The manager had engaged with people and families, who indicated their experience of service management had improved. Comments from family members included, "Much better since January", "It's now on an even footing, things running smoothly" and "I haven't seen a difference in things good or bad. However [manager's name] is very nice, very nice." During the inspection the manager frequently visited people's homes to discuss concerns, however we found written records were often absent and the office space was disorganised.

We found risks to people using the service were not clearly identified and managed. People's care plans often contained outdated information or lacked sufficient detail to provide staff with enough information about how to safely manage risks. We also identified significant concerns in relation to the safe management of medicines, concerns regarding staff testing for COVID-19 and a lack of recording and oversight in relation to accidents and incidents.

The service identified required learning for staff and had sourced a new training provider, however training records showed significant gaps in training across the staff team. We identified several concerns in relation to the recruitment and deployment of staff. Since our last inspection staff rotas had been adjusted to consider travel time, and people and families indicated timekeeping had improved. People's comments included, "Pretty much on time. Let me know if they are going to be late", "95% of the time they are on time" and "They don't come on time, they are late."

Care plans did not always provide staff with details of people's likes, preferences or protected characteristics. Since our last inspection we found people were more likely to receive support from regular staff and this also considered people's cultural and language needs. People told us staff treated them with respect and communicated effectively. Feedback from families included, "They all speak Punjabi", "They know how to communicate with Dad" and "They know how to make a cup of tea the way she likes and when she wants." People described positive interactions with staff, with comments such as, "Very kind and respectful" and "The staff are all nice to me."

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.

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 4 March 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an announced focused inspection of this service on 25 January 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and 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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains inadequate. This is based on the findings at this inspection.

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

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 person-centred care, safe care and treatment, safeguarding from abuse, recruitment and staffing practices, good governance, duty of candour, assessing people's mental capacity to consent to care, display of CQC ratings, and in informing the Commission of information they are

required to.
Please see the action we have told the provider to take at the end of this report.

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 from 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.

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.

Forever Homecare

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 carried out by one inspector and two Experts by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. When a manager is registered with the Care Quality Commission, 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 unannounced.

Inspection activity started on 12 August 2021 and ended on 24 August 2021. We visited the office location on 12 August 2021, 13 August 2021 and 16 August 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from local authority professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with six people using the service, 17 family members and one friend of a person receiving support. We also spoke with nine members of staff, including six care and support workers, the care coordinator, manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also sought feedback from three further care and support workers by phone but received no replies.

We reviewed a range of records. This included 12 people's care and support plans, and eight people's medication records. We looked at 13 staff files in relation to recruitment, training and supervision, and records in relation to five agency staff. We reviewed a variety of records relating to management of the service including policies and procedures, a staff handbook, training and supervision matrixes and quality assurance surveys.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from five professionals and received written feedback from one professional during the inspection process.

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 inadequate. At this inspection this key question has remained the same.

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 implement effective systems to investigate and appropriately respond to allegations of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff handbook provided by the manager contained information about whistleblowing procedures but no information in relation to wider safeguarding of adults. Some staff had access to the service's safeguarding and whistleblowing policies. During our inspection two staff members told us they had not received these policies, and one stated they had searched online for two days to try to identify where they could raise concerns externally.
● Training records indicated most staff had received safeguarding training within the last two years, however training had expired for two staff and two staff were not included on training records. A further two new members of staff had not completed training, one of whom had completed shadowing and was working in the community.
● At our last inspection, feedback identified a potential omission of care following a person's hospital discharge in September 2020. We returned to review what internal investigation had taken place, and whether the service had identified any wider learning, such as how the service would monitor hospital admissions. The concern was not found within the service's safeguarding folder. The nominated individual advised, "Aside from the gaps showing on the care records there is no other record on the system." The nominated individual told us they had contacted the hospital and spoken to staff, but made no record of this. This meant there was no documented evidence systems had been reviewed to protect the person or others from similar omissions of care.
● We found no evidence a safeguarding concern had been responded to. An email was found in a filing cabinet dated April 2021 raising concerns regarding a person's living environment and alleged poor care. The manager explained there had been concerns of self-neglect. The manager believed the nominated individual had been dealing with the concern. The nominated individual advised they could not recall receiving the safeguarding concern in April 2021. This meant we could not evidence the service had responded to the allegations of neglect. The person was no longer using the service and therefore no longer at risk.
● During the inspection we received verbal feedback from the manager regarding allegations made against a member of staff of rough handling. The manager had received a call from Police, and believed the person's

family had informed the Police of their concerns. We received no written evidence during the inspection in relation to the manager's internal investigation, and information was not included within the service's safeguarding records folder.
● Safeguarding concerns had identified the need for manual handling refresher training. Online training was offered to staff. The service had not completed competency assessments to verify whether staff understood and could implement learning. This meant we could not be confident people had been protected from neglect from risks of poor manual handling, particularly as two members of staff expressed concern about their colleagues' ability to safely use moving and handling equipment. One staff member commented, "Staff don't know how to use hoist." Another staff member advised, "Staff coming say don't know how to use standing hoist…if I show them, not enough, need proper training."

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was 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.

● People told us they felt safe. People's comments included, "Yes, very safe. Wonderful carers" and "No worries. I feel very safe with them. They go the extra mile."

Assessing risk, safety monitoring and management

At our last inspection we found risks to people were not clearly identified and managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people were not clearly identified and managed. Risk assessments were either not present, had not been updated in a timely manner, or lacked sufficient detail to help staff understand and respond to risks.
● One person could not be left unsupervised with meals was prescribed thickener which is used to alter the consistency of fluids for people experiencing swallowing difficulties. The person's care plan had not been updated, stating "I do not have any swallowing difficulties. I enjoy normal diet and fluids and can eat independently." There was no evidence staff had been given written instructions regarding the correct amount of thickener to use. We viewed a message sent to staff which stated, "He is on thickening so please ensure to put some in his drinks". We were not satisfied the service had provided staff with sufficient guidance to provide safe care.
● At our last inspection, we identified one person was transferred using a hoist, however their care plan had not been updated and stated they refused to use the equipment. At this inspection a staff member explained the standing hoist had been replaced with a full body hoist since the last inspection, and was in use. We found the care plan had still not been updated and stated a hoist was "Not in use at present."
● Three people using the service were prescribed anti-coagulant medicines. These are blood thinning medicines and risks can include bleeding more easily than normal. When we asked the manager whether anyone was taking anti-coagulant medicines, they responded, "Don't think there is". We found this statement was incorrect, risks assessments were not in place, and staff demonstrated varying levels of awareness in relation to the potential risks associated with these medicines.
● One person received support from two staff commencing June 2021 due to concerns about a deterioration in mobility. We found there was no care plan in place. This meant there was no evidence a falls risk assessment or moving and handling risk assessment had been undertaken when double-handed care commenced.
● One person using the service had diabetes, and their regular carer told us they would check the person's

blood sugars "when not feeling well", roughly "every other day". The person's care plan did not refer to a diagnosis of diabetes or how this should be monitored or managed by staff. The nominated individual advised they were not made aware of the diagnosis. The staff team, including the regular carer, had not received training in relation to diabetes awareness and management.

● One person using the service had a diagnosis of epilepsy. The service's care plan contained no information regarding the type of seizures experienced, known triggers for seizures or how risks in relation to seizures should be managed. The care plan also failed to robustly consider how the risk of seizures may impact other daily activities, such as safety when showering or using the kitchen.

● One person living with dementia had received support until August 2021. It was described the person would refuse entry to staff, or would lock staff into the home, including the bathroom. We found the person's care plan had not been updated, which meant there was no information within the care plan to advise staff on how to respond to these incidents to ensure their safety and that of the person.

● One person's care plan stated they had one tooth and no dentures. Their care plan contained contradictory information about their food needs, including statements such as, "I am on normal fluid and soft fork mashable diet" and "I like tea and sandwich in the morning." Daily records showed the person was regularly given foods which required chewing. The provider could not explain why the person's diet had changed, or how risks had been assessed. We also asked the manager of the service how risks in relation to non-fork mashable food were managed but received no response.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found evidence safe medicine practices were not promoted and record keeping was inconsistent and at times incomplete. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines administration records (MARs) were disorganised, and it was unclear who was responsible for ensuring all medicines records were subject to necessary checks and audit monitoring. The manager advised this task had been given to the nominated individual as they had insufficient time. The nominated individual indicated both they and the manager should undertake audits, advising, "[Manager's name] expected to do some." On the day of our inspection, the manager commented, "MARs all over the place, not had a chance. Found some this morning in filing cabinet." The Inspector located MARs in an unlocked drawer and within a filing cabinet of mixed paperwork, and some MARs could not be located during the inspection.

● Staff competency to administer medicines had not been robustly assessed. During our inspection we located a single competency assessment for one member of staff. One member of staff expressed concern about the competency of colleagues to safely administer medication. The staff member described concerns about visiting people's homes and finding "tablets...around on the floor" and occasions when medicines administration records (MARs) had already been signed for the following day.

● Medicines audits were not effective and MAR records frequently contained gaps. We found only five medicines audits had been completed since January 2021. This meant medicines audits had not been effective in monitoring safe administration of medicines across the service and audits had not been effective in identifying the issues we found.

● We viewed the records for a person supported to take medicines in the morning and evening. In the absence of medicines audits, we crossed referenced several gaps in MAR records against electronic daily

records. This identified four dates between April 2021 and July 2021 where the person did not receive some medicines because stock had run out. The manager advised they were only informed once that medicines had run out. This meant insufficient action had been taken to investigate the missing signatures or prevent reoccurrence.

● We located a month's MAR record for one person using the service. The MAR was undated and staff could not determine which month the document related to, meaning missing signatures for three medicines could not be investigated. The manager confirmed the person received ongoing care and could not explain why only one month's medicines documentation was available, stating, "All paperwork should have come back in. Fact is, where [is it]?." A senior care worker visited the person's home but could not locate any further MARs.

● One person was prescribed two different creams. No signatures for either cream were found on MAR records between 1 April 2021 and 28 May 2021. Body maps were not in place to show where staff should apply cream. The manager telephoned a care worker who confirmed one cream was applied all over the person's body daily, and the second cream had been applied until around three weeks earlier. Two audits carried out by the manager on 4 May 2021 had failed to identify the concerns we found.

● Some people were prescribed medicines with specific instructions for safe administration. One person was prescribed Levothyroxine, which should be taken at least 30 minutes before breakfast or a drink containing caffeine. Records showed, and feedback from a regular staff member confirmed, all morning medicines were given with breakfast, usually around 9.00am. Staff also supported the person to take Lorazepam and staff applied two prescribed creams, however these medicines were not included on the MAR.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service's infection control policy was not supplied during the inspection. A policy was supplied after the inspection ended, however made no reference to COVID-19. The policy did not refer to the use of face masks or eye protection. This meant information in key areas such as personal protective equipment (PPE) was not in line with national best practice guidance.

● Training was inconsistent in relation to preventing infection. Training records showed staff had been offered training courses in relation to infection control, COVID-19 and use of PPE. Training records showed the three training courses had been completed inconsistently across the staff team, with nine staff having training gaps for the course entitled PPE (COVID-19) Essentials.

● Staff risk assessments in relation to COVID-19 were not supplied. At our last inspection we found some staff risk assessments in relation to COVID-19 were incomplete, and it was unclear how the information had been used to mitigate the risks for staff at greater risk. At this inspection we requested a copy of staff risk assessments but no information was supplied.

● Testing for COVID-19 remained inconsistent, and some staff were not regularly tested for COVID-19 infection. We observed a supply of test kits and some staff confirmed they were taking weekly tests. Records indicated one staff member had missed every weekly COVID-19 test from the start of April 2021 onwards. At the time of our inspection the staff member remained on the rota and was scheduled to work Saturday 14

August 2021 and Sunday 15 August 2021. Another staff member had been working for the service since October 2020 initially as an agency worker, and subsequently as an employee but had not received COVID-19 testing.
● People and families indicated staff use of PPE was sometimes variable. Some family members indicated PPE was worn, with comments including, "They wear masks, gloves and aprons", "Yes they wear PPE" and "The staff use PPE and will dispose of it in my outside bin." Some family members indicated PPE was not always worn appropriately, with comments such as, "Most of the time the staff wear PPE but some do not, so I phoned [manager's name] to say PPE was hit and miss" and "One or two don't wear masks."

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager of the service explained spot checks had helped address infection control concerns, providing an example of a staff member seen donning gloves and an apron before entering someone's home. The staff member had been asked to remove the PPE before entry. Team meeting records also showed staff had been reminded in relation to PPE and COVID-19 testing.
● Staff confirmed they had access to sufficient supplies of PPE. We observed a good stock of PPE at the office location and staff including a senior care worker helped to distribute PPE to other workers when required.

Learning lessons when things go wrong

At our last inspection we found systems were not established to promote learning from incidents to mitigate risks to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not protected from risks of avoidable harm as incidents and accidents were not always appropriately recorded, reported or followed up. We looked at the accident and incident records for the service. We found only two incidents had been logged during 2021. During our inspection, feedback from staff, review of records and information from a family member identified events which had not been logged as incidents or accidents. This included incidents such as falls and staff providing single handed support when two staff were required for safe moving and handling.
● There was no accident policy in place. We requested a copy of the service's policy in relation to accidents and incidents. The provider advised they could not locate the policy and stated they would contact their policy provider to address this. The provider confirmed there were no formal audit processes in place to identify wider learning from incidents across the service.
● We viewed records in relation to compliments and complaints. Information from January-March 2021 was stored within a complaints folder. Information relating to part of March, April and May 2021 was later located within a plastic wallet on a desk containing a mixed bundle of paperwork. Whilst the outcome of each complaint had been logged, there was no wider formal analysis of learning for the service, and complaints records weren't collated in one accessible location.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with were aware to call for medical assistance and inform the manager when incidents

such as falls occurred. One staff member described an incident where they had arrived to find a person on the floor, and immediately called for ambulance assistance, and remained with the person. One staff member advised they had not received a copy of the service's policy in relation to responding to incidents or accidents, advising, "Say an incident happens while I'm on my own, [I] don't know any procedures within the company."

Staffing and recruitment

At our last inspection systems were not in place for the safe recruitment of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Effective systems were not in place for the safe recruitment of staff. Some staff did not have a valid DBS or identification (ID), gaps in employment were not explored, references had not always been taken, and reasonable adjustments were not explored for staff with identified health conditions.
● One staff member had worked at the service since October 2020, initially as an agency worker, and became an employee in June 2021. The service had no staff file for the employee and confirmed the person supplied no proof of address or DBS certificate. In response to our concerns the staff member was removed from the rota.
● We viewed the records for a former staff member who had initially shadowed and then assisted with people's care. Systems showed the staff member attended 13 care visits between April 2021 and July 2021. The person's staff file showed no evidence of an interview record, training, references or a DBS certificate. The manager of the service explained a DBS application was "pulled as [staff] didn't stay".
● We viewed the records for a staff member whose employment had been terminated in March 2021 due to poor performance. The staff member had been re-hired in April 2021. There was no risk assessment in place, or a record of a supervision or spot check since employment recommenced. The manager advised, "[The service was] short staffed, didn't want to re-hire, bullied into it." The manager advised they had visited the staff member whilst they were working, although did not record this formally as a spot check.
● One staff member was exempt from wearing a mask due to a lung condition and wore cotton gloves under PPE due to their skin needs. There was no risk assessment in place regarding the staff member's health conditions to explain how risks to the staff member would be mitigated. When asked about the service's health questionnaire, the manager advised "[I] think she has returned it." The document could not be located with the staff file. The person's job application listed three current jobs, however there was no evidence their previous work history or gap in employment had been adequately explored.
● At our last inspection, we identified staff working without a DBS from their current employer. At this inspection we found there had been significant delays in obtaining DBS certificates and DBS risk assessments were not routinely in place. One staff member, employed since December 2020, had supplied a photo of a previous DBS certificate and the nominated individual confirmed the original document was not seen. Delays meant a new DBS certificate was not obtained until July 2021 and no DBS risk assessment had been in place.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from staff indicated travel time between visits had improved since the last CQC inspection, however some rotas still contained insufficient travel time. For example, a rota for 8 August 2021 showed a visit finishing at 8.00am and the next visit commencing at 8.00am. An online search indicated the postcodes

were a 30 minute drive apart.
● Concerns were raised regarding one staff member completing a night shift, followed by a further 24 hour shift for the same person on a weekly basis. The nominated individual suggested the person's night-time needs had "calmed down a bit" however the person's care plan stated, "He demands the toilet every hour or less prompting for his care routine to be split between two care workers covering day and night, as it was too much demand on one carer covering the day and the night-time needs." When presented with the concerns about the staffing arrangement, the nominated individual advised, "He's been able to manage that, family are happy with that, [staff name] doesn't complain about having to do that."
● During the inspection, evidence from records, and feedback from staff and a family member confirmed some double-handed care visits had been undertaken by one staff member. These incidents were not formally logged as accidents or incidents, and therefore it was unclear whether robust action had been taken. A family member commented, "Sometimes one carer instead of two. They can cope with using the hoist. I do worry about them."
● During our inspection the manager and nominated individual advised due to staffing pressures they were required to cover care duties in the community. We were not satisfied this enabled the manager to fulfil their other responsibilities, as a number of care plans required updating or creating. Following our inspection the service asked the local authority to find alternative care providers for some people. The manager advised this had made it easier to ensure staff cover.

The service had failed to ensure there were sufficient numbers of suitably qualified staff to be deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager advised they had tried to improve rotas to ensure staff were given travel time, advising, "[I] do look at rotas daily…sometimes can't see any other way…I do know ones [visits] time specific for medication…make sure factored in." Staff were given a 15 minute leeway for arrival times.
● Risks in relation to a previous criminal conviction had been considered before employment. One staff member had a criminal conviction relating to a driving offence. A DBS risk assessment had been completed to evidence the decision to employ the member of staff.
● Systems were in place to monitor daily visits. The care coordinator reviewed the electronic system daily, which indicated when staff had logged in at each visit. A telephone call would be made to staff if any visits had not been logged, to confirm staff had attended. The care coordinator explained in their absence this task would be picked up by another manager to ensure the system was monitored daily.

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 the last focused inspection this key question was not rated. At this inspection this key question has now deteriorated to inadequate.

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

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

● We found four people did not have a care plan in place. This meant staff had either minimal or no written guidance to refer to in relation to people's assessed needs. One person had received care since October 2020 however there was no care needs assessment or care plan in place. Another person had also received care since October 2020 and their care plan had been reviewed at the last inspection. The manager could not locate either a paper or electronic copy of the care plan, and stated they didn't see the care plan when visiting the person's property. It appeared the care plan had been misplaced by the management of the service since the last inspection.

● Several people advised they either had no care plan, or had not seen their care plan. This meant people did not have information about how their needs had been assessed. A family member commented, "I have not seen a care plan, but the manager has written one, and will often say 'I will add it to the care plan'…The staff do not write anything while they are here, nothing is logged."

● One person had received care since July 2021. The manager had assessed the person's needs, however at the time of our inspection no care plan was in place, and staff referred to a description of daily tasks included within an electronic application. The care assessment identified a need for staff to ensure the person had taken their medicines, however this instruction had not been included in the written overview provided for staff.

● Care plans were not updated as people's assessed needs and choices changed. One person was receiving end of life care at the time of our inspection. This person's care plan had not been updated to reflect their changing needs or end of life care wishes. The person was receiving care in bed, however the care plan referred to them showering weekly, using a walking frame and using the toilet independently.

● At our last inspection we identified gaps in care records meant staff were not fully equipped to meet people's individual needs. Care plans frequently listed people's religion as "not to be mentioned" which appeared to be a standard approach as there was no indication religious or cultural needs had been explored. We found some care plans had not been updated and still included this standard phrase.

● Some care plans lacked sufficient detail to enable staff to meet people's needs. One person had received care since June 2020, however no care plan was in place until May 2021. The person used known signs and gestures to indicate basic needs, such as wanting a drink or the toilet. The care plan stated the person experienced "frustration and agitation when he is not able to express himself or when he feels he is being misunderstood." The care plan did not include a description of the specific signs or gestures used. A regular staff member explained staff covering had found it "very difficult", explaining, "If he want cup of tea, carer doesn't understand, tell them a time, this time serve him tea." The staff member explained they had to

suggest when to give drinks, as other staff could not understand if the person asked for a drink.

People's needs were not always assessed, and where assessments or care reviews had taken place, there was a delay in producing or updating care plans to ensure people received person-centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People received support from staff who could speak their first language and engaged with people about their needs and interests. A family member advised, "I do think they are safe because the staff can speak the language and I am always around and can see their compassionate work." A person using the service also commented, "I am pleased the staff are interested in my knitting and speak to me about everyday things that matter." This meant whilst care plans lacked detail, staff had developed experience of people's needs.

Staff support: induction, training, skills and experience
● Training records showed incomplete or expired training in several key areas of learning. We found some staff had not undertaken training in relation to first aid skills, fire safety awareness, equality and diversity, oral health care, GDPR data protection, skin integrity, health and safety, and the control of substances hazardous to health (COSHH).
● Policies in relation to the induction, training, appraisal, supervision and monitoring of staff were requested but not received during the inspection process. A supervision policy reviewed at the previous inspection in January 2021 indicated the service specified a minimum supervision frequency of three monthly.
● No staff supervisions had taken place between January 2021 and March 2021. Supervisions had been carried out inconsistently across the staff team since the arrival of the manager in March 2021. Records showed between January 2021 and August 2021 four members of staff had received no supervision, and we also identified three staff who were working for the service but not included on the supervision matrix. We found no evidence yearly appraisals had been undertaken.
● Systems in place to monitor staff competency were ineffective. The manager and care coordinator advised spot checks had been undertaken. Following three days of on-site inspection and extensive searches through documentation, one medicines competency assessment and two spot checks were located for 2021. The two spot check forms indicated insufficient action had been taken to address concerns. One spot check identified several concerns, however the actions required contained a single word "Training" with no specific details of training required, or a target date for completion.
● Staff did not access training to gain awareness of people's specialist needs. One person had a diagnosis of epilepsy and a staff member regularly attended a 12 hour shift, however they had not completed epilepsy awareness training. Another staff member supported a person with diabetes, and regularly checked their blood sugar readings. Training records showed no staff had received diabetes awareness training.

Effective systems were not in place for the safe training of staff. Some staff had not received training, supervision, competency checks or appraisals. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our last inspection the provider had identified a new training provider and we observed a schedule of online training sessions which had been booked for July 2021. This had included refresher training for staff in relation to moving and handling, and safeguarding adults.
● Some people felt staff were trained to support them, although feedback was variable. Comments from family members included, "Some staff are better than others. It is basic training that they have", "They are trained to use the hoist" and "Some people are trained I think." Feedback from people using the service also varied, with comments including, "Yes they have the training to look after me" and "Training yes and no.

Some don't know how to make a bed. "

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 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.

● Several staff had not received training in relation to the Mental Capacity Act. Records showed training was in date for six staff, expired for three staff, and not completed by five staff. Figures on training records included two recent new starters, but did not include two other staff working for the service.
● The provider did not understand their responsibility to undertake mental capacity assessments, and had been involved in care assessments and reviews. The nominated individual advised by email, "I was not aware that as a care provider we had to complete MCA's, my understanding was that we can identify where capacity is questionable and refer to a [blank space]."
● MCAs had not been documented for some people experiencing an impairment of their mind or brain. One person had a diagnosis of dementia and was described as a Hindi speaker, who "can speak few words of English". There was no evidence a MCA or care needs assessment had been completed to formally ascertain whether the person could consent to the package of care in place. Another person had a learning disability and received 24 hour live-in support. The person was unable to communicate using speech and their care plan stated, "[Person's name] cannot make his wishes known due to his learning disorder". We found no MCA documentation to evidence whether the person had been able to understand and consent to their care.
● Where MCAs had taken place, there was a poor standard of documentation. One person was living with dementia, and had been assessed to lack mental capacity. The MCA was not decision specific. Under the heading "What is the exact decision to be made", the assessor had documented, "[Person's name] has been diagnosed with Dementia." MCA recording did not include best interests decisions following the mental capacity assessment, meaning there was no rationale as to how decisions had been reached in the person's best interests.
● People's care plans did not consistently identify whether a DNACPR was in place. DNACPR stands for do not attempt cardiopulmonary resuscitation and a DNACPR form is used where a decision has been reached that if the person's heart or breathing stop, cardiopulmonary resuscitation (CPR) should not be attempted. The absence of this information could lead to uncertainty for staff or paramedics should an emergency occur.

People's mental capacity assessments recording was not in line with the Mental Capacity Act 2005 Code of Practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and families confirmed staff sought consent as part of day to day support. A person using the service commented, "Yes they ask before washing my face". A second person commented, "They respect my choices." A family member also advised, "Yes ask consent when using hoist."

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

● Some people using the service required physical assistance to eat and drink, or assistance to prepare meals to a suitable consistency or texture to ensure food safely met their requirements. Training records identified a course entitled "Food (support eating and drinking)". Records showed eight staff had not completed the training and training had expired for a further three staff. Some staff we spoke with supported people who required physical assistance or supervision to eat and drink, but had not received training to enable them to undertake this safely.

● People's care plans did not provide detailed information about food likes, dislikes and preferences. Four people's care plans stated staff were required to prepare people's "favourite meals" without specifying what these were. Other care plans made very general references to food preferences, with statements such as "I like most of the food" and "All kinds of food".

● People told us they received support with meals and drinks when this was required. Comments from people included, "I hate microwave meals, so I start the meal and staff finish off", "Breakfast if I want it, and then a sandwich for lunch plus two more in case I am hungry in the afternoon" and "They know how I like my drinks." One family member expressed concern about staff awareness of food use-by dates, stating, "There is a safety issue, food not being used in date order. I raised with the carers, risky and wasteful."

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

● Staff understood their responsibility to report any changes or concerns to the manager to determine if liaison was required with another agency. An on-call system was in place to enable updates and outstanding tasks to be shared between the manager, care coordinator and nominated individual. The service also used a staff messaging group to share updates and important information.

● People had confidence staff would seek medical advice if they became unwell or needed healthcare support. People's comments included, "Staff would get me an ambulance if I needed one", "They would contact the GP if they needed to" and "If I needed help I am sure they would, but I don't."

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 inadequate. At this inspection this key question has remained the same.

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

At our last inspection management systems were not in place to promote high quality, person centred care. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

● At our last inspection we identified concerns regarding disempowering language used within care plans. At this inspection we found further examples of similar language. One person's care plan advised staff, "I can follow the verbal command of the staff and can assist intermittently during personal care." Some care plans described people as making demands when asking for assistance with essential tasks. One person's care plan stated, "[Person's name] declines to open her bowel or pass urine into her pads, she demands that she uses the commode anytime she has the need." Another person's care plan stated, "[Person's name] has no incontinence needs and demands to use the toilet as much as every hour. He declines to wear a pad." The language used was disrespectful for people who experienced a sense of urgency to use the toilet.
● Our previous inspection identified concerns regarding staff culture. The manager indicated pay may be a factor in being able to recruit suitable staff, commenting, "[I'm] trying to get [nominated individual] to put wages up, not getting good staff." The manager indicated some staff lacked a caring attitude, advising, "A lot of carers inherited, just want to do work, have money and go, some caring and do care. Think at the moment a lot of the culture has changed, are starting to be more caring and reporting."
● The manager advised everyone's care had been reviewed by either the manager, care coordinator or nominated individual since January 2021. The manager advised around 11 of 38 reviews had been typed up. This meant a significant proportion of care plans had not been updated. We were advised any important updates had been shared with staff either by conversations or instant messaging, however this meant people did not have an up to date care plan to refer to in their own home. Some care plans either lacked sufficient detail or contained out of date information, meaning staff could not refer to an accurate care plan outlining the person's needs.
● We identified concerns people and families were given misleading information about the service. The manager wore a badge with the title 'Registered Manager' although their registration had not been authorised by CQC at the time of the inspection. The service's website provided misleading information,

including the statement "Our carers pursue NVQ's as extra skills to build up their abilities". During the inspection we found no evidence of NVQ training and we heard staff had been given but not returned booklets for the Care Certificate.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and families found the manager open and honest, and told us there had been an improvement in the communication and response from management. People's comments included, "Yes, it's improved. More helpful", "The manager is very approachable person but I don't know others in the office" and "Yes I know the manager…it has improved over the past 2 or 3 weeks since [manager's name] came." Some family members felt changes had not occurred, with comments including, "I have noticed no changes" and "No improvements in time keeping."
● People told us they were treated with respect by staff. People were satisfied the service tried to meet their cultural needs in relation to preferred staff gender and by matching staff who could speak their first language. Comments from family members included, "Majority of the carers speak Punjabi", "Dad laughs with the carers" and "They define kindness and are respectful."
● Staff we spoke with provided positive feedback regarding the manager's impact since their arrival in March 2021. A staff member commented, "She's so lovely…can speak to her about anything." A second staff member advised, "Things have changed compared to the last time you talked to me…new manager is good, [manager's name] changed a lot of things…rota, travel time for carers, before [had] no travel time."

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

At our last inspection we found people did not receive care from a service which was effectively monitored and managed. Systems were not in place to identify learning or required improvements in the quality of care people received. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was no registered manager in post. The previous registered manager left 3 October 2018. A manager had been recruited in March 2021 however during our inspection the manager indicated their intention to leave the service.
● We asked the service to provide their policy in relation to quality monitoring and governance of the service. This was not supplied during our inspection, and was supplied after the inspection concluded. The policy did not clearly identify which aspects of the service should be subject to auditing or quality monitoring, stating audits should follow the regulations monitored by CQC.
● Systems to monitor the quality of the service were absent or ineffective and had not identified the issues we found. We found no documented evidence the service had considered wider themes or learning from complaints, safeguarding concerns or accidents and incidents. The manager advised verbally the main theme of complaints had been human error, advising, "All got improved with communication… communicating back out to field."
● Minimal auditing had taken place. The manager and nominated individual confirmed with the exception of medicines audits, no other internal auditing took place to monitor the quality of the service. The manager explained the nominated individual informally monitored the timeliness of visits when processing staff wages. A senior care worker advised they had been asked to attend addresses and wait in their car to see if staff spent the full visit time with people, and challenged staff if they left early. It was unclear how this

information had been used by the provider to improve the service as these visits were not referenced as part of a quality monitoring strategy.
● We were advised a recent external audit, in the form of a mock CQC inspection, had taken place. No evidence of this work was provided during or following the inspection.
● There were concerns about a former manager's access to confidential information. The manager left the service in January 2021 however the current manager advised their access to confidential computer systems had only been removed in "May time". Concerns were raised the former employee may have retained a key for the office and the manager explained they were trying to get the locks changed. We observed information was left insecure throughout our inspection, including medicine records stored within unlocked desk drawers, invoices and a folder of staff information left on a desk.
● The office environment presented as disorganised and chaotic. This was acknowledged by the manager who commented, "One of biggest downfalls trying to catch up with work, not even time to do it, time management isn't it." The Inspector spent considerable time on-site with the manager and care coordinator trying to locate documentation to support the inspection process. A large filing cabinet with a drawer for staff files was found to contain a mixture of paperwork. For example, the staff file for one individual contained supervision records for two other staff. Records including details of safeguarding concerns and complaints were left unfiled amongst staff records. Medicine records were spread between drawers of a filing cabinet and a desk drawer.

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop their approach and stated they planned to recruit a quality assurance officer to review medicines records and lead on auditing of the service. The provider also planned to contact the landlord to ask for the office door lock to be changed.

At our last inspection systems were not in place to make the required notification to CQC in relation to the service's statement of purpose. This was a breach of Regulation 12 (Care Quality Commission Registration Regulations 2009).

● Following our last inspection in January 2021, a retrospective notification was not submitted in relation to the statement of purpose dated 2020.
● The provider supplied a copy of the current statement of purpose, updated during 2021 to include details of the current manager. This had not been shared with CQC and the provider was not aware of the requirement to do so.

Systems were not in place to make the required notification to CQC in accordance with requirements. This was a continued breach of Regulation 12 (Care Quality Commission Registration Regulations 2009).

● Care providers are required to display their CQC rating at their premises and on websites no later than 21 calendar days after the rating is published on the CQC website. At the time of our inspection the service's inadequate rating was not displayed at the office location. The rating was published 4 March 2021.
● The service's website displayed misleading information regarding the CQC rating. The website referred to the rating of requires improvement and described the company as "CQC compliant". At our last inspection in January 2021 the service was rated inadequate and was found to be non-compliant and in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two regulations of the Care Quality Commission (Registration) Regulations 2009.

The provider had failed to display their rating at the location which delivered the regulated service and on their website. This was a breach of Regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service agreed to display their rating at the office location and printed a temporary sign during our site visit. The service's website was taken offline several days after concerns were brought to the provider's attention.

At our last inspection systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

● Since our last inspection, notifications in relation to safeguarding concerns had been submitted to CQC in accordance with requirements. During our inspection we identified one safeguarding concern which had not been shared with CQC, however we were satisfied other concerns had been appropriately reported.
● We were advised notifications were submitted to CQC by either the nominated individual or the manager, dependent on who had received the concern. This meant there was not one person responsible for ensuring all notifications were submitted to CQC in accordance with requirements. The manager indicated whichever manager received the concern would make the statutory notification, commenting, "If reported to me I would do it."

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

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

At our last inspection the service had failed to effectively seek and act on feedback from relevant persons, including staff and people using the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection the service had received a low response rate from quality assurance questionnaires, and had failed to document an analysis of the findings or consider reasons for the low survey uptake. The service distributed a further questionnaire and received a response from only seven of 38 recipients. The manager advised any specific concerns raised had been followed up, however there was no written analysis of the results to identify any wider themes or learning for the service.
● The service had limited links with the local community, and no formal systems were in place to gather feedback from professional stakeholders.
● One member of staff described their experiences of raising concerns and explained they had not felt supported or protected. They advised, "Felt like getting little support [from manager]". The staff member commented, "I feel my voice is ignored."

During this inspection we found sufficient improvements had not been made and there was still a breach of the regulation. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had introduced an employee of the month initiative to build staff engagement. The service had also appointed a senior care worker who had additional responsibilities and was encouraged to provide feedback to the management of the service.

● Staff team meetings had been held in March, May and June 2021 which provided an opportunity for staff to receive updates and give feedback.

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

At our last inspection we recommended the provider referred to current guidance to develop and implement a policy in relation to the duty of candour. The provider had not made enough progress and we identified additional concerns.

● Duty of candour requirements were not met. We asked the manager if any incidents had taken place requiring a formal duty of candour response since they commenced employment in March 2021. The manager stated there had been no incidents, however we were aware of a serious incident in June 2021 which met the definition of a notifiable safety incident. The manager explained the only written correspondence shared with the person's family had been an email expressing condolences. The duty of candour regulation required the service to provide written information including a true account of what happened, an apology and an update on any enquiries.
● Several staff had not received training in relation to the duty of candour. The service's training records showed training had been completed by four staff. Records showed a total of ten staff, including two new starters, had not completed duty of candour training.

Effective systems were not in place to ensure applicable incidents were identified and an appropriate response made. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A duty of candour policy was in place. The policy outlined actions which should be undertaken "as soon as reasonably practicable" following the identification of a notifiable safety incident requiring a formal duty of candour process.
● The manager of the service was aware of their duty to be open and transparent with people and families using the service. They described their approach, advising of the importance of, "Being transparent, making sure people aware of what's going on, [I'm] always transparent."

Working in partnership with others
● The service worked in partnership with a local authority who commissioned care and support for people. A professional provided feedback regarding difficulties liaising with the management of the service, explaining, "The family is not happy with the documentation, communication, and general coordination as Forever Homecare is unable to provide a well-defined care plan for this user…The care documents are not up-to-date, and despite reminders, the care provider is unable to resolve the issue."
● The manager of the service told us they worked closely in partnership with other professionals, including social workers, occupational therapists and a pharmacist. We asked the manager of the service verbally and in writing to provide evidence to demonstrate how they worked effectively with others. Limited evidence was supplied during the inspection process.
● Feedback from people and families indicated some partnership working was taking place, although feedback was variable. A person using the service commented, "[They do] not work alongside other professionals." Comments from family members included, "They would contact GP or social worker", "Not really work alongside" and "They work alongside the social worker." This meant we could not be assured the service consistently worked well in partnership with other professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had failed to submit the required notification to CQC after updating the company Statement of Purpose.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity assessments recording was not in line with the MCA Code of Practice – assessments were recorded in non-decision specific language, best interests decisions were not recorded, and some MCA assessments had not been completed.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Effective systems were not in place to ensure applicable incidents were identified and an appropriate response made.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display their rating at the location which delivered the regulated service and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always assessed, and where assessments or care reviews had taken place, there was a delay in producing or updating care plans to ensure people received person-centred care.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed, and systems were not established to promote learning from incidents to mitigate risks to people. Records did not evidence safe medicines administration had consistently taken place.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not effective in identifying or responding to safeguarding concerns. Where safeguarding concerns had been brought to the service's attention, insufficient action was taken to prevent reoccurrence.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People did not receive care from a service which was effectively monitored and managed. Systems were not in place to identify learning or required improvements in the quality of care people received.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Effective systems were not in place for the safe recruitment of staff. Some staff did not have a valid DBS or ID, gaps in employment were not explored, references had not always been taken, and reasonable adjustments were not explored for staff with identified health conditions.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective systems were not in place for the safe training of staff. Some staff had not received training, supervision, competency checks or appraisals.

The enforcement action we took:

We have proceeded with enforcement action to cancel the provider's registration.