Servicescale Limited

inTouch Home Care

Inspection report

Sutherland House
Matlock Road
Coventry
West Midlands
CV1 4JQ

Tel: 02476012130
Website: www.intouchhomecare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
InTouch Home Care is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 68 people with personal care at the time of our inspection.

People's experience of using this service and what we found
The provider had not learned lessons since our last inspection and their governance systems to monitor the service remained inadequate. In addition, the quality and safety of the service had deteriorated further over the last 14 months which demonstrated the provider was unable to make and sustain improvements. Information we received from the management team following our inspection visits informed us action was being taken to make improvements.

The provider's systems to keep people safe were ineffective. We found action had not always been taken to protect people from the risk of ongoing abuse. The provider told us they planned to strengthen their safeguarding systems to improve safety. People did not always know their care workers which made them feel unsafe. Staff had completed safeguarding training and described the types of abuse people could experience.

The information staff needed to help them manage some risks and provide safe care was not always in place. Auditing processes had not identified when risks associated with people's care had not been assessed. Action was taken in response to our feedback to drive forward improvement in this area.

The management of medicines was not safe, and the unsafe administration of medicines had placed people at risk of significant harm. Action had not always been taken to mitigate known medicine management associated risks and prevent reoccurrence. The provider was not working in line with their medicines policy or national medicines guidance and their audits of medicines were not effective. Some action was taken following our inspection to improve medicines safety. Staff had completed COVID-19 testing in line with national guidance, but individual risks to people and staff who were at increased risk from Coronavirus had not been assessed.

Staff were recruited safely, and the provider was open and honest about their challenges in relation to the recruitment and retention of staff. Prior to our inspection they had been unable to provide safe care to people due to low staffing levels. At the time of our inspection people had received their planned care, but people and their relatives were dissatisfied because their care was not always provided on time. In addition, care was not always provided by staff people knew and trusted.

An open culture was not embedded at the service. Complaints continued not been managed in accordance with the provider's policy and people and their relatives did not always feel well treated and listened to. Staff provided mixed feedback when we asked them if they felt valued and listened to by their managers. The management team were open and honest during the inspection and recognised good outcomes for people

had not always been achieved.

Staff continued not to receive all of the training they needed to carry out their roles and meet people's specific needs. Feedback gathered demonstrated how the lack of training impacted negatively on people's lives. Checks to ensure staff were competent and skilled to carry out their roles did not always take place. Responsive action took place following our inspection to start to address this. Staff told us the induction they had completed when they had started work at the service had helped then understand how to support people.

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.

People's dietary requirements and preferences were documented and overall, positive feedback was provided about the support people received to eat and drink. When required, referrals had been made to health professionals such as district nurses to access the support people needed to remain healthy and well.

Whilst assessments of people's needs had been completed before they started using the service, care and support was not personalised. Some people felt respected whilst others did not. Staff told us how they supported people to remain independent, but people's dignity was not always maintained.

More information needed to be added to some care records to help staff provide care in line with people's wishes. Care records contained some information to help staff understand how people preferred to communicate and information about the service was available to people in a variety of formats including large text.

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

The last rating for this service was requires improvement (published 19 October 2020). At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and was also prompted due to the provider informing us they could not provide safe care to people.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

We have identified breaches in relation to providing safe care and treatment, staffing, consent, dignity and respect, person centred care, complaints and governance at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work alongside the provider and local authority to monitor actions taken to address the concerns we identified.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 caring?

Inadequate

The service was not always caring.

Details are in our caring findings below

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

inTouch Home Care

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 completed by five inspectors, one assistant inspector and an Expert by Experience. Calls to people and their relatives were carried out by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors visited the provider's offices and two inspectors, and an assistant inspector gathered feedback from staff via the telephone.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of the inspection there were 68 people using the service.

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

The service did not have a manager registered with the Care Quality Commission. This means the Provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the manager 24 hours' notice of our first inspection visit. This was because we needed to be sure that they would be in the office to support the inspection. Our second inspection visit was unannounced. Inspection activity started on 27 October 2021 and ended on 05 November 2021. We visited the office location on 27 October 2021 and 04 November 2021.

What we did before the inspection
We reviewed the information we had received about the service since our last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also gathered feedback from the local authority who fund the care provided. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and six relatives. We spoke with 13 members of staff, including care workers, community assessors, the manager, the head of quality and compliance and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, including seven people's care records and the recruitment records for three staff. We looked at records in relation to staff training, safeguarding, complaints and the management of the service including quality audits and checks and a range of the provider's policies and procedures.

After the inspection
We spoke with the nominated individual and received information from the management team to validate the evidence we found. We also shared our inspection findings with the local authority.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

At our last inspection we found the risk associated with people's care was not well-managed and the providers systems and process to safeguard people from harm were ineffective. This was a breach of Regulation 12 (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 remains in breach of Regulation 12.

● Previously, safeguarding systems had not been effective to mitigate risks to people. At this inspection the concerns remained. Several allegations of abuse had not been investigated, and action to protect people from the risk of ongoing abuse had not been taken. For example, a relative told us about an incident that had happened in August 2021 which had put their relative's eyesight at significant risk. The manager confirmed action to investigate and mitigate the risk had not been taken at the time of our inspection.
● Previously, risk assessments lacked information to help staff provide safe care. At this inspection not enough improvement had been made. One person had a urinary catheter and a risk assessment was not in place to help staff provide safe catheter care or to identify risks such as the catheter being blocked which placed the person at risk. A risk assessment was completed on our request and was shared with staff following our first inspection visit.
● The providers systems did not identify when risks associated with people's known health conditions and support needs had not been assessed. This exposed people to the risk of receiving inappropriate care as information used by staff did not accurately reflect people's current needs.

We found no evidence that people had been harmed however staff did not always have the information they needed to provide safe care and the providers systems and processes to safeguard people from harm were ineffective. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people's risk assessments contained the information staff needed to safely manage identified risks including risk associated with eating and drinking and health conditions such as diabetes.
● Following our second inspection visit, the provider sent us an action plan which informed us they were implementing a new system in an attempt to ensure their processes protected people from the risk of abuse.

● We received mixed feedback when we asked people if they felt safe with their staff. Some people felt unsafe because they did not always know the staff who completed their calls.
● Staff had completed safeguarding training and described the types of abuse people could experience. One staff member said, "Abuse is any kind of situation that would compromise the safety or the wellbeing of the individual such as financial abuse. We are trained to report it to the office immediately and discuss concerns."

Using medicines safely
● At our last inspection the management team had assured us the safety of medicines management would be improved. We found that had not happened.
● The management of people's medicines was not safe. Between May and September 2021 staff had failed to administer people's medicines safely on three occasions and as a result people had been put at risk of significant harm. The manager was aware of the unsafe practice but had not taken any action following two of the incidents to mitigate risk and staff responsible for the poor practice had continued to administer people's medicines without receiving further training or checks of their practice.
● The provider was not working in line with their own medicines policy or national medicines guidance. Guidance to inform staff when 'as required' medicines needed to be given was not in place at the time of our first inspection visit. That meant people could be given too much or not enough of their medicines.
● Information staff needed to administer people's medicines was not always in place in line with national medicines guidance. One person's medicines assessment advised staff to administer medicines contained only within their blister pack. (Blister packs are dispensed by pharmacies with pre-prepared doses of medicines) However, staff had administered a range of medicines that were not in the blister pack including eye drops and creams that were not part of the persons agreed plan of care.
● The manager told us audits of people's medicines had not taken place in the few months prior to our inspection visit. Whilst audits were being reintroduced at the time of our inspection the provider could not demonstrate people had received their medicines as prescribed.

We found no evidence that people had been harmed however, the management of medicines were not safe. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information we received from the provider following our inspection visits demonstrated some reactive action had been taken to improve the safety of medicines. Protocols for 'as required' medicines had been written and medicines training and staff competency assessments had started to take place.

Preventing and controlling infection
● Individual COVID-19 risk assessments for people at increased risk from Coronavirus had not been completed to ensure risks associated with health conditions including asthma and COPD (Chronic Obstructive Pulmonary Disease) were assessed to ensure safe care was provided.
● The individual characteristics of staff including staff from Black, Asian and Ethnic Minority groups (BAME) had not been assessed to ensure staff were kept as safe as possible at work during the COVID-19 pandemic in line with national guidance. Following our visits action was being taken to address the shortfalls we had found.

We found no evidence that people had been harmed however, risks associated with prevention and control of infections had not been assessed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed COVID-19 testing in line with national guidance and staff confirmed they had completed infection prevention and control training which helped them to protect people from the risks of infection. One staff member commented, "We are trained. We wear masks, gloves and aprons; I make sure my hair is tied back. I make sure my nails are cut."

Staffing and recruitment

● The provider was honest about the challenges they faced in relation to staffing and recruitment. On 22 September 2021 they had notified us they were unable to provide safe care to people because they did not have enough staff to cover people's care calls.

● 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 dissatisfaction and frustration.

We found no evidence that people had been harmed however, sufficient numbers of staff were not deployed to meet the needs of people and keep them safe at all times. This was a breach of Regulation 18 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to the inspection we had discussed the recruitment challenges with the manager. They explained the actions they had taken and actions that were planned to overcome their challenges. This included requesting local authority commissioners re-allocate people's care packages to other providers.

● Records we viewed confirmed people had received their care but not always at the planned time. In response the manager told us, "We have been struggling, we have had to move staff around and office staff have been providing care. We know that has had an impact."

● We received mixed feedback from staff when we asked them about staffing levels. Comments included, "There is a bit of a shortage of carers at moment, but people get their care," And, "There are not enough staff. My rota changes daily. It means I have to go to a new person I don't know. I just have to figure it out."

● Staff were recruited safely. Safe recruitment procedures were followed to make sure staff were suitable to work with people who used the service.

Learning lessons when things go wrong

● Whist we acknowledge the challenges the provider has faced over the last 12 months our inspection findings demonstrate the provider has not learned lessons since our last inspection and the overall quality and safety of the service had deteriorated.

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 inspection in April 2019 this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- At our last inspection staff had not completed some of the training they needed to meet people's specific needs. We found the management team had failed to address this issue. Eight people had urinary catheters but the staff members caring for them had not completed the catheter care training they needed. One staff member said, "Quite a lot of my service users have catheters, but I've not had any training. I just copy other staff. We roll the person on the bed to wash them, and just watch out for the catheter."
- It was evident the lack of catheter care training impacted negatively on people. On 02 November 2021 a staff member had failed to correctly attach a night bag to a person's catheter. As a result, the person had slept in a urine-soaked bed and urine had leaked over the floor which had caused their relative to become very upset.
- Another person had a stoma bag. (A stoma bag is an external pouch that collects waste from the body following a surgical procedure). A staff member caring for the person told us, "I have changed the stoma bag (relative) showed me how to do it. I think I know what to do, but I haven't had training."
- The management team were aware staff had not completed all of the training they needed. They assured us during our first visit they would source the required training. However, when we returned eight days later that had not happened. Following our second inspection visit and at our request training was obtained and provided to staff.
- Some relatives lacked confidence in the ability of staff to provide effective care. One relative told us they frequently had to tell staff how to provide their relation's care. They commented, "I think they (staff) are poorly trained but some are better than others." People provided mixed views about the abilities of the staff who provided their care.
- The provider could not assure themselves their staff were competent and skilled to carry out their roles because a robust system to monitor and assess staff competency was not in place. Staff did not have regular opportunities to meet with their managers on an individual basis to support them to carry out their roles and reflect on their practice as outlined in the provider's policy. The manager had already identified this was an area requiring improvement and plans were in place to address this.

People were at risk because staff were not always suitably trained to carry out their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The induction staff completed when they had started working at the service reflected nationally recognised induction standards. Staff told us they had spent time with more experienced staff members to understand how to support people.

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

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● One person lacked capacity to consent to their care. However, their care records confirmed their relative had agreed to their care and had signed consent forms 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 agree to decisions, which indicated managers lacked knowledge and were not familiar with the principles associated with the Act.

We found no evidence that people had been harmed however, the provider was not working within the requirements of the Mental Capacity Act. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed training to help them work within the principles of the MCA and provided examples of how they upheld people's rights. One staff member said, "If I need to get someone ready for a shower, I would say, 'Is it okay if I assist you to remove your clothing or is it okay if I put cream on your leg'. I always ask people before I do anything."
● Assessments of people's needs had been completed before they started using the service.

Supporting people to eat and drink enough to maintain a balanced diet
● Overall, we received positive feedback when we asked people and their relatives about the support they received to eat and drink.
● People's dietary requirements and preferences were documented. Staff told us they read people's care plans to understand how they needed to support people to eat and drink.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records confirmed when needed staff had made referrals to health professionals such as district nurses to meet people's needs. In addition, the provider worked with other agencies such as the local authority.

Inadequate

Is the service caring?

Our findings

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

At the inspection in April 2019 this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Some people did not feel respected. One person said, "No respect. Whenever you phone the office and want to speak to someone, they rarely call back." In contrast another person thought staff were polite and had good manners.
- A relative explained on occasions staff members had spoken to each other in a language their relative did not understand whilst they provided their care. The relative felt that behaviour was disrespectful and unkind because it excluded their relative from the conversation. On another occasion staff had transferred their relative from their bed to into a chair using a hoist whilst they were wearing only an incontinence pad which had compromised their dignity.
- Relatives did not always feel their views were listened to. One relative explained they had requested a particular staff member did not provide care to their loved one. However, the staff member had been sent to their relatives' home because there was no other staff available to provide their care. The relative said, "I really don't think our views are taken on board." In contrast a person told us staff offered them daily choices which meant they felt involved and in control of their care.

People were not always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff provided examples of how they supported people to remain independent, including how they encouraged people to wash their hands and face.

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

- Feedback confirmed the provider's core value of excellence had not been achieved because some people and their relatives did not feel well treated and their care lacked consistency. Comments included, "They (staff) do seem kind natured, but some don't know what to do," And, "The regular staff who look after me are fine but when they are off there is no organisation of my complex care. I dread my regular carers going off and the office staff are not very helpful when it comes to sorting things out for me."
- Other people shared more positive experiences. A relative said, "Very happy with what [Person] is getting from the carers they do exactly what [Person] wants."
- We received mixed feedback when we asked staff if they would let the service care for their family members. Comments included, "No, I wouldn't feel I could trust all of the staff to look after my relatives because some carers rush in and rush out," And, "Yes. We try to give the service users the best support we

can. That's what I would want for my loved ones."

● The provider had not ensured people received their care and support in line with legislation and best practice guidance and had not supported staff to develop knowledge and skills to meet people's needs.

● Discussions with staff assured us they understood the importance of promoting equality and treating people equally.

Inadequate

Is the service responsive?

Our findings

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

At the inspection in April 2019 this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's neds.

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

- People did not receive timely responsive care and their experiences demonstrated their care and support was not personalised and did not always meet their needs.
- Relatives told us people's care calls were frequently late. One relative explained during September 2021 calls had been up to 90 minutes late and on one occasion there had been no staff available to get their relation out of bed for over two hours later than the agreed time. They commented, "[Person] was lying in a soiled pad all that time and was getting distressed. It was an appalling situation to be in and it was clear to me [Person] was not important. "
- People did not always receive care from staff they knew and trusted. One person said, "I can't cope with different carers all the time. It's potluck what carers you get at weekends." A relative commented, "At one point there was a different pair of carers every evening. Weekends and evenings were the worst."
- Another relative told us, "We are rarely given any warning if the staff are running late, we end up just sitting with [Person] wondering if and when someone was going to turn up."
- More information needed to be added to some care records to help staff provide personalised care to people in line with their wishes. For example, their life histories and cultural needs. This was important because staff provided care to people, they did not always know well.
- Reviews of people's care records had not always taken place in line with the providers timescales. This meant staff did not have the accurate, up to date information they needed to ensure people's needs were met. Plans were in place to drive forward improvement in this area.

The provider had failed to ensure people received appropriate person-centred care that met their needs. This was a breach of Regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Previously, we identified complaints about the service had not been managed in accordance with the provider's policy. This meant opportunities to identify where quality could have been improved had been missed. At this inspection improvements had been made and we found the same concerns.
- People and relatives told us their complaints were not always acted upon. One person said, "I have raised plenty of concerns, but they fall on deaf ears, no one listens. In August I rang the on-call phone to put in a complaint about a carer. From what I can gather nothing came of it." A relative commented, "We as a family have given up complaining, there is not point as things don't get any better for [person]."
- A complaint dated 01 October 2021 had not been investigated until we bought it to the attention of the

manager during our first visit over three weeks later. Following our inspection, the manager told us they were in the process resolving the complaint and they were keen to learn lessons to prevent reoccurrence.

We found no evidence that people had been harmed however the provider had failed to ensure complaints were investigated and responded to. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). AIS should be in place for prospective service users for who the standard printed information is not suitable. The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers

- Care records contained some information which helped staff understand people's communication needs for example, if they wore hearing aids.
- Information including information for people about the service was available in a variety of formats including large print text and audio tape.

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 this key question was rated as inadequate. At this inspection the rating 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.

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

At our last inspection the provider's poor governance meant people who used the service were at risk of avoidable harm. This was a breach of Regulation 17 (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 remains in breach of Regulation 17.

● Lessons had not been learned. Our inspection findings demonstrated the provider was unable to make and sustain improvements to benefit people. In September 2021 the provider had informed us they could not provide safe care to people. Similar failings had occurred in 2019 and again in 2020.
● The provider has a history of not meeting the regulations. Following our last inspection, we issued the provider with a warning notice because the quality and safety of the service had fallen below legal requirements. At this inspection we found the requirements detailed within the warning notice had not been complied with and some previously demonstrated standards had not been maintained. In addition, people's experiences and high levels of dissatisfaction confirmed the quality and safety of the service had deteriorated further.
● All three members of the management team told us their contractual commissioning obligations and ongoing recruitment challenges had been the main reason for the service's failings. The manager said, "People get their calls, but our compliance and governance has slipped as a result."
● Whilst we acknowledge the provider's challenges, their governance systems to monitor the quality and safety of the service remained inadequate. Systems had not identified the significant risks and shortfalls we found previously and at this inspection. For example, ineffective safeguarding systems and the failure to take action to improve safety following known incidents continued to expose people to avoidable harm and indicated poor practice was accepted by the management team.
● The provider had repeatedly failed to ensure their staff had received the training they needed to carry out their roles and provide safe care. This placed people at risk.
● The provider continued to fail to meet their responsibilities to work in line with the requirements of the Mental Capacity Act (2005).
● The provider had failed to identify they were not consistently following their own policies and national guidance, including the safe management and administration of medicines, complaints about the service

and COVID-19.
● The provider had failed to ensure accurate and up to date care records were maintained. This placed people at risk as staff did not have the important information, they needed to provide safe care.

Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team consisted of the manager, the head of quality and compliance and the nominated individual. The manager had applied to register with us.
● Following our inspection visits, we requested and received information which assured us some action was being taken to start improving the quality and safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● An open culture was not embedded at the service. People and their relatives did not always feel listened to and their complaints were not acted upon. Allegations of abuse had not always been investigated, and action had not been taken to protect people from the risk of ongoing abuse.
● People had some opportunities to provide feedback about the service they received. Between January and August 2021 records confirmed feedback gathered by the provider had been overall positive.
● Staff provided mixed feedback when we asked them if they felt valued and listened to by their managers. Comments included, "Recently everything has gone downhill. Communication with the office is poor but I think it will get better now," And, "I think the communication is good. Everyone in the office is approachable. Whenever, I have had concerns I have relayed it back to the office. I have been listened to."
● Whilst staff told us they did not have opportunity to attend meetings with their managers, newsletters and communication bulletins were sent to staff electronically which contained updates about the service and also thanked them for their hard work, commitment and dedication to the service.

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; Working in partnership with others
●The management team were open and honest during the inspection and recognised good outcomes for people had not always been achieved. The provider had sent letters to apologise to people and their relatives when things had gone wrong and when the quality of care had fallen below their expectations.
● The management team worked with other organisations including social workers and commissioners to improve outcomes for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received appropriate person-centred care that met their needs. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not working within the requirements of the Mental Capacity Act. Regulation 11(1)(2)(3)(4)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always responded to and investigated. Regulation 16(1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Staff did not always have the information they needed to provide safe care to service users. Systems and processes to safeguard people from harm were ineffective. The management of medicines was not safe. Risks associated with prevention and control of infections had not been assessed. Regulation 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

Notice of decision to cancel to registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

Notice of decision to cancel to registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Service users were at risk because staff were not always suitably trained to carry out their roles and sufficient numbers of staff were not deployed to meet the needs of people and keep them safe at all times. Regulation 18(1)(2)(a)

The enforcement action we took:

Notice of decision to cancel to registration