Dial A Carer Group Limited

DAC Essex

Inspection report

Unit 4, Whitbreads Business Centre
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Tel: 01245410560

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
DAC Essex is a domiciliary care service providing long term personal care and short term reablement to older and younger people in their own homes. The service supported approximately 170 people at the time of the inspection.

People's experience of using this service and what we found
People told us that they were not always safe and were not provided with a high-quality service that met their needs, wishes and preferences. Missed and late calls meant that people were being left unsafe and without care. Risk assessments did not provide assurances that people were receiving safe care. Risks to people's safety had not been reviewed or care plans updated with their up to date needs. The recruitment process and checks on the safe employment of staff were not robust or completed in line with the law. People were being cared for by staff who had not always been recruited safely. People's medicines were not always given at the time prescribed due to missed and or late calls. The lack of available information, regular audits and analysis of errors meant that we could not be assured that people received their medicines safely to manage their physical and/or mental health needs.

The service had not learnt from incidents, concerns and investigations to make improvements to the service for people using it and staff working within it. Staff were not provided with appropriate induction, training, supervision and support to carry out their role effectively. The service could not demonstrate that new staff had the necessary skills and training in the core subject's necessary for a care worker to understand their role. We were not assured that people were being cared for by staff who were fully trained and supported. People were not always supported to have enough food and drink. The poor rota arrangements meant that people had calls too close together or too far apart which resulted in people not having their meals at a time that was convenient for them.

Though people using the service and their family members said staff were caring and kind and they had built up good relationships with them, our findings did not suggest a consistent caring service or a service that was always respectful and treated people with dignity. The assessment of people needs was not robust, reviewed or adequately recorded. Whilst people contributed to how they wanted their care arranged, the care plans did not contain up to date information about people's needs or circumstances for staff to understand their changing needs. Care was not provided in a responsive way as people did not receive their care and support when they needed it. People's concerns were not always responded to and used to improve the service. People knew how to make a complaint but felt that they were not listened to or responded to appropriately when they had concerns about their care.

There was not a clear vision, strategy or support system to deliver high quality care. The culture was not inclusive or person centred and the management unclear of their responsibilities. Quality assurance processes were not in place for the safety of the service and records management were disorganised. People and staff were not involved in the development of the service and their views not listened to.

People consented and made decisions about their day to day care provision and their capacity to make those decisions was assessed and discussed with them, their representatives and family members. Staff supported people in the least restrictive way possible and in their best interests. However, people were not supported to have maximum choice and control of their lives due to the lack of organisational systems in place to manage the service. Staff worked with other organisations to provide additional care and support to people. People were supported to access healthcare services and referrals were made in a timely way to ensure people received information and treatment. People were supported at the end of their life and staff worked well with professionals to ensure people's end of life care was well managed and comfortable.

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

Rating at last inspection
The last rating for this service was Good (published 16 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received from members of the public, staff and the local authority about risks to people's health and safety, late and missed calls and staffing issues. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the relevant key questions sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We found eight breaches of the Health and Social Care Act 2008 in relation to person-centred care, safe care and treatment, meeting nutritional and hydration needs, receiving and acting on complaints, good governance, staffing, fit and proper persons employed and duty of candour.

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
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?

Requires Improvement

The service was effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

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.

DAC Essex

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 two inspectors 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. Since the last inspection, a reablement service was being provided to people for up to six weeks after leaving hospital.

The service had a manager registered with the Care Quality Commission. 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
We gave the service five days' notice as we needed to obtain people's names and addresses to write to them about being contacted during the inspection to share their views with us.

Inspection activity started on 2 October 2019 and ended on 30 October 2019. We visited the office location on 10 October 2019.

What we did before the inspection
We reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service must let the CQC know about by law. We also reviewed safeguarding alerts, information received from the local authority and information provided to us by staff and people who used the service and their family members. We used all this information to plan our 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 used all of this information to plan our inspection.

During the inspection
We spoke with 19 people who used the service and eight of their family members about their experience of the care provided. We spoke with eight members of staff including the registered manager, group operations manager, care manager, office administrator and four care staff.

We reviewed a range of records. This included eleven people's care records and daily notes of care provided. We looked at four staff files in relation to their recruitment. Due to a lack of records maintained, we were unable to review any induction, supervision, medicines management and overall governance monitoring.

After the inspection
We continued to seek clarification from the provider to validate evidence found. They sent us information which we used as part of this report.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Lessons learnt

- Risks to people's health and safety were not always appropriately assessed, monitored and recorded. Care plans did not always contain up to date information about the risks people may face in their day to day lives. For example, risk of falls, moving and handling people, use of equipment and pressure care. One family member said, "My [relative] had been having the reablement service for the second time after a spell in hospital. They were sent home without an assessment of their needs of any sort and was told that the staff were not supposed to do anything for them."
- Some people's risk assessments were a tick box exercise, completed by a staff member with no oversight, supervision and guidance of how to mitigate the risks identified and keep people safe. Some of these assessments had looked at the safety of people's home environments, whilst in other care files, there was no information at all.
- Risks had not been reviewed to ensure staff were providing the correct care for people and in the right way. In one care file, we saw basic information to indicate new pressure care equipment had been purchased for one person, but no information within the care plan to identify there was a risk or guidance on how to look after the person's skin. One staff member was moving and handling people alone when two people were required to use the hoist. This meant people and staff were put at risk of harm.
- People were being left unsafe and uncared for as they experienced late and missed calls. All of the people we spoke with and, those who contacted us before the inspection, told us staff had often been late or not turned up at all.
- People had been left soiled and uncomfortable as calls were late, people were sitting in nightclothes all day and not having food and drink at appropriate times, waiting for staff to turn up. One person said, "I don't really know what is going on now, my calls are all over the place. I never know when they will arrive especially on a morning, so my day is all to pot. I can't plan anything as I never know. Should I try and get ready myself or sit around in my night clothes, waiting." A family member told us, "[Relative] has care three times a day and staff are supposed to come at certain times as my [relative] needs changing regularly. When they are late, my [relative] is so often soiled and uncomfortable and I can't manage to do this on my own."
- People told us they had help with their medicines but did not receive them at the same time each day. One person said, "I have to take my medicines and let staff know so they record it. My usual staff member tries hard to keep things on a level so it's up to date. As soon as they are not working, it all goes haywire." One family member told us, "Staff do the pills for [relative], at times they have turned up late, maybe three or four times when we've had to ask where they are recently. The impact on [relative] when they haven't had a morning call and no cover has been arranged, has been hard."
- Care plans were not always clear about whether people administered their own medicines or how. One staff member told us about one person who they said did their own medicines, however, care records identified that staff administered their medicines for them. The person could be at risk of receiving their

medicines twice. Another example was a person prescribed two medicines to be taken/applied at specific times and not with other medicines. There were no instructions as to whether staff should administer these for them or they did this for themselves. We could not be assured that the person was receiving their medicines as needed.

● People's medicine administration records (MAR) had not been audited to ensure people had their medicines as prescribed and in a safe way. The registered manager told us they had not completed this task since the last inspection in December 2018 and was unable to supply us with copies of MAR to look at.

● Checks on the skills, knowledge and competency of staff to administer medicines for people in a safe way had not been undertaken. People were at risk of being given their medicines by untrained staff.

● The service did not investigate, analyse or learn lessons from concerns, incidents and issues to support the improvement of the service.

Risks were not assessed or monitored and medicine management processes were unsafe. This demonstrated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Recruitment practices and checks did not provide assurance people were safe. Application forms were not fully completed and did not contain a full employment history. One file did not have a Disclosure and Barring Service (DBS) check on record to show that they were suitable to work with vulnerable people and were working on the rota alone. Two files had only one reference. A written record was not completed or retained to demonstrate discussion had taken place as part of the interview process and the rationale for the staff member's appointment. The service had not followed its recruitment policy which stated two references must be gained, prior to employment and, where these are unobtainable, a risk assessment will be carried out. Risk assessments had been carried out when staff had a criminal conviction to ensure they were safe to work with people.

The registered provider was not following Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which provides reference to the recruitment checks and documents required when appointing staff. This demonstrated a breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Concerns had been raised by people, their relatives, staff and professionals about people's risk of harm due to missed and late calls and lack of staff available to care for them. At the time of the inspection, these concerns were being investigated.

● The provider was assisted by the local authority to put systems in place to ensure people were kept safe.

● People told us they felt safe when staff visited them and trusted them. They did not have any concerns about their safety or welfare from the staff. One person said, "Yes I feel safe with them [staff] and comfortable." Another said, "I feel I can talk to my staff without concern. Things are manageable, and I've built trust with them."

Preventing and controlling infection

● People told us staff were well presented in their uniforms and wore gloves and aprons as appropriate when providing their care and support.

● Staff members were adequately provided with protective equipment which was obtained from the office as and when required.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- The registered manager told us staff were given an induction programme which included looking at policy and procedures and shadowing more experienced staff. However, they were unable to provide any progress records for newly employed staff as to how their induction was being supported. They could not confirm that staff had been assessed as competent and adequately trained when the induction process had been completed. One member of staff said, "I had some training then went out with staff for a while, then was on my own."
- Staff were supported to complete the Care Certificate if they were new to working in the care sector. The Care Certificate is a set of standards that social care and health workers should adhere to in their daily working life. We asked to see completed sections of the Care Certificate for the new employees to evidence learning, but the group operations manager could not find any for us to view.
- Staff told us they had received training in a range of subjects since starting at the service but some of their training was not up to date. We were unable to establish if all staff had received up-to-date training in subjects relevant to their work such as moving and handling people, safeguarding them from abuse, health and safety and medicine administration.
- The registered manager was unable to provide us with a programme of completed training undertaken by all staff to show that they had the skills and knowledge to care for people effectively.
- People who used the service told us they thought their regular staff were well trained as they had had the same staff for some time. Whilst they reported no impact on them of their staff's ability to do their work, lack of checks and reviews of care meant that quality and safety of the care provided may not be as effective as it should be.
- There was not an effective process in place for the regular supervision of all staff to discuss their work and performance. Spot checks on staff to ensure they were carrying out their role and responsibilities were not in place. We could not be assured that people were receiving care by staff who were skilled and who were following company policy and practice. One staff member told us, "I manage my own time and workload. If I need anything I will contact the office but otherwise am left to my own devices, which is fine by me."

The lack of induction, training and supervision demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service was not effective in assessing or meeting people's needs and choices. People and their relatives told us they were not happy with the timings of their calls or the management of the rota. They told

us of incidents where they had been left long periods of time without care and care calls being cancelled by text message at the last minute.
● People did not know who and when staff would visit. This left them isolated for long periods of the day and they could not make plans to go out. This isolation had the potential to affect people's relationships, social networks and their mental health. One person said, "There are times where I've had to wait or haven't had chance to leave the house because of not being told when staff are going to turn up or not. I never know if someone will come." Another told us, "Late or missed calls are very stressful for me." A third said, "Missed visits are annoying, also when staff are late, I have to chase them up myself."
● The service was not provided to people in a way they should expect or in line with good practice. The registered manager had not utilised national guidance or professional bodies to achieve effective outcomes for people.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always receive food and drink as part of their plan of care and at a time of their choosing. Due to staff turning up late or not at all, mealtimes were not flexible or evenly spaced. Some people were at risk of not having anything to eat or drink for long periods at a time. One person had a morning call at 11.45 and then lunch call at 12.30 but they did not have their evening call and were not visited until the following morning. One person told us, "I never know what time they [staff] will be here. On a couple of occasions someone has not come at all. I can just about manage to make a drink and get something to eat" Another said, "I don't have any fixed times for my calls, but it sometimes means that I am hungry when they come to help me with my meals." A family member said, "It has an impact on [relative] when staff have not done the morning call, someone is ill, and no cover has been arranged. [Relative] doesn't prepare meals themselves, so staff have to do it."

The service does not demonstrate it supports people with meals and drinks in line with their plan of care. This is a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's care plans identified if they needed support with hydration and nutrition and what support they needed. The daily notes contained information showing how staff had supported people with their meals, snack and drinks in discussion and agreement with them. One person said, "The staff work very hard and do prepare snacks in the morning and drinks during the day." Another said, "I have no problems at all with anything. My staff are all very good and help me with my food and give me my tablets."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to health professionals as required. If staff were concerned about a person's health and wellbeing, they relayed these concerns to the registered manager for escalation and action. One person said, "I wasn't very well last week and after the staff member had finished helping me, they rang the doctors and asked them to call. I told her I could do it, but she said it was no trouble. They were not coming back that day but they rang me later to see if I was feeling better, they didn't need to do that."
● Records showed that professionals such as the GP, district nurse and occupational therapist had been involved in supporting people. Staff were proactive in making sure people got the treatment or equipment they needed.

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.

● People told us staff sought their consent prior to providing care and support and enabled them to make their own decisions and choices. One person said, "The staff ask me if it's okay to do things for me all the time."
● People's capacity to make decisions was assessed and recorded. They were involved in making decisions about their care and support. We saw in the daily log that staff sought consent when supporting people with their daily care. One staff member told us, "I know usually how people like things done, but I never assume and always ask them. They might want something different today."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Though people using the service and their relatives said staff were kind and caring, our findings did not suggest a consistently caring service.
- People felt that they no longer were in control of their day to day life. Staff were rushing between calls and, in some cases, only staying the minimum amount of time. People who required minimum personal care but had planned time allocated for 'company' to reduce loneliness and isolation were not receiving what they had been assessed as needing. One person said, "Sitting and talking is part of what I use the service for, but they [staff] rush in, do what they have to and then leave as they have so many calls to fit in. The staff are very apologetic about this but say they just don't have the time to sit and talk as they need to be with the next person as soon as possible as they are already running late."
- Staff told us they were concerned about the rota arrangements and lack of staff for the amount of people using the service. People were not receiving their calls at the agreed times, they had no time in between calls to get from one person to the next and in some cases, they had to miss some calls completely. Most staff had a regular call list of people they saw, but some were being taken away from this rota to travel some distance to cover other areas. This added stress to their work and concern for their regular people who were not getting their calls.
- The provider was not providing person centred, respectful and dignified care to people as they did not have enough staff and appropriate systems in place for people to receive a quality service. This is evidenced in our safe and effective sections of the report.

People did not receive a service that was appropriate and met their needs. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- We were assured by people that staff treated them well, and their dignity and privacy was respected by individual staff in relation to their personal care needs. One person said, "The staff make sure that they have the towel ready to cover me when I get out of the shower." Another told us, "I have either male or female staff, my dignity is always respected, and I feel safe." A family member said, "If I need to speak to anyone in the office, I am always spoken to respectfully by whoever answers the phone."
- Staff supported and encouraged people to maintain their independence and to do as much for themselves as possible. Reablement support enabled them to improve and regain skills of day to day living after being in hospital or a period of ill health. One staff member said, "It's great to see people moving again or doing those things they took for granted. It makes them happy again and our job is done."

Supporting people to express their views and be involved in making decisions about their care

● People received care and support from staff who were kind, caring and hardworking. The staff did what they could to make sure they had everything they needed till their next call. One staff said, "I really care about the people I see and have known them a long time. I feel terrible for them being left. I sometimes go in my own time to make sure they are okay."

● Staff involved people in their day to day care and helped them make decisions and choices. People told us they usually had regular staff who they knew. One person said, "Both me and my [relative] are treated with total respect at all times by all of the staff." A family member said, "Every staff member who has been to our home has always been very kind and caring and apologised for being late." Another said, "Generally, staff are very good and [relative] is provided with gentle care. The staff are easy to get on with and have gelled really well with [relative].

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

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

- Not all people using the service had a care plan in place detailing the level of support required and their preferences, wishes and circumstances relating to their needs. Information relating to people's care and support needs was a mixture of paper and electronic-based information which was confusing, inconsistent and poor in quantity and quality. There were basic details in some care plans with their home details, next of kin and key safe number, whilst in others, the paper file was overflowing with information ranging from 2007 with little understanding of the person's up to date needs.
- People's changing needs were not being reviewed and recorded in their care plan. One person had developed a medical condition and was receiving care from the district nurse and the staff were no longer required to administer their medicines. None of this information was written in the care plan and therefore staff would not be able to respond appropriately and safely to their needs. One person told us, "I can't remember if any one came and did my care plan but the staff write in it each time they come, but when someone new comes, they don't always read it as they are usually in a rush."
- Information about people was not written in a person centred and respectful way. For example, in one person's electronic care plan it gave a standard statement about their needs such as using the hoist, continence and personal care needs which was repeated for every call, every day without any change. However, the daily journal entries by staff were written in a respectful and considerate way describing the visit and any issues or concerns.
- Minimal information was recorded relating to people's culture, ethnicity, sexual orientation, religion or faith except for gender, age and marital status. For example, one person whose first language was not English did not have their ethnicity or culture recorded for staff to understand their background. The staff were advised to use the translation App on their phone to communicate with them which would enable communication both ways. The staff member told us that the person did not like using it and preferred to use gestures to get their needs known but this was not recorded. The care plan had not been translated into the person's preferred language for them to understand and sign their agreement.

People's needs, and preferences were not assessed appropriately, and they did not always receive personalised care. This is a breach of Regulation 9 (Person-centred care) 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). 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 family carers.
● People's sensory and communication needs were not always assessed and recorded. The registered manager was unaware of the requirement of the AIS but told us that they could easily make information into accessible formats on request. They assured us they would update their knowledge of the standards.

Improving care quality in response to complaints or concerns
● People told us they had made complaints to the service. One person said, "When I ring up I get taken notice of and things improve for a while then go back to bad again. I just say I will leave and it's all good again. I am convinced there just aren't enough staff to see to people." Another said, "If I have ever needed to complain about call times, I have spoken to someone and have always been told they would do what they could to sort it out, usually it is for a short time, but it soon goes back to the way it was. "A family member told us, "What's the point complaining nothing changes. I am just happy when someone turns up on time."
● The service recorded written complaints and had responded to two complaints with one still to be resolved. Numerous verbal concerns and issues had been raised by people and their relatives' regarding poor care and missed and late calls but these were not dealt with as complaints, were not responded to appropriately and were not used to improve the service.

The service did not operate effectively a complaints process and this demonstrated a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● The service was providing end of life care and support to one person. How the person wished to be cared for was outlined in their care plan and was detailed, considerate and respectful. A consistent group of staff had been allocated to provide ongoing support, so they had the same staff members around them.
● Staff were working with relevant professionals and liaising with the family in a responsive way to ensure the person received appropriate and timely care and support at this difficult time.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The leadership and overall management of the service did not ensure the service was consistently well-managed and led. Comments about the management of the service from people, their families and the staff were variable and suggested not all people using the service received positive outcomes.
- The lack of oversight, clarity of roles and responsibility and a lack of support to staff at all levels of the organisation did not demonstrate a solid, responsible and accountable management team.
- Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. These included recruitment practices, a lack of training and induction, late and missed calls, a lack of detailed care plans and risk assessments and ineffective medicines management.
- A computerised system recorded late, missed and cancelled calls. However, it was not audited to look at the outcomes for people because staff did not know how to use it effectively. Risks to people's health and wellbeing were not being monitored and action taken.
- Systems and records including medicine administration, care plans, risk assessments and daily records were not audited to ensure their quality and make sure they were reflective of people's needs. There was no analysis of the current concerns, problems with rota arrangements, and communication systems which showed a lack of oversight and planning.
- The management team did not know how many people they were providing a service for. They told us 56 people were using the service. We learnt after the inspection from the local authority that there were approximately 170 people recorded as needing a service. We were not assured that the registered manager was managing people's care safely as people were at risk of not receiving their care visits.
- Lessons were not learned as failings identified had not been addressed by the provider to make the required improvements.

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

- The service did not have a vision and culture which was respectful of people using the service and staff. Its values were not person centred or open and transparent and staff at all levels of the service were not supported. This had led to a culture of blame and poor team work. One staff member said, "People are just not getting the care because of the lack of management with the rotas and lack of staff. We [staff] are left to pick up the pieces." Another said, "They have taken on too many people, we can't manage. I really worry about people when I have my days off." Management meeting notes confirmed this culture of blame and the

lack of respect shown for staff and managers. The provider had not dealt with the staff and management issues effectively, resulting in poor outcomes for people who used it and staff working in it.

● Not all people using the service, or their relatives knew who the registered manager was, although those using the service for many years, did. People and their relatives commented that they were aware of a lot of changes to the management of the service which was unsettling as they did not know who to contact. One person said, "I know we have had a new manager recently but I don't know their name but I have spoken to them and they seem very nice." Another said, "I don't know who the manager is off hand, senior staff came when they first set up the package."

● Arrangements were not in place for gathering people's views of the service either via phone calls checks, reviews of people's care or through surveys to understand how people and their relatives felt about the service. People told us, "We never had a meeting before the staff started coming but apparently all my information and what I need is on the staff's mobile" and, "No one's asked any questions in the post or sent surveys for feedback. I'd say 99% of the time the staff have looked after [relative] to a satisfactory level."

● Staff meetings were not being held to give staff the opportunity to express their views and opinions on the day-to-day running of the service. Staff told us they were not involved formally and, whilst they did speak up about issues of concern, informally, they were never listened to.

● People and their relatives told us they would recommend most of the staff who cared for them but would not recommend the service, as a whole, to anyone.

Effective arrangements were not in place to assess and monitor the quality of the service provided to ensure compliance with regulatory requirements. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not understood their responsibilities in relation to their duty of candour. Safeguarding concerns, complaints and notifications were not always dealt with, managed and responded to in a timely way in line with the regulations.

The provider was in breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The service was able to demonstrate they were working in partnership with others, such as the local authority, healthcare professionals and equipment services for the benefit of people who used the service.

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 People's needs, and preferences were not assessed appropriately, and they did not always receive personalised care.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always get meals and drinks in line with their plan of care.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not operate effectively a complaints process.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider was not following Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which provides reference to the recruitment checks and documents required when appointing staff.

Regulated activity	Regulation

Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not understood their responsibilities in relation to their duty of candour.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Induction, training and supervision processes were not in place to ensure staff were competent to work with people.