Jiddak Limited

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Inspection report

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14 November 2022

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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
Jiddak Limited is a domiciliary care agency providing personal care to people living in their own homes in the community. The service provides support to older and younger people with dementia or mental health issues, people with complex health needs and to those who may have physical or sensory disabilities. They were also supporting people who had a learning disability and autism. At the time of our inspection there were 34 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 provider told us a different number of people were in receipt of personal care throughout the inspection and were unable to tell us an exact number.

People's experience of using this service and what we found
People were at risk of harm because there was not sufficient guidance to inform staff how best to provide support. Medicines were not managed safely. People were not protected from the risk of abuse and had been harmed. The deployment of staff put people at risk and was not safe, the registered providers system for monitoring staffing was ineffective. Staff were not recruited safely, well managed or supported and their competency was not checked to ensure people received safe care and treatment. There were no systems in place to learn from accidents or incidents.

People were not assessed prior to them being supported by Jiddak Limited, which meant there were no assurances people's needs could be met by staff. The provider and registered manager had poor oversight around the training needs of staff, they could not provide assurances staff had specialised training to support people with complex needs.

People were not treated with dignity and respect, language used in their care plans was derogatory. Equality, diversity and the individual needs of people had not been well considered.

Some people did not have a care plan, some documentation used disrespectful language which was not person centred or empowering. Complaints were poorly managed. People did not have end of life information in their care plans although some staff had received training in this area.

A positive culture was not promoted, and people were not treated with respect. The providers oversight of the service was poor, they did not oversee or assess the quality of the service they delivered. The provider and registered manager did not identify when things had gone wrong or taken action to learn from those errors. The provider and registered manager were not open and honest when things went wrong and did not understand their regulatory responsibilities as registered persons. The registered manager and provider did not always work well with other health care professionals or act in response to the concerns they raised. The registered manager and provider had failed to notify other professionals about incidents that should have

been reported.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Right Support: Staff did not support people to play an active role in maintaining their own health and wellbeing. The service did not support people to have the maximum possible choice, control and independence over their own lives.

Right Care: People did not receive kind and compassionate care. Staff did not protect and respect people's dignity. They did not understand or respond to their individual needs. Staff did not assess risks people might face. Where appropriate, staff did not encourage and enable people to take positive risks.

Right Culture: People did not lead inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff. The service did not enable people and those important to them to work with staff to develop the service.

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
This service was registered with us on 01 October 2020 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We received concerns in relation to management and oversight of the service. As a result, we undertook a comprehensive inspection to review all key questions.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to managing risks to people, safeguarding people from harm, staffing, poor recruitment, person centred care and lack of governance systems at this inspection.

Following the inspection, we took immediate action to restrict admissions to Jiddak Limited. We took urgent enforcement action and suspended the registration as a service provider in respect of the regulated activity of personal care. The provider de-registered Jiddak Limited with the Care Quality Commission and is no longer a registered service.

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 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.

Jiddak 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 two inspectors.

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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave a short period notice of the inspection because we initially planned to inspect using remote technology. When we inspect using remote technology the performance review and assessment is carried out without a visit to the location's office. We would use technology such as video calls to enable us to engage with people using the service and staff, and electronic file sharing to enable us to review documentation. We were unable to proceed with the inspection using remote technology because the registered manager and provider did not provide us with the information we requested, and we were made aware of information of risk from the local authority. We therefore converted from a remote inspection to an onsite inspection where we visited the registered office.

Inspection activity started on 31 October 2022 and ended on 14 November 2022. We visited the location's office on the 10th and 14 November 2022.

What we did before the inspection
We reviewed information we received about the service, including things the provider must notify us about, for example, accidents or safeguarding concerns. We sought feedback from the local authority and other professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with three staff this included the nominated individual and two care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The nominated individual was also the provider. The registered manager was not present throughout the inspection and did not speak to us. We received feedback from four professionals who were involved in supporting people who used the service. We also received feedback from three staff by email.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of harm because there was not sufficient guidance to inform staff how best to provide support. Some people lived with very complex health needs, however guidance for staff was not detailed enough for them to support people. One person had an incident where they become very distressed, and injured a staff member, and was at risk from members of the public. Despite this incident, the person did not have a care plan or risk assessment to inform staff how best to support them, or how they should reduce the risk of harm when the person became distressed. This person did not have a comprehensive care plan in place for any of their health needs.
- The care plans we looked at lacked important information about people's needs. The provider and registered manager sent us a care plan they had re-written. This care plan stated the person was at risk of aspirating and needed to be monitored closely overnight. However, the person did not receive support at night, and had a live-in carer that supported them during the day. The provider and registered manager had not considered how to mitigate the risks to the person at night.
- One person had very complex health needs. Throughout the day Jiddak Limited staff worked with another agency to provide support to the person. Staff did not have information about how they should support the person during the night when other health professionals were not available.
- One person had a number of wounds and a catheter and stoma (a catheter is a tube that is inserted into the bladder allowing urine to drain freely. A stoma is an opening on the abdomen that can be connected either to your digestive or urinary system to allow waste to be diverted out of your body). We asked to review the person's care plan and the provider informed us they did not have one. The person was no longer receiving care, however we could not be assured that when they did receive support from Jiddak Limited staff, they received the support they needed.

Using medicines safely

- Not everyone supported by Jiddak Limited had a medicine administration record (MAR) to inform staff how best to support them with their medicines. MARs we did see were poor and were not in line with NICE guidelines. (National institute for health and care excellence are evidence-based recommendations and guidelines providers should follow).
- Some people lived with conditions and had medicines which were time sensitive and needed to be evenly spaced throughout the day. However, their MAR did not detail times the medicines were given. Therefore, we could not be assured people received their medicines as required.
- The provider, and registered manager did not understand or follow NICE guidelines for medicines administration. They failed to identify that medicated creams were medicines, and therefore needed clear records confirming when and how they were given.

● Some people had 'as and when' medicines, such as pain relief. The provider was unable to provide any evidence that there were protocols in place for staff to follow, for example explaining the maximum dosages in a 24-hour time period. One person was unable to verbalise when they were in pain. There was no information to inform staff how they could recognise when the person was in pain so 'as and when' medicine could be administered.

Learning lessons when things go wrong

● There was no system in place to learn from accidents and incidents. The provider and registered manager had no oversight of accidents and incidents. This meant any patterns and trends could not be identified or reviewed so improvements could be made. The provider said they had learnt lessons following a previous safeguarding incident where the local authority had told them they had not acted quickly enough to look into concerns that had been raised. No lessons had been learnt because they still did not report incidents or respond to them in a responsive way. Incidents were not reviewed to ensure improvements were implemented and the incident was investigated. This left people at risk of harm.

● Accident and incident forms were not always completed by staff. Some incident forms referenced other incidents that had occurred. However, there was no other recorded information about those incidents and the registered manager and provider had taken no action to investigate further.

● The provider and registered manager had not informed CQC about incidents which they are required to do. During the inspection the provider said they had sent two notifications to CQC which should have been sent previously. Oversight systems were not in place which could have identified the notifications had not been submitted.

The provider failed to ensure people always received care and support in a safe way, which put people at risk. The provider had not ensured risk to people had been assessed and was not doing all that was reasonably practicable to mitigate any such risks. The provider had failed to manage medicines safely putting people at risk. The provider had failed to do all that was reasonably practicable to learn lesson when things went wrong leaving people at risk of harm. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse and had been harmed. The registered manager and providers oversight of safeguarding was poor. Documentation around potential safeguarding incidents lacked important information or was missing.

● A relative had reported concerns of unexplained bruising on their loved one to the local authority safeguarding team. The provider and registered manager had not responded to the local authority's requests for information in a timely manner. They failed to investigate the concerns and make improvements promised.

● Another relative had raised concerns that their loved one had unexplained bruising and had not been supported with their personal care. Staff failed to document the bruising or report it to the provider or to the local authority safeguarding team.

● The provider and registered manager had failed to share information required of them about abuse, and allegations of abuse to the Care Quality Commission (CQC).

Systems had not been established to safeguard people from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The deployment of staff put people at risk and was not safe. The provider and registered manager were unable to provide evidence of all rotas for shifts worked. Rotas we did see evidenced that staff were not given time between calls for travel. Staff shared concerns that they were always late, causing them and people stress, however there was no resolution or action taken by the registered manager to address these concerns. Multiple concerns were made by people and their relatives about calls being late or missed from Jiddak Limited, there was no action in response to these concerns.
● One rota evidenced that staff worked day shifts, followed by waking night shifts. The provider told us that sometimes, for example when new packages started staff worked these hours. The provider confirmed that this was not safe for people being supported by staff, or for the staff members.

The provider had not ensured sufficient numbers of suitably qualified staff were deployed to meet the needs of people. This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not recruited safely. We looked at three recruitment files which all missed important checks on the suitability of new staff. Up to date DBS checks had not been obtained until after staff had begun work. 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. References were either missing or had not been obtained until many months after staff had begun to work with people. Required checks on the eligibility of oversea workers had not been made.

The provider failed to ensure staff were all of good character and suitable to work with people who used the service. These concerns were a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider told us they provided staff with personal protective equipment (PPE) to carry out their duties.

● Staff had received training in infection control and prevention, hand hygiene and Coronavirus COVID-19.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate.

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

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

- People were not assessed prior to them being supported by Jiddak Limited. We asked the provider to show us an assessment they completed on any person prior to providing support, but they were unable to evidence they carried out an assessment. The provider could not be assured they would be able to meet the needs of people. A healthcare professional said, "I think they took on everything they could at the beginning, they took on too much from the beginning, they provide a lot of care hours."
- The provider informed us they used the information provided by the local authority as their assessment and used this to form people's care plans. However, people who had been provided with support for a month did not have care plans in place.
- The lack of assessment placed people at risk of harm. One person was taken back into hospital on the same day they were discharged due to the lack of assessment. When staff attended the first care call to the person, it was evident they needed support that Jiddak Limited were unable to give, and the person was re-admitted to hospital.

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

- People were at risk because their health needs were not supported. Information was missing in peoples care plans to inform staff what action should be taken or how to identify when further healthcare support may be required.
- For example, one person had a lot of complex health needs which required urgent action to support them to stay well. The provider said staff asked the other health professionals that supported the person for guidance if this was required. However, the other health professionals only worked throughout the day. During the night only staff from Jiddak Limited worked. This meant the person was at risk of not receiving further specialised healthcare in a timely way should they need it during the night.
- Two health professionals told us the provider and registered manager were difficult to work with and were not good at communicating. The provider did not respond to their recommendations or act on advice to improve the service or the care and support people received.

The provider failed to ensure people always received care and support in a safe way, which put people at risk. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● The provider was unable to demonstrate staff had the skills and knowledge to support people with their complex needs. The oversight of staff training was not robust which meant the registered manager and provider could not identify where there were gaps in training.
● We requested information about the training staff had received in specialised areas for example, catheter care, oxygen management, and Percutaneous endoscopic gastrostomy (PEG). (PEG is an endoscopic medical procedure in which a tube is passed into a person stomach most commonly to provide a means of feeding when oral intake is not adequate or possible). The provider was unable to provide information about which staff had received what specialised training. We were not assured staff had the right skills to support people with their needs.
● Staff were not well managed or supported. Staff had received some supervisions; however, these were tokenistic and did not address any issues raised. For example, a person had raised concerns about staff to the provider. We asked the provider what action they had taken to investigate; and they confirmed they completed supervision with staff. However, documentation of the supervision evidenced that the issue was not discussed. The provider told us another staff had had supervision but was unable to evidence that this had occurred.
● Some spot checks on staff had been completed. However, the staff member who had carried out spot checks lacked knowledge about how to support people well. The registered manager and provider were unable to give assurances the staff member had the right skills to be able to check other staff members competency. The provider told us the registered manager conducted spot checks on staff but there was no evidence this had happened.

The provider had not ensured sufficient numbers of suitably qualified staff were deployed to meet the needs of people. This was a breach of regulation 18(1)(2) of the Health and 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.

● Although some capacity assessments had been completed for people the provider, registered manager and staff did not understand the principles of the MCA. Daily notes evidenced that staff attempted to stop people leaving their home, without any legal authority to do so.
● One person's daily notes indicated staff had stopped someone getting out of their bed, and 'pulled' them out of a 'dangerous fall'. There was no investigation from the registered manager or provider that staff had appropriately supported the person, and they had not restricted the person in their own home.

The provider had not ensured care and treatment was provided with the consent of the relevant person.

This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Peoples care plans lacked important information about how much they should eat and drink to remain healthy. There was no information about people's preferences around food or drink. For example, one person's care plan said staff should offer water at times to avoid dehydration but there was no information about how often, how much water or if the person liked other drinks apart from water.
- Peoples care plans were contradictory and unclear about the specific support they needed around eating and drinking leaving them at risk of being supported in a way which did not meet their needs. For example, one person's nutrition assessment stated they did not require any support with any aspect of their nutrition but then went on to say the person needed support with all meal preparation and may require physical assistance with eating.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not treated with respect. The provider and registered manager sent us a care plan they had re-written. This care plan stated that if the person was not offered regular snacks this could 'trigger a challenging behaviour / meltdown,' and that 'regular snacks should be offered to maintain good behaviour.' The language used in the care plan was not respectful of the person and their needs.
- Time and care had not been taken to ensure peoples care plans and information was a true reflection of them and their needs. This did not demonstrate a caring approach or person-centred care. For example, one-persons care plan stated staff should change the TV programme/movie but there was no information what the person enjoyed to watch and the person was unable to verbalise this.
- The provider was unable to give us any assurances that people's feedback was considered, or they were asked about their views on the care and support they received. Where concerns had been raised these had been ignored or not investigated fully.
- Regard for people's equality and diversity had not been significantly considered. The only example of this in peoples care plans was 'Does the client have any cultural or religious beliefs that Jiddak Ltd need to be respectful and mindful of?'. The information about people's responses was minimal and did not have regard for their individual needs. For example, the response to this question in one person's care plan was, 'I don't have any preferences'. There was no other information about how people's diverse needs were explored or supported.

Respecting and promoting people's privacy, dignity and independence

- People were not treated with dignity. The provider and registered manager sent us care plans they had re-written for three people. These contained language, which was derogatory, for example when describing the continence aids people used.
- Staff did not have adequate travel time between calls and calls were often late. This meant there was a risk staff would be rushed and unable to support people to be as independent as possible or be supported in a way that respected their dignity because there was not enough time.
- Peoples personal information was spoken about in public places, for example when staff had meetings. We have reported on this further in the well led domain.
- We received a mixture of positive and negative feedback from healthcare professionals. One healthcare professional said, "The provider manages with their heart which is unique and lovely for the clients. They could maybe benefit from having an assistant to help them with the management workload."

People were not treated with dignity and respect. People did not receive care and treatment in a caring and compassionate way at all times. This was a breach of regulation 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

- There was a not an effective system in place to log complaints and ensure each issue had been investigated and responded to in a timely manner. There was no system in place to check if people were satisfied with the outcome of their complaint.
- The provider and registered manager failed to investigate and act on concerns raised. A relative had raised concerns about staff being asleep, however this was not documented or investigated by the provider.
- Several complaints about similar themes had been received throughout 2022, however action to address and improve had been ineffective. For example, people and their relatives had shared concerns about missed or late calls, personal care not being delivered, and care plans not being in place. We continued to find these issues during our inspection.

The provider failed to act on complaints, investigate or take necessary or appropriate action. This was a breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People's care plans were not personalised, and they lacked information to inform staff how best to support them. Some people did not have a care plan in place which meant people were at risk of receiving inappropriate care and support. The provider did not understand the significance of missing or incorrect documentation. They had not considered what would happen if the usual staff were unable to support people and staff unknown to people had to cover care calls with no documentation or guidance to refer to.
- The provider told us some of the care plan information which was missing was kept in people's homes and they did not have copies at the office. We were not assured the provider or registered manager reviewed information about people regularly or when their needs changed to ensure staff had the information they required. The provider told us they were in the process of transferring information to an electronic system. They did not assure us they or staff understood how to use the system. They were unable to give us documentation about people when we requested it.
- The provider and registered manager sent us three care plans they had reviewed and re-written. However, these contained incorrect information, for example one elderly person's care plan suggested to report concerns to their mum, who would not have been alive for years.
- There was no information in peoples care plans about how they would like to be supported at the end of their lives. The provider had not considered if people had cultural wishes which may be time sensitive they wanted to be respected at the end of their life.
- Some staff had received training in end of life awareness. However, there was no evidence this training

had influenced how people were supported or cared for at the end of their lives.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not clearly documented within care plans. For example, one person could not express verbally if they were in pain. There was no documentation in place to inform staff how to check for pain or what to do if they thought the person was in pain.
● Other care plans we reviewed contained basic information about how they preferred to be communicated with. However, not everybody had a full care plan that considered their communication needs, therefore we could not be assured peoples communication needs were being met.

The provider had not ensured people received person-centred care. This was a breach of regulation 9(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- The provider and registered manager were not open and honest when things went wrong. Complaints and concerns were poorly managed and were not responded to.
- The registered manager and provider did not always work well with other health care professionals. Two health care professionals told us the provider would often say they were unavailable and would avoid communication and the provider and registered manager did not respond or take action to concerns they raised quickly.
- During our inspection the registered manager was not present. The provider was not responsive to our requests of information and we had to make repeated requests for information which we did not always receive. The provider and registered manager did not understand their regulatory responsibilities and acknowledged they had been obstructive throughout the inspection, they apologised for this.
- The provider had asked staff for anonymous feedback about the service, but no action was taken in response to concerns raised. Some of the comments included, 'A lot of stress, especially from the service users due to the late coming of some carers' and, 'It's quite stressful because some team members do not take over on time because they come late', 'A great deal of stress. Care work is stressful especially dealing with different clients, but it is manageable', and 'The main stress is from the families of the people we care for'.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A positive culture was not promoted, and people were not treated with respect. Staff meetings had been arranged at public places such as fast food restaurants and people's personal information had been discussed.
- The registered manager and provider did not improve care for people when they were told things could be better. When staff did express concerns for example, in relation to the lack of travel time, and multiple care calls being scheduled at the same time, no action was taken by the provider and registered manager. The solution from the provider stated, 'could be difficult to set goal but to have effective communication with clients with reasons for been late. Informed the difficulties to keep to a specific time slot but would try to keep close to time.' This issue continued to occur.

● The registered manager was absent throughout the inspection. The provider told us the registered manager completed some of the care calls and drove carers to care calls. The provider said the registered manager made checks on staff but there were no records of this occurring. We were not assured the registered manager understood their role as a registered person.
● The provider and registered manager lacked understanding about how to meet regulatory requirements or the importance of effective oversight of the service. They had no systems in place to assess the quality or safety of their service.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. This enables us to check that appropriate action had been taken. The provider and registered manager had failed to inform the CQC of safeguarding incidents, and police incidents when they occurred. This meant that the CQC could not maintain an informed overview of events and incidents happening in the service. During the inspection we identified two incidents, the provider then submitted retrospective notifications. We identified a further seven incidents we had not been notified of.

The provider had failed to notify the Commission without delay of incidents which they are required to do. This was a breach of regulation 18(1)(2) Care Quality Commission (Registration) Regulations 2009.

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 registered provider had failed to notify the Commission without delay of incidents which they are required to do. This was a breach of regulation 18(1)(2) Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received person-centred care. This was a breach of regulation 9(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. People did not receive care and treatment in a caring and compassionate way at all times. This was a breach of regulation 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for

	consent The provider had not ensured care and treatment was provided with the consent of the relevant person. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people always received care and support in a safe way, which put people at risk. The provider had not ensured risk to people had been assessed and was not doing all that was reasonably practicable to mitigate any such risks. The provider had failed to manage medicines safely putting people at risk. The provider had failed to do all that was reasonably practicable to learn lesson when things went wrong leaving people at risk of harm. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure people always received care and support in a safe way, which put people at risk. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been established to safeguard people from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to act on complaints, investigate or take necessary or appropriate action. This was a breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff were all of good character and suitable to work with people who used the service. These concerns were a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified staff were deployed to meet the needs of people. This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured sufficient numbers of suitably qualified staff were deployed to meet

the needs of people. This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We suspended the providers registration from the 17 November 2022 to 17 January 2023.