Immaculate Care Limited

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Inspection report

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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
Immaculate Care Limited provides personal care and support to older people and people with disabilities living in their own homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. At the time of our inspection all 23 people received personal care.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who had a learning disability.

People's experience of using this service and what we found
People's medicines were not being managed in a safe way which put people at risk. Not all staff were assessed as safe to administer medicines to people. Accidents and incidents were not always reported, and actions were not always taken to reduce reoccurrence of them. Risks associated with people's care was not being assessed appropriately.

The provider had not ensured that there was sufficient organisation of the staff rotas and we found that staff were at times late for calls and did not always stay for the duration of the call. The recruitment of staff was not robust which put people at risk. Staff were not sufficiently trained or supervised to ensure that they were competent to carry out their role.

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.

Prior to people receiving care there was a lack of assessments of their needs. People's care was not provided in a consistent way. Care plans lacked detailed and guidance for staff. Care plans lacked information about people's backgrounds, interests and things that were important to them. Where people were being cared for at the end of their lives there was no care planning in place around this.

There were no systems in place to assess the quality of the care being provided. The provider and registered manager were not always being open and transparent in relation to the care that was being delivered.

Staff understood what to do to prevent infections however relatives fed back that staff were not always wearing personal protective equipment. We have made a recommendation around this.

There were people and relatives that told us that they felt safe with staff. However, staff were not aware of

the procedures around reporting a safeguarding concern. There was also information missing in people's care plans around their nutritional and hydration needs. We have made recommendations around both of these areas.

People and relatives felt some staff developed good relationships with their loved ones. People told us that staff were respectful towards them. Staff fed back they felt supported by the leadership.

Right Support: People's care was not always being assessed to ensure they were receiving the most appropriate care.

Right Care: Care was not always person-centred around the wishes of the people they were supporting.

Right Culture: The provider and registered manager lacked an understanding of the needs of people with a learning disability.

Rating at last inspection
This service was registered with us on 19 November 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 and as part of our inspection scheduling for newly registered services.

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 will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the safe care and treatment, the lack of robust recruitment and staff levels, training and supervisions. We have also identified breaches in relation to the lack of care planning, lack of understanding of capacity assessments and lack of effective audits.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards. We will work alongside the provider and 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 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? 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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Immaculate Care 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
Our inspection was completed by two inspectors 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 homes.

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 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 28 October 2022 and ended on 31 October 2022. We visited the location's office on 31 October 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) 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 information gathered as part of monitoring activity that took place on 7 September 2022 to help plan the inspection and inform our judgements. We also asked for feedback from the local authority.

During the inspection
We called and spoke with five people and six relatives of people who used the service about their experience of the care provided. At the office we spoke with the registered manager and the provider (who was the nominated individual) and two members of staff. We called and spoke with two members of staff.

We reviewed a range of records including five people's care plans, daily care notes, staff rotas, multiple medication records, safeguarding records and complaints. We reviewed a variety of records relating to the management of the service including six staff recruitment files and spot checks.

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.

Using medicines safely

- Medicines were not managed in a safe way. The medicine administration record (MAR) did not contain information on whether the person had any allergies or information on the person's GP. There were multiple MARs that had no month recorded so it was not clear the date the medicine had been given.
- Recording of reasons why medicines were not given were inconsistent and unclear. There were gaps on the MAR charts with no additional information on whether the person had been offered and refused or whether the medicine had been missed. Where people required creams there was no body map in place to show staff where it needed to be applied.
- Where people required 'as and when' medicine there was not always guidance for staff on when this needed to be offered to the person. The MAR did not contain information on how the person needed to take their medicine or whether staff needed to prompt the person or administer the medicine.
- Where people were supported with time critical medicine there was a lack of information for staff on the importance of giving the medicine at the same time each day. One person's care plan just stated to 'use the medicine regularly'.

As medicines were not managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider did not operate safe recruitment practices when employing new staff. Three recruitment files did not have a full employment history. There was no evidence the provider had sought this information to assure themselves of reasons for the gaps in employment. This was despite the providers policy stating they will "Check work history; note and investigate all periods of no work and reasons for leaving the position."
- Appropriate references had not always been sought for staff. The policy stated that two references needed to be provided by the two most recent employers. The provider had not proactively sought references in this way. One member of staff listed their previous employers however the reference provided was a character reference from a family member despite there being details of other previous employers. This meant the provider could not be assured of the member of staff's conduct at their previous employment.
- Although the provider had undertaken Disclosure and Barring Service (DBS) checks on all staff; they were not waiting for the response to the DBS before the member of staff was attending people's homes. We saw one member of staff had attended shadow shifts to people's home before the DBS response and there was no risk assessment in place in relation to this. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider failed to undertake robust recruitment practices which is a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us that in the main staff arrived at the calls. However where two staff were required to support a person on each call this was not always taking place. One person required support to re-position them and the provider told us two staff were required to attend their calls. However, a member of staff we spoke with told us they always attended the call on their own. They said, "(Person) doesn't need help a lot so I won't need to move her." This put the person at risk of unsafe care.
● The provider and registered manager had failed to have robust systems in place, so they knew that staff had arrived at a call. The provider told us there were people that lived on their own and would be unable to alert the office if the carer had not arrived for the call. They said they had an electronic logging system so if staff had not turned up, they would be alerted. However, both the provider and registered manager also provided care all day every day. This left no one in the office to monitor late and absent calls.
● One member of staff was providing live in care to a person. However, there was no process in place to ensure they had a break each day. The registered manager told us they covered a two-hour break on some days and other days the family of the person were at the home. They said, "I tell the carer if we can't cover, we will pay for the break." The registered manager said they did not always have available staff to cover the break.
● Staff were not always given enough travel time in between calls. We saw from one rota that a member of staff was given five minutes to travel from one person to another. However, the member of staff needed to use public transport to travel between visits. They told us it took them at least 12 minutes by bus to get to the person's home. This was despite the provider telling us, "We make sure we put them in a locality where all the calls are in an area. So, the travel time is not much." A member of staff told us, "I think the only thing is the way they rota the calls. Most carers would like to be in one area."
● We saw from the daily notes for people that staff were not accurately recording when they arrived and left a person's home. For example, on one occasion a member of staff recorded they had left a person's home at 09.05 but arrived at their next call at 09.00 which was a 15-minute drive away.
● The provider told us they had difficulties recruiting and retaining staff and they and the registered manager were having to cover calls. However, this had not prevented the provider taking on additional packages of support despite not having the available staff to cover the call.

As staff were not deployed in a way to ensure that all calls were attended this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People's care plans did not have sufficient information for staff to reduce the risks associated with their care. All risk assessments were a tick box form with no additional guidance for staff.
● One person had diabetes and the care plan stated staff were to support the person with measuring their blood sugar levels. There was no guidance for staff on how they would support the person with this. There was also no information or guidance on the risks associated with the person having high or low blood sugar levels. The provider told us, "We need to monitor (person) that he is doing it at right time. We have to train the (member of staff) taking care of how to do that." The training had not taken place.
● Where people were at risk of falls there were no risk assessments in place. One person's mobility had decreased. The registered manager told us the person now required a full body hoist however this had not been updated in their care plan. There was no risk assessment in relation to the hoist.
● There were people that smoked yet there were no assessments in place to manage this risk. This was of particular concern where the provider confirmed people smoke when staff were present.

● The provider told us they had identified one person's meals needed to be pureed due to the risk of choking. There was no choking risk assessment in their care plan or information on the consistency of food the person required. One member of staff who supported this person did not know whether the person required a modified diet. This meant there was a risk the person would be offered food that was not suitable.
● Accidents and incidents were not always recorded with the actions taken to reduce further risks. One person had hurt themselves on the moving and handling equipment. Although health care support was sought by staff there was no information on the incident form as to what actions had been taken to reduce further risks.
● The registered manager was not collating all the incidents and accidents which meant that analysing them to look for trends was not always possible. We saw that two incidents for a person in September and October 2022 were inside the person's care plan. There was a lack of information on how the risks were mitigated to reduce further incidents.

As risks were not being managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We saw that staff had received infection control training. Staff we spoke with had an understanding of what they needed to do to reduce the risk of spreading infections. One member of staff said, "We wear a mask, apron if required and gloves." Another said, "We use gloves and masks. We get them in every client's house."
●The registered manager told us, "I always drop off PPE to them and when it is getting low, they will tell us. I have PPE in my car."

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with staff and their families felt their loved ones were safe with staff. Comments included, "It's taken a load off my mind knowing he's being safely cared for" and, "I feel safe with them coming in and looking after him."
● Staff understood what constituted abuse and said they would contact the registered manager if they had concerns. However, staff had a lack of understanding of what they would do if they needed to report the concerns outside of the organisation. Staff we spoke with did not know who the agency was that dealt with safeguarding. Comments from staff included, "I would call the Police or something like that. CQC deal with Safeguarding", "If the line manager doesn't do anything about it I will, if emergency then call 999 or 111" and, "I would report it to my supervisor and ask in a couple of weeks if something has been done."
● The registered manager investigated any concerns and reported to the Local Authority safeguarding team where appropriate.

We recommend the provider ensures staff are provided with appropriate safeguarding information in the event they need to report concerns outside of the service.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The provider told us they did not undertake an assessment of people's needs before they accepted the package of care. his meant there was a risk the person's needs may not be able to be met by the provider.
- The provider told us that care plans for new clients were developed with 72 hours of providing care. However, we found one person had been provided care the week prior to the inspection and no care plan or risk assessments had been recorded.
- All of the people being provided care were introduced to the service by the local authority. We saw there were assessments from the local authority, but these had not always been incorporated into people's care plans. There was information missing in relation to people's mobility, communication and dietary needs.
- The provider and registered manager were not using any recognised good practice and national tools to ensure that people's care was provided appropriately. For example, there was a lack of evidence in care plans where NICE guidance was used to assist them with care for example in relation to moving and handling and skin integrity.

As an appropriate assessment of people's needs was not taking place in relation to people's care this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People and relatives did not always feel staff were appropriately trained. Comments included, "Some are absolute beginners for instance they will let me walk into my lounge unsupported which I need, I need help walking" and, "Sometimes when I ask them to change the bed they only change the sheet. I really don't like a dirty bed, so I end up doing it myself."
- People were not always supported by staff that had undergone a thorough induction programme to give them the skills to care for people effectively. The registered manager told us all staff had to complete two days of shadowing another member of staff. We saw that one member of staff, who had no background in care, had only completed two care calls and then started providing care independently the following day.
- Staff had not always received training specific to the needs of people they supported. There were staff that regularly supported people with Parkinson's and diabetes, yet no staff had received training on this. One member of staff, who regularly supported a person with diabetes was unable to provide information around what they would do if the person had high or low blood sugar levels. The member of staff said, "I don't know. Just make them comfortable and don't let them panic and keep calm."
- The provider was not working to their policy that stated, "(Registered Manager) will also outline training that is required to meet the very specialist needs of both service users and specialist roles." According to the

training record there were also two staff that had not received any required training.
● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. The registered manager told us all staff had one to one supervisions every three months. However, when we reviewed staff files, we saw there were staff that had only received one supervision since July 2022.
● The registered manager also told us these supervisions were taking place at people's home. A member of staff told us, "I can't recall a one to one supervision. The only time I see (registered manager) if she meets us at a clients." This was despite their policy stating, "Formal supervision sessions must take place somewhere that is away from the frontline working environment" and, "Offers privacy for the duration of the session."

As there is a lack of staff training, knowledge and competency this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were people and relatives that fed back positively about other care staff's abilities. Comments included, "I think they're well trained for my purposes", "I think the carers are well enough trained" and, "I see everything they do for him and it's is really good."

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We found the provider and registered manager were not aware of the principals involved to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. The provider told us there were families who had Power of Attorney (POA) to make decisions for people around health and welfare. However, they had not always asked for evidence of POA which meant there was a risk that families would be making decisions for people where they may not have had the right to do so. The provider told us, "Sometimes we ask for the POA . I'm learning. I want to learn."
● We noted there were capacity assessments for all the people the provider supported. The provider and registered manager lacked an understanding that assessments only needed to take place where the person's capacity was in doubt. Despite their policy stating, "Immaculate Care Limited understands a capacity assessment is not required if there is no doubt about an individual's capacity."
● Another person had an assessment in place where it was deemed they lacked capacity to accept the care package. This also included a best interests record involving the person's relative. However, the provider had got the person to sign a form consenting to the care.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation

11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● There was a lack of information in people's care plans around people's preferences with food and drink. There were frequent references to cares needing to prepare the person's food. There was a lack of information on people's likes and dislikes.
● Where people had specific dietary needs such as people with diabetes or where food needed to be modified there was no information in the care plans around this. This was also reflected in staff feedback where they did not always know what foods people needed to avoid.
● However, people and relatives told us they had no concerns with how people were supported with their nutrition and hydration.

We recommend the provider reviews the nutritional and hydration needs of people to ensure they are supported appropriately.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The provider and registered manager monitored people's health and liaised with relevant health care professionals to ensure people received the care and treatment they required.
● We saw that the provider had contacted a speech and language therapist in relation to concerns about a person's eating and drinking.
● Staff told us they would ensure they raise concerns about a person's health with the office or health care professionals.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People and the families were not always told when care staff were running late. One relative said, "Their timing can be random, yes quite random and there's is no point ringing her (family member) cos she has dementia, they really need to ring me if they're running late." Another said, "Weekends can be a bit erratic timing wise."
- We saw from the rotas that staff were not always attending the call at the time that was planned with the person. One person told us, "When they come in, I'm still in bed and would like them to come a bit later it makes my day very long." Another told us, "Timings are not always good."
- There was not always consistency for people in relation to which member of staff would attend the call. One relative said, "She's (person) had a main carer but the other one can change on a daily basis."

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- For the most part people and the relatives fed back about the caring nature of staff. Positive comments included, "They seem to be very kind caring and compassionate carers", "Her carers are kind and caring, they're chatty and one always allows time to chat to her" and "They're very kind to him and will have a good chat too."
- People and relatives said staff were supportive when maintaining people's independence. A person told us, "They wash me well and I can do some bits too by myself." One relative told us, "We like him to maintain his independence and they help with that."
- People and relatives told us staff were respectful when providing support. One person told us, "Staff are nice and respectful towards me."

Requires Improvement

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 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; End of life care and support

- Care plans were not personalised and did not always have detailed guidance for staff specific to each person needs. One care plan had a local authority assessment where it stated the person had a cognitive impairment and may display certain behaviours. There was no guidance in the care plan for staff on how best to support the person with this.
- People's care was compromised as care plans were not updated or revised when they had a changing need. We saw from a complaint that a person's needs had increased and now required additional equipment for moving. There was no information in the person's care plan in relation to this.
- People life histories, likes, dislikes and interests were lacking in their care plan. There was some information that people had family there was no further detail including names of family members and important people in their lives. Staff we spoke with were not familiar with people's life histories. One member of staff said, "I don't really know life history, I haven't focused on that" and "I don't know much about that."
- Staff were not always aware of the health needs of people. We saw from one person's care they had a diagnosis of dementia. However, when we spoke two members of staff who supported this person, they told us the person did not have dementia.
- There was a lack of guidance on how best to support people with a learning disability. When we spoke to the provider about this, they had a lack of understanding of the potential support the person may need.
- People were not always supported with their end of life care planning. There was no information in their care plans on discussions with them and their relatives on their wants and wishes.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- There was a lack of information in people's care plan on how the person communicated or guidance for staff. One care plan stated the person had 'an issue' with communication but there was no further information.

● Another care plan had information from the local authority that the person had a visual impairment. There was no reference to this in the person's care plan or how if affected them.

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to raise a concern. One relative said, "They're generally responsive." Another told us, "I'm sure if I had any problems, they would help me."

● We reviewed the complaints received by the provider. There had been three complaints that had been investigated thoroughly. This included where staff were not always checking for out of date food in a person's fridge. The registered manager spoke with the member of staff involved and contacted all staff to remind them.

● People had access to a complaints policy and staff spoke to people about what they needed to do if they were unhappy about something.

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.

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

- The provider and registered manager did not have robust oversight of the service. Both attended care calls throughout the week all times of the day. As such they did not have sufficient time to maintain the smooth running of the service.
- There was a lack of auditing by the provider and registered manager to identify where improvements needed to be made. We found concerns around care plans, risk assessments, training, supervisions, recruitment and the MCA. None of these areas had been audited by the provider or registered manager. Where audits were taking place, these were not effective in identifying shortfalls for example in relation to the MAR charts.
- The provider and registered manager were not open and transparent with us at the inspection. In the morning of the inspection, they told us they only occasionally covered care calls. They asked a member of staff to tell us they had been rostered on to calls that morning however the registered manager and provider had already undertaken some of the calls before we arrived. The provider told us, "We asked her to say she did the calls."
- After the inspection they confirmed that five staff who they told us had been rostered to work the week of the inspection were not working that week." . The provider said, "We added those names just to populate the staff as we don't want you to know we are attending many calls." We saw from the previous weeks' rotas the provider and registered manager were working full time covering care calls. The provider told us, "I know that we should be in the office doing loads of paperwork."
- The provider failed to tell us about a person they were providing care to. The provider told us, "I didn't tell you because I had not done the care plan."
- The provider and registered manager told us they monitored the length and promptness of calls through their online systems where staff had to log in and out of calls. However, there was no oversight of this as we saw frequent incidents where the provider, registered manager and staff were not logging in or were arriving later than planned. There was no oversight from the provider or registered manager to ensure they knew that a carer had turned up. The registered manager told us, "We need to get a carer to be the field supervisor into the office."
- In additional to recording the care on the online system the provider told us they required staff to handwrite care notes in the person's home. The provider told us, "They write the time they arrive and the time they go. We need to know if they spend their time there that they attended the client." We saw from the notes there were frequent times the provider and registered manager had written when they left a person's

home but then recorded they had arrived at the next call before the end of the last visit. This meant there was no accurate record of how long they had been at the call.

The failure to ensure quality assurance and governance systems were effective and records related to the provision of support for people were adequately maintained is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

● The provider had not undertaken surveys with people and the relatives to gain feedback about the service. The registered manager told us, "We rely on telephone monitoring for our feedbacks for now." One relative said, "They have never asked me for any feedback."

● Staff told us that although they felt supported by the management, the communication could be improved upon. Comments included, "There could be better communication. Probably the manager doing care calls can affect the communication" and, "I can't always get hold of her (registered manager). I will leave a message, or she will say, 'At clients house, will call you later.' She will call though."

● The provider undertook a survey with staff in August 2022. However, the feedback was not always used to make improvements. Staff had raised they wanted more training and concerns with the rota. There was no evidence changes had been made in relation to this.

The failure to ensure the service performance was evaluated and improved is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There was positive feedback from staff about the management. Comments included, "The boss gives me good compliments" and, "There have been times where I haven't been able to go to one of my calls. (Registered manager) has been able to cover for me."

● We also received some positive feedback from relatives about the service. One relative told us, "This service is 100% good."

● We saw compliments had been received into the service with comments including, "Thank you for all the care you gave to (person) in her last weeks" and, 'We cannot thank the Immaculate Care personnel enough for the wonderful care they showed. The whole team were kind, compassionate, dependable and respectful."

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

● The provider and registered manager had a lack of understanding of duty of candour. When asked the registered manager told us, "It's all to do with recruitment, how we treat staff, make sure we competency assess?" This meant there was a risk when something went wrong at the service the providers may not follow the current procedures of informing people about the incident providing truthful information and an apology.

● The provider worked with external organisations in relation to people's care. The service worked with other organisations including the health care professionals and local authorities.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people's care was planned delivered in relation to their needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to follow the principles of the Mental Capacity Act

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have robust systems in place when recruiting staff.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe care and the management of medicines was not robust.

The enforcement action we took:

We issued the provider and registered manager a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have robust oversight of the service

The enforcement action we took:

We issued the provider and registered manager a warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficiently trained and supervised staff.

The enforcement action we took:

We issued the provider and registered manager a warning notice.