Care 24x Limited

Care 24x Limited

Inspection report

14 Lydia Road
Walmer
Deal
CT14 9JX

Tel: 03301744220
Website: www.Care24x-uk.co.uk

Date of inspection visit:
05 April 2022
22 April 2022

Date of publication:
18 May 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Care 24X Limited is a domiciliary care agency which provides personal care to people living in their own homes. At the time of the inspection 18 people were receiving personal care. Not everyone who used the service received personal care. The Care Quality Commission (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
Feedback from people and their relatives was mixed. Whilst in the main people were positive about the care staff, feedback about the management of the service was not positive. Comments included, "The carers are lovely, and I can't fault them", And, "We didn't have any induction, brochure, contact numbers. No one phoned. I had to look up on the website for a contact number for them."

The support provided to people continued not to be safe. People's needs were assessed. However, risk assessments were not in place for some risks. Other risk assessments lacked information to provide guidance to staff. We identified an incident which had not been investigated or reported to the local authority or CQC when it should have been. There was no effective system for learning lessons from incidents.

Medicines were not managed safely. For example, some information for 'as and when' medicines was not in place when it needed to be.

There was not enough staff suitably deployed. Staff did not always arrive on time. People and their relatives told us staff sometimes arrived early for evening calls and the records reflected this. Staff had no travel time between calls and left calls early. Staff were not always recruited safely to ensure they were safe to work with vulnerable people.

The provider continued to rely on staff training provided by staff's previous employment and had not checked this training was of a good standard. The provider didn't have sufficient oversight of what training staff had or had not done or when refresher training was due. Staff has not been trained in areas such catheter care and were providing this support.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not support this practice. Staff understood the Mental Capacity A and knew to offer people choices. However, the provider had not kept records to confirm where relatives had power of attorney.

Systems in place to monitor and improve the quality of the service were not effective. Audits had not always identified concerns. Where concerns had been identified action had not been taken to address the concern.

The provider was not able to demonstrate they had undertaken spot checks to assess staff performance or that all staff had had a recent supervision.

There was no evidence people and their relatives had been asked their views about the service. People and their relatives told us they did not know who the manager was and communication with management was poor.

Staff wore personal protective equipment, such as face masks, when they provided support to people. People were supported with meals and drinks where they needed this support. People were supported to access healthcare. The service worked in partnership with other services such as healthcare providers.

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 (29 December 2021). The service remains rated inadequate. This service has been rated inadequate for two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. And in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We also identified new breaches in regulations of regulation 13, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Why we inspected
We carried out an announced comprehensive inspection of this service on 25 June 2021 and 28 June 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 safe care and treatment, good governance and notifying CQC of incidents.

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.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has not changed from 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 Care 24X Limited 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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, providing safe care, the management of the service, protecting people from abuse, safe staff recruitment, and reporting significant events to CQC 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care 24x Limited

Detailed findings

Background to this inspection

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

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

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 05 April 2022 and ended on 22 April 2022. We visited the location's office on 22 April 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service. The provider was not asked to complete a Provider

Information Return (PIR) immediately prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, the manager and the care coordinator. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to do all that was reasonably practicable to assess the risks to the health and safety of service users and to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There continued to be a lack of guidance for staff about risks to people to ensure staff had the information they needed. At the last inspection there were variable standards of guidance for staff to follow about risks to people's health, as some information was missing or inconsistent. At this inspection we found the same concerns. For example, one person was cared for in bed. Staff were supporting the person to change their position to reduce the risk of pressure sores. However, there was no guidance to inform staff on how to identify concerns and what to do if there was a concern.
● One person had risks associated with their breathing and there was a lack of guidance for staff on safe practice. Staff told us they were checking the person's oxygen levels each morning. There was no evidence staff were trained to check oxygen levels. There was no information in the person's care plan in relation to what the oxygen level should be and what action to take if there were concerns. Staff told us the person had oxygen in their home which they could use if their oxygen was low. There was no guidance for staff on this, or evidence staff were trained to use home oxygen.
● Some risk assessments were missing important information. For example, one person's updated risk assessment was sent to us after the inspection. This indicated the person was at high risk from skin infection. here was no information for staff on what the signs of infection were to support staff to identify concerns. If staff did identify concerns, they were instructed to document any concerns or phone through to the office. There was a risk concerns would not be followed up quickly if they were left to wait until documentation was reviewed.
● There was a lack of guidance to ensure risks associated with people's bed rails were well managed. One person was cared for in bed and there were bed rails in place. There was guidance for staff on how to support the persons upper limbs from being trapped or injured by bed rails when moving them during personal care. However, there were no mitigations in place to reduce the risk of their lower limbs being caught on the rails or for times between being moved during personal care.
● There were no risk assessments about the risk of fire in relation to the use of emollients. Staff were not aware of the risk of fire from using these creams regularly.

The provider had continued to fail to do all that was reasonably practicable to assess the risks to the health

and safety of service users and to mitigate any such risks. 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 the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Medicines were not managed safely. At the last inspection we found some people needed as and when required (PRN) medicines and PRN guidance were not in place. PRN guidance includes information such as when the person might need the medicine, the maximum dosage that can be given, safe intervals between doses and what to do if the medicine did not have the expected effect. At this inspection we identified the same concerns and the provider could not evidence if these medicines were being used safely. For example, one person's care plan stated they took PRN medicines which are usually used for constipation and pain. There was no medicine administration records (MARs) or PRN protocols or any other records for these medicines.
● Most MARs were electronic, but one person had handwritten MARs. National guidance requires handwritten MARs to be countersigned to check they are correct, and this had not been done. The dose to be given was recorded but the strength of the medicine was not recorded to enable staff to check this before administration to ensure the medicine was the correct strength.
● There were no body maps or clear guidance for tell staff where to apply people's creams or cream charts to show these had been applied. This meant staff may not have administered these medicines when people needed them or in done so in a consistent way to ensure they were used effectively.
● At the last inspection we were not assured the provider had checked all staff had completed competency assessments to ensure staff were undertaking safe practices for medicines. At this inspection we found the provider lacked good oversight of medicine competency checks. During the inspection they were not able to confirm staff had had these checks. Having a lack of oversight meant there was a risk competency checks would not be redone when they were due. Following the inspection, we received evidence checks had taken place.

Medicines were not managed safely. This was a continued breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider had failed to do all that was reasonably practicable to assess the risks to the health and safety of service users and to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider did not have good oversight of incidences and accidents to ensure action was taken and lessons were learnt. At the last inspection the provider told us there had been no incidents or accidents. However, we identified a concern which should have been reported as an incident. At this inspection we

requested an up to date copy of the incident log, but staff could not find this. However, prior to the inspection on 01 April 2022 we had received a copy of the incident log in response to a concern we had raised with the provider. The incident we had identified relating to medicines was not on that log and the provider could not evidence action had been taken.

● The incident log had not included information on any learning that had taken place as a result of incidents. There were two incidents recorded on this log, both incidents were related to medicine errors and we identified concerns with the oversight of medicine competency checks and medicines training. There was no evidence incidents had been analysed for trends.

The provider had continued to fail to do all that was reasonably practicable to assess the risks to the health and safety of service users and to mitigate any such risks. This was a breach continued of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection we identified safeguarding as an area for improvement. This was because the provider had not recognised the failures in relation to administration of medicines and the management of risk represented potential abuse. At this inspection we identified further concerns.

● The provider continued not to recognise safeguarding concerns. One person was referred to the service for personal care and meal preparation in February 2022. The person's medicines were being administered by their family. There was no assessment setting out that staff were to administer medicine. The provider put a medicine administration record in place and staff were instructed to administer medicines, when they should not have done so. The provider neglected to understand this was not their role and this led to an over overdose of medicines on 4 days. The provider failed to recognise this was a safeguarding incident and act upon it as such.

● On 08 February 2022 the daily notes for the same person stated, 'We have given [them their] medication (fully taken).' There were no MARs in place to record medicine administration for this date and nothing in the care plan to indicate staff should have given the person their medicines on this day which meant there was a risk the person had not been given their medicines as prescribed.

● There was no incident record for these concerns. There was no record to evidence the incident had been reported to safeguarding. Whilst staff had stopped administering medicine to the person there was no evidence of an investigation to determine what had gone wrong and how to reduce the risk or a similar event re-occurring.

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

Staffing and recruitment

● Staff were not always recruited safely as the provider had not completed the checks required to do so. There was no information on employment history for one new member of staff. There was one reference in place for this member of staff. This was not sent from a company email address and there was no evidence any action had been taken to verify the reference was from the company as stated.

The provider had failed to ensure staff were recruited safely. This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other employment checks, such as right to work in the UK and a DBS had been completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on

the Police National Computer. The information helps employers make safer recruitment decisions.

● People's care visits were sometimes shorter than planned, meaning there was a risk some care tasks might not be undertaken. Staff were not allocated travel time to enable them to stay the full length of the visit and get to the next visit on time. For example, one person's visits were for planned 30 minutes. We looked at their visit record for a week in April and identified visits for 9 minutes, 13 minutes, 15 and 16 minutes. There was no explanation as to why these calls were so short. The care plan indicated staff were to apply creams to reduce the risk of pressure sored during these visits. There was no evidence this was being done which increased the risk of the person developing a pressure sore.
● Care visits were not always on time, so people knew when to expect their care and could be left waiting. For example, one person's morning call was scheduled for 9:30am. Staff were 50 minutes late and noted that the person was very wet. This increased the risk of the person developing issues with their skin from being in a wet pad.
● Feedback from people was mixed about visit times. One relative told us the visit times had been changed without them being informed or consulted. Comments from people and their relatives included "They tend to come early in the evening. Should be 9pm but often it's 7pm", "They arrive mostly on time but sometimes they are in a bit of a rush." And, "They aren't always on time. I think they are supposed to be with me for an hour but I'm not sure, but I don't feel rushed and they concentrate on me while they are here."

The provider had failed to deploy sufficient numbers of staff 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.

Preventing and controlling infection
● People and their relatives told us staff used appropriate personal protective equipment (PPE) when they came to visit them. Staff told us they had sufficient access to PPE.
● Staff told us they continued to test for Covid 19 prior to each call.
● The provider had a Covid-19 policy in place. However, these needed to be updated as they did not reflect the latest Government guidance. The policy included linked to Government guidance which had been withdrawn. However, we did not identify areas where this increased risk to people. This was an area for improvement.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure persons providing care or treatment to service users had the competence, skills and experience to do so safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last inspection we found the provider relied upon training provided by previous employers and delivered very limited training themselves. At this inspection we found the same concerns. The nominated individual told us staff had done training with previous employers. However, the provider had not assured themselves training provided by other services was of sufficient quality. Feedback from people and relatives on the quality of staff training was not always positive. Comments included, "I'm not sure how skilled they are, sometimes it seems to be learning on the go.", "The staff are not well trained, we have to show them how to do things", And, "It's the basic things like the hygiene in the kitchen. I leave messages for them, but carers should know."
● There was a risk staff training would not be kept up to date. The provider lacked oversight of staff training and could not evidence staff training was up to date for all staff during the inspection. There was no record of what training had been completed and no information on when refresher training was due for some staff. One member of staff sent us evidence they had completed training in a number of areas, whereas the provider's record showed only training in medicines management had been completed.
● One member of staff had been assessed as competent to administer medicines. However, there was no record of them having completed medicines training prior to the assessment of competency.
● Some staff told us they had not had any recent supervision to provide support them and monitor practice. During the inspection supervision records were not made available. The nominated individual told us new staff should have three probation supervisions in the first 12 weeks of employment. We found one new member of staff had been at the service for 11 weeks. No probation supervisions meetings or spot checks had been carried out to provide support and guidance to the person and assess performance.

The provider continued to fail to ensure persons providing care or treatment to service users had the competence, skills and experience to do so safely and that they were appropriately supported and supervised. This was a continued breach of Regulation 18 (Staffing) of the Health & Social Care Act 2008

(Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

● At the last inspection we found the provider had not always retained a copy of power of attorney orders to evidence these were in place and check the appointee had the right to make decisions on a person's behalf. At this inspection we found the same concern. The nominated individual told us one person's relative had power or attorney, however they could not evidence this was the case.

The provider had failed to maintain an accurate and complete record in respect of each service user. This was a continued breach of Regulation 17 (Good governance) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people lacked capacity to make decisions their capacity to consent to care had been assessed and decisions had been made following best interest practices.
●Staff understood the principles of the MCA 2005. Staff knew people with capacity had the right to make decisions they might consider to be unwise. Staff knew understood the importance of offering day to day people choices where people were not able to make larger decisions for themselves.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to receiving care, this included using some nationally recognised best practice tools. However, people's care plans did not always reflect their assessed needs as some risk assessments were not in place or needed more information. For example, where people had risks to skin integrity.
● Some relatives told us they were involved in planning people's care where appropriate. However, other relatives said they were not when they should have been. One relative told us, "We have never had my [relatives] care needs discussed."
The provider had failed to maintain an accurate and complete record in respect of each service user. The provider had continued to fail to seek from relevant persons and other persons on the services provided. This was a continued breach of Regulation 17 (Good governance) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Where people had needs relating to protected characteristics under the Equality Act 2010, which includes disability, culture and religion these needs had been identified and included in the care plan as required.

Supporting people to eat and drink enough to maintain a balanced diet
● Not everyone using the service needed support to eat and drink.

● Staff told us they offered people choices on for eating and drinking. One person said, "I know what I have in my fridge and freezer, and they always ask me what I would like to eat and drink". Another told us, "They help my [my relative] get their breakfast and make them a roll to put in the fridge for their tea."
● Where people were at risk from not eating and drinking there was information in their care plan for staff to encourage this. People were referred to the dietician where this was needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Most people did not need support from staff to access healthcare as they had family and friends to support them with this or were able to undertake this task themselves.
● Where people needed this support people and their relatives said they received it. For example, one relative said, "This week a carer phoned the doctors as my dad had a pressure sore, which was good". One person told us staff had identified they had a urine infection and let them know so they could seek medical assistance.
● People were referred to services, such as the GP, where this support was needed.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating for 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.

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

At our last inspection the provider had failed to establish effectively operated systems or processes to assess, monitor and improve the quality and safety of the services provided; or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and maintain securely an accurate, complete and contemporaneous records in respect of each service user. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service was rated inadequate at the last inspection. At this inspection we found the provider lacked the systems, processes and oversight they needed to improve the quality, effectiveness and safety of the service. The provider had been provided with support from commissioners to make improvements to the service following the last inspection. However, the provider had failed to make sufficient improvement and the service remained inadequate. Action had not been appropriately taken to meet the breaches in regulation and we found further breaches.
● At the last inspection we found auditing had been ineffective. At this inspection we identified the same concern. For example, audits of late and short calls had been completed. These identified significant numbers of calls were not on time or shorter than planned. However, action, such as reviewing staff travel time, had not been taken to address this. One person's care plan had been recently reviewed. This did not identify that staff were measuring the person's oxygen levels when this was outside of the scope of their assessed role. Auditing of medicines had not led to improvements.
● At the last inspection we found the registered manager and nominated individual were not open and transparent. At this inspection we continued to have concerns about transparency. Following the last inspection, the provider had conditions placed on their registration which included the need to report to CQC monthly. These conditions included reporting on a summary and analysis of audits carried for care planning, risk assessments, medication, safeguarding incidents, training delivered, and staff competency assessments completed. These reports did not always accurately reflect our findings during the inspection. For example, the audit of medicines stated no concerns were identified that needed action. The audit of care plans stated care plans and risk assessments were completed.
● Records continued to be poor and inaccurate in areas. Some records were not in place. For example, one

person's care plan included sections where another person was named. This information had been copied and pasted from another care plan and did not reflect the needs of the person. Another person had a live-in carer and there were no daily records for this care to enable the provider to monitor activity during care visits and identify concerns.
● The provider lacked oversight of the quality of the service. They were not able to evidence regular spot checks were taking place to monitor staff performance and ensure staff were practicing safely.

The provider had continued to fail to establish effectively operated systems or processes to assess, monitor and improve the quality and safety of the services provided; or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to maintain accurate and complete records in respect of each service user. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to inform CQC of a notifiable incident. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● At the last inspection the provider failed to notify us that a care commissioner had taken urgent action to avoid calls missed. At this inspection we identified a safeguarding incident which had occurred in February and March 2022 where staff were administering medicines to a person when they should not have been. A notification for this incident should have been sent to CQC as required and it was not.

The provider failed to notify the CQC without delay of a notifiable incident. This is a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement for services to display their CQC rating on their website. Prior to the inspection the rating was not on display. However, this was addressed during the inspection and the rating was on display.

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
● At the last inspection we found a formal process to seek people's views had not been introduced. At this inspection there was no improvement. There had been no surveys for people and their relatives to feedback to the service. There was no evidence feedback had been sought in other ways.
● The culture needed to be improved as people and their relatives did not feel that the management were open and effective at communicating with them. Most of the people and relatives we spoke with were unsure who the manager was. One relative said, "There doesn't seem to be information on changes, no newsletters and we are not asked for feedback. There has been better communication more recently, but we still don't know what the management arrangements are." Another told us, "There is a terrible lack of communication from management."
● Staff told us they felt listened too. However, the staff team meeting notes did not reflect that communication was two way or that there were opportunities for staff to discuss their views during these meetings.

The provider had continued to fail to seek and act on feedback from relevant persons and other persons on the services provided. This was a continued breach of Regulation 17 (Good Governance) of The Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC without delay of a notifiable incident.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had continued to fail to do all that was reasonably practicable to assess the risks to the health and safety of service users and to mitigate any such risks. Medicines were not managed safely.

The enforcement action we took:

We took enforcement action against the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were operated effectively to prevent abuse of service users.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had continued to fail to establish effectively operated systems or processes to assess, monitor and improve the quality and safety of the services provided; or assess, monitor

and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to maintain an accurate and complete record in respect of each service user. The provider had continued to fail to seek and act on feedback from relevant persons and other persons on the services provided.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure staff were recruited safely.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider continued to fail to ensure persons providing care or treatment to service users had the competence, skills and experience to do so safely and that they were appropriately supported and supervised.

The enforcement action we took:

We took enforcement action against the provider