Bespoke Care at Home Ltd

Bespoke Care At Home

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
Bespoke Care at Home is a domiciliary care agency. The service delivers personal care to people with mental health needs, people living with learning disabilities, autistic people and people with dementia. At the time of the inspection there were 63 people who received the regulated activities.

People's experience of using this service and what we found
Most people said they felt safe from harm, but we found unsafe work practices that amounted to abuse. A person told us, "One of the carers was showing another carer what to do, and when [the staff] left the house, they left my door wide open. That's not safe. When I complained, they just had to apologise".

The provider used illegal restrictive practices and was not aware of their responsibility to identify and report potential abuse. The provider did not do all that was reasonably practicable to mitigate risks to people's health and safety. Systems in place to assess the deployment of staff were ineffective and unsafe recruitment practices meant the provider did not always protect people from unsuitable staff. Medicines practices were safe. We have made a recommendation relating to infection control.

The provider did not ensure the design and delivery of care and support was delivered in line with current evidence-based guidance, standards, best practice, legislation. The provider did not make sure all staff were appropriately skilled, knowledgeable, and qualified to ensure people's care and support needs could be met. The provider worked with external agencies, we saw some good examples but this was not consistent. People's nutritional needs were met.

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

People were not always treated with dignity and respect. Their preferences for care and support were not always met. People said they were involved in making decisions about care and support, but we found actions taken, and outcomes achieved were inconsistent. People said staff knew them well and electronic care records provided more information about people's lives.

The provider did not always meet the care and support needs of people with learning disabilities and people with dementia. People had expressed dissatisfaction with call times and duration of care call visits. We found the provider's complaints systems were ineffective as the provider was unable to appropriately address them.

Quality assurance systems used to assess, monitor and improve service delivery were inadequate. The nominated individual and senior management did not have all the necessary skills and knowledge to become compliant with the regulations and associated legalisations.

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 have a learning disability and or who are autistic.

Right Support:
People were not supported to have maximum choice and control of their lives. Not all staff had not received appropriate training to support autistic people, people with learning disabilities and people with dementia. Staff failed to design and deliver care and support relevant to their learning disability needs and protected characteristics as outlined under the Equality Act 2010.

Right Care:
People were not always treated with dignity and respect. The provider did not have enough appropriately skilled and knowledgeable staff to meet people's individual needs. Especially when they were communicating a need when distressed or anxious.

Right Culture:
People were supported by staff who did not always understand best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not always receive compassionate and empowering care that was tailored to their needs.

Rating at last inspection and update
The last rating for this service was inadequate (published 1 October 2022) and there were breaches of regulations. The provider sent us action plans on a monthly basis, to show what work they had undertaken to become compliant with the regulations.

At this inspection we found the actions taken by the provider was not enough to become compliant with the regulations and therefore, they remained rated inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bespoke Care at Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified continued breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, receiving and acting on complaints, good governance, staffing, fit and proper persons employed, duty of candour and notifying the Commission of notifiable incidents. We found a new breach in relation to need for consent.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always 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.

Bespoke Care At Home

Detailed findings

Background to this 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 3 inspectors and 1 Expert by Experience. An Expert by Experience (EXE) 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.

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 not a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection.

Inspection site visit activity started on 20 and 21 February 2023 and ended on 1 March 2023. Day 1 of the inspection was attended by two inspectors and days 2 and 3 was attended by 1 inspector. We visited the office location to see the provider and office staff to review care records, records relating to the management of the service, policies, and procedures. The EXE made telephone calls on 1 and 2 March 2023. An inspector made calls to staff on 23 February 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from local authority Commissioners and health and social care professionals.

During the inspection-
We spoke with the provider about the improvements they had made since our last visit.

We spoke with 8 people and five relatives, 9 care workers, an office administrator who was also the champion for risk management, field care supervisor who was also the champion for DoLS, safeguarding lead who was also the training coordinator, operations director, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We viewed 4 care plans in detail, 10 staff files in relation to recruitment, induction and supervision records, training data, policies and procedures and a variety of records relating to the management of the service.

We received feedback about the service from a relative shortly after our inspection.

We sought clarification from the provider to validate evidence found. All information received was used as part of our inspection process.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection we found the registered person did not ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12 of the Health and Social Care Act.

- The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of people who received care and support. A person with a learning disability was diagnosed with epilepsy had a risk assessment for a prescribed medicine that staff would need to administer when they had seizures. The risk assessment stated staff should administer the medicine when episodes lasted for 10 minutes.
- However, this information contradicted the direction given in an epilepsy care plan dated 20 February 2020 from a hospital's specialist consultant. This stated staff should administer the medicine if episodes lasted 3 minutes and provided a protocol for staff to follow. The provider's failure to update the electronic care record to reflect this epilepsy care plan, placed the person at risk of avoidable harm.
- Another person with a learning disability had a medical condition which caused them to eat inedible objects. This medical condition placed the person at risk of serious harm. The person's care plan advised staff to watch them at mealtimes as they had no awareness of food and to ensure they did not put any objects in their mouth. However, the provider failed to assess this risk. Information to staff was ineffective to help staff safely manage this condition.
- Staff were not appropriately trained to use nationally recommended de-escalation techniques to ensure the safety of people with learning disabilities and themselves. A person could not use words to communicate and, on occasions, would express feelings of distress and become physically aggressive to anyone who was close by. A staff member who worked with the person 6 days a week told us, they had not received any training in breakaway techniques and felt that if they had restrictive practice training or similar training, they would learn how to block the person from physically assaulting them.
- This staff member's training record confirmed what they had told us.
- People were not adequately protected from the risk of falls. For example, a person electronic care plan had an alerted staff, they 'recently' had 3 falls. We looked at incident records and found no written records of the falls. One of the falls resulted in the person's hospitalisation. However, the provider failed to review the risk and appropriately manage it after the person was discharged from the hospital.

● The same person also had a diagnosis of epilepsy. Medicine administration charts showed the person was on prescribed medicine for epilepsy. There was no care plan to guidance staff on how to manager this person's epilepsy and what to do if they had a seizure

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● The provider's business continuity plans ensured people could continue to receive support in the event of an emergency.
● An on-call system in place ensured received support should they required help and advice.
● The provider carried out a health and safety assessment of the environment to make sure people, their family and staff were safe during the delivery of care and support.

Learning lessons when things go wrong
● Lessons were not learnt when things went wrong. We have reported about this under the Well-Led section of this report.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found the provider did not ensure their systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13 of the Health and Social Care Act.

● Most people said they felt safe from harm, but we found unsafe work practices that amounted to abuse including people's houses being left insecure.
● The provider used restrictive practices without consideration for the law and relevant legislation.
● Care staff used restraint on a person with a learning disability to enable them to provide personal care. The person's care record showed the rationale for the restraint however, the provider failed to follow legal requirements before instructing staff to restrain the person. This meant illegal use of restraint deprived the person of their Human Rights.
● Training provided to staff about restraint did not accord with best practice by a certified trainer and did not sufficiently consider people's learning disability needs.
● The provider was not always able to identify when there was a potential for neglect to happen. On 7 November 2022, an ambulance service reported an allegation of negligence against the provider as they believed there was no food in the person's home, and they were not eating.
● A local authority's (LA) safeguarding team contacted the provider when investigating this concern. The provider told them they had been aware of the person's poor nutritional intake. However they failed to report it to the LA at the time they became aware.

The provider used illegal restrictive practices and was not aware of their responsibility to identify and report potential abuse. This was a continued breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing

At our last inspection we found the provider did not ensure there were sufficient numbers of staff deployed effectively to ensure they can meet people's care and treatment needs. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18 of the Health and Social Care Act.

● The provider failed to ensure care visits were planned in a manner which supported a personalised and dignified service. We looked at staff rotas, daily notes completed by staff and complaints received from people about call times and duration of call visits, which was extremely poor.
● People and their relatives told us staff did not arrive on time or stay for the duration of the call and how this negatively impacted them. Comments included, "No not really. I don't know what time they (staff) are supposed to be here really. I don't want anyone before 8 am, and I have told them. But occasionally they are here at 7.30," and "No, they are supposed to stay for 30 minutes. They usually come for 10 minutes and leave."
● The monitoring care calls did not ensure the deployment of skilled and qualified staff, was organised to ensure people's safety.
● This was due to an ineffective call monitoring system. We have reported about this under the Well-Led section of this report.

This was a continued breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

At our last inspection we found the registered person had not obtained all the information required by the regulations to ensure the suitability of all staff employed. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19 of the Health and Social Care Act.

● The provider did not establish nor operate effective and robust recruitment and selection procedures to ensure they employed suitable staff.
● The provider did not complete all required recruitment checks before staff started work. The recruitment records of 10 staff members did not contain all the necessary information, such as evidence of entire employment history and any gaps explored, staff's conduct in previous employment and verifying the reasons for leaving and, Disclosure and Barring Service (DBS) checks before newly recruited staff started to work. Disclosure and Barring Service (DBS) checks provide information, including details about convictions and cautions held on the Police National Computer. The report helps employers make safer recruitment decisions.
● Failing to obtain all the required recruitment information before allowing staff to work placed people at risk of receiving care from unsuitable staff.

This was a continued breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider's 'Coronavirus (Covid-19) management for Dom Care policy' dated 3 August 2022 did not reflect the latest government guidance regarding the use of personal protective equipment in adult social care settings, which was updated on 30 January 2023.
● Senior management was not aware it was no longer required for care staff to wear face masks when providing care if people and staff were not displaying COVID-19 symptoms.
● People and relatives confirmed staff wore PPE when visiting and while supporting them.
● Staff told us they had received infection control training and it had been emphasised during the COVID-19 pandemic, and was therefore aware of their responsibilities to maintain good infection control practices.

We have made a recommendation for the provider to seek up to date national guidance and best practice regarding the use of PPE.

Using medicines safely
At our last inspection we found the medicine management was not robust enough to demonstrate that medicines were managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made in relation to management of medicines.

● People's medicines were managed safely
● Most people said staff managed their medicines safely. Comments included, "Yes, they (staff) have the right training. The 2 (staff) in the morning are regular and are good", "They (staff) check if I have had it (medicine) or not", and "They give it me and I take it" and "They put cream on and some days they forget. The new staff don't read notes, it's a bit hit and miss."
● Electronic medicine administration records (MAR) contained information about what the medicine was and reasons for it, how and when to administer, and any side effects to observe.
● 'As and when required' medicines protocols were in place for each person who took 'as and when' required medicine. These explained when medicines would be required.
● Staff told us everything relating to people's medicines were recorded in people's electronic care records which provided details about what medicines was needed to be administered safely. Training records confirmed staff were up to date with medicines training.
● Medicines administration and PRN policies and procedures dated 3 August 2022 were in place and were informed by national guidance and best practice.

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 Requires Improvement. At this inspection this key question has remained 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

At our last inspection we found the provider did not ensure people's care and treatment was appropriate and met their needs. This was a breach of Regulation 9 Person-Centred Care of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9 of the Health and Social Care Act.

● Staff failed to design care and support plans relevant to people with a learning disability's needs. Therefore, the service could not guarantee people would always receive care and support that was person-centred. Staff who completed assessments of people's care and support needs failed to explore and document what specific diagnosis people with learning disabilities and people with dementia, had.
● For example, a person's needs assessment that was completed in 2019 stated they had a learning disability. Staff failed to explore what the learning disability was and how it impacted upon the person's life. We looked at the person's current care plan. It showed staff had not put an appropriate care and support plan relating to the person's disability. People could not be confident the provider would provide effective care and support.
● A view of staff training records and the staff training matrix showed that staff responsible for assessing people's needs had not received the relevant role-specific training. Staff undertaking assessments must demonstrate an understanding of current legislation that underpins best practices and national guidance to provide people with practical care and support. A view of completed assessments showed this did not happen. As a result of this, we were not assured staff work practices would not discriminate against people, as the provider failed to consider their protected characteristic under the Equality Act 2010.
● For example, a person's assessment stated they had a medical history of epilepsy. Staff did not consider this medical condition when they designed the person's care plan. The provider did not always ensure that the staff created care plans to meet all of people's care and support needs.

This was a continued breach of Regulation 9 Person-Centred Care of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection, the registered person did not ensure all staff were competent, skilled and had up to date training in order to carry out their role when supporting people and perform their work. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

Not enough improvements had been made and the provider was still in breach of Regulation 18 of the Health and Social Care Act.

● People and relatives gave feedback about staff skills, knowledge, and competence to support their varied needs. Comment included, "I think they (staff) need more training. They (staff) put cream on and some days they forget. The new staff don't read the notes, it's a bit hit and miss", "I think they (staff) should know what to do before they come here, some of them don't know what to do" and "We have a hoist…It's very hit and miss. They work as a team, and one is very good and the other isn't. We wonder if there is sufficient training. When it's new staff, more training is needed. Some [staff] haven't even seen a hoist before coming to the house. I often stay when a new carer comes as I know the other carer will need my help and I shouldn't have to do that."
● The provider did not support staff to be able to fulfil the requirements of their roles. A view of the service's staff training matrix, that recorded the provider's mandatory and specialist training, showed staff had not completed, or were not up to date with the relevant training.
● For example, pressure area care, essential life support, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and supporting people when upset, anxious or distressed. Some staff told us they did not have training for Buccal Midazolam to help with seizures, even though they provided care to people who may require staff to administer this medication.
● Staff did not always have the skills and knowledge to meet people's complex healthcare needs effectively. Training records indicated many staff had not had training to support people with percutaneous endoscopic gastrostomy (PEG), a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. We asked the provider if they had trained and assessed the competency of staff delegated to the task's competence of practice with PEG, catheter, or stoma care. The provider's response to our question was, they had carried out spot checks and competency checks (to confirm staff were assessed as competent).
● We found staff designated to carry out these tasks had no specific training to be an assessor or trainer for these areas of care. There were no records to confirm staff had been trained and assessed by relevant health and social care professionals in relation these specific tasks. We brought this concern to the provider's attention at our last inspection, but it still did not meet legal requirements.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2019 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 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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of

the MCA.

At our last inspection we recommended the registered person to seek advice and guidance from a reputable source about MCA legal framework, and their responsibilities to ensure people could express their views and be involved in decision making.

Not enough improvement had been made at this inspection and the provider was now in breach of Regulation 11 of the Health and Social Care Act.

● The provider failed to follow the requirements of the Mental Capacity Act 2005 and its Codes of Practice.
● The provider sought consent from people where relevant health and social care professionals had assessed them as unable to make specific decisions. For example, a local authority (LA) obtained a Court of Protection order for a person who had been assessed as not having the mental capacity to make decisions about their finances. This meant the LA was now solely responsible to manage the person's finance, on their behalf. However, the provider still sought consent from the person in relation to their finances. A signed signature showed the person had given staff consent to help them with a task requiring access to their finance.
● The provider failed to assess a person's capacity when there were concerns around their capacity to make decisions in relation to the medicines and receiving care and support.
● Management and senior staff lacked knowledge of MCA legislation. They were unaware it was their responsibility to complete mental capacity assessments and told us the burden remained with health and social care professionals. The management team's understanding was inaccurate, and their work practice was inconsistent with MCA legislation and its Code of Practice. Therefore, people could not be confident they would always get the support they needed to make specific decisions when required.
● Completed mental capacity assessments showed senior staff failed to document what specific decisions they had assessed people for, which made the mental capacity assessments ineffective. We saw these inaccuracies in 3 people's care records.
● Where Best Interest meetings happened, records showed the expressed views of people, their legal representatives, and relevant agencies, where applicable, were not documented. We could not be confident minutes of Best Interest meetings accurately reflected what people or their legal representatives, had consented to.

This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People and relatives told us how staff supported them to maintain their nutrition and have good fluid intake. People and relatives gave us positive feedback about such support. However, one person was not happy the way the staff supported their meal preparations saying, "They (staff) can't cook, not even poach an egg. The food is very boring".
● Most people and relatives agreed that amongst others, staff supported them with meal preparations.
● Where someone needed help with eating or encouragement with drinking and having a balanced diet, basic guidance was provided to staff.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People said staff would contact health and social care professional if they required support, a person commented, Oh yes, absolutely, [care worker] even notices things on my body and called the GP about a

mole [care worker] thought was growing. [Care worker] even sent a picture of it to my GP. GP came out to have a look and said, "What a good carer you have."

● People were supported to maintain their health. We saw good examples of joint working to ensure people got good health outcomes however, this approach was inconsistent.

● The service made referrals to external healthcare professionals when required. For instance, to occupational therapy and district nursing services.

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 requires improvement. At this inspection this key question remained 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; Respecting and promoting people's privacy, dignity and independence

At our last inspection, the registered person did not ensure people were treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10 of the Health and Social Care Act

● People and relatives gave mixed feedback, some told us, "They (staff) rush [the person] and don't know how to treat [the person] without upsetting them", "No, they are not good with the [person]. I have complained about them, but nothing happens. The manager comes out and it gets a little bit better" and "They are pleasant enough. They are not unkind; they are just polite. I don't really want them in my house."
● Whilst other people felt staff were treating them better, with respect, compassion, and kindness during their visits. They said, "Yes, they are all polite and very nice, it's quite nice to see them when they arrive", "Yes, I just think they are kind, it's hard to give examples because [staff] are all just generally sweet" and "They do treat [the person] well. The way they talk and joke about, it is lovely".
● People were not always treated with dignity and respect, we have provided examples in the Safe, Responsive and Effective sections of this report.

The provider had still to make improvements to ensure all staff consistently treated people and their families respectfully. This was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made improvements to electronic records by ensuring they were more detailed to make sure care and support would be centred around people rather than, only on the care and support tasks required.
● People spoke about the caring nature of staff. Comments included, "They (staff) have a laugh and talk about football, they have a joke and make fun of [person's] football team, all in jest. I think that helps [the person] a lot" and "Yes, (know a person well) and when the 2 carers started, it wasn't great but now, I trust them and we talk."
● Electronic care plans instructed staff to promote people's independence, staff we spoke with confirmed

this was their work practice.
● People's care plans had more comprehensive information to help staff focus on what people could do and how staff could help them to maintain their independence wherever possible.
● Staff told us about respecting people's differences and individual needs and ensuring that they provided the care that the person needed in the way they wanted. Staff added "We are not here to judge anyone" and "Everyone must be treated fairly". Staff also were able to explain about the importance of ensuring people were supported to make choices about their care and support.

Supporting people to express their views and be involved in making decisions about their care
●People and relatives were involved in providing views on the support they received. People confirmed they were asked their opinion, or they would ask to make some changes in the support. However, the actions taken were not always to their satisfaction and they did not feel listened to.
● People's confidential information was kept in the office, on a password protected computer and in a place of people's choice in their homes. Staff understood the importance of keeping information confidential. They would only discuss things in private with people, when necessary.

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 requires improvement. At this inspection this key question remained 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.

At our last inspection we found the provider did not ensure care and treatment was appropriate, met people's needs and reflected their preferences in a consistent way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9 of the Health and Social Care Act.

- People gave mixed feedback about whether their preferences for care and support needs were met. Some people said they were and some people said, they were not.
- People's care and support needs were not always reviewed to make sure care and support delivered still effectively met their needs. Electronic care records showed completed home reviews were not detailed enough and therefore, we could determine if people's preferences in all areas of care and support, were met. For example, a view of a home review meeting notes dated 9 February 2023, showed a person stating they had a concern about some care staff's work practice. The assessor did not acknowledge the concern or even document what action they were going to take in response. Therefore, we could not determine, if the person's concern had been dealt with.
- Home reviews did not always happen regularly, and staff did not always make enough effort to ensure people or those who represented them, could be present for these meetings. For example, electronic care notes stated one person's legal representative had refused to make themselves available for a care review. However the legal representative told us they had not been available at the times offered and the service had not been flexible with offering a review meeting out of normal working hours. This legal representative explained there were issues in relation to the care package that remained unresolved because a review meeting could not take place
- We looked at the provider's 'home review' spreadsheet which documented the dates and names of people they had visited from November 2022 to February 2023. The records showed no home reviews had taken place with the person and their relative during this period. The person had multiple health needs and therefore we were not assured the provider was effectively meeting their care and support needs.

Reviews of people's care and support needs were not always responsive, did not happen regularly to ensure all relevant persons could be present. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

At the last inspection, the registered person did not establish and operate an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 16 of the Health and Social Care Act.

● People did not always have confidence in the provider's complaint's system. Some of the comments received included, "Yes, [we raised] quite a few [complaints] but nothing gets done" and "Yes, I have made complaints. I told them not to send a certain [staff] and they stopped and then sent [the staff] again" and "Yes, [we raised] quite a few [complaints] but nothing gets done"
● The provider did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.
● The provider had improved some parts of their complaints system since our last inspection, but processes in place that monitored complaints were ineffective.
● We looked at the provider's audit for January 2023 to establish how they responded to complaints. However, the auditors did not document all complaints received and actions taken.
● For example, the provider's complaints audit for January 2023 recorded the service had received no complaints in January. This did not reflect the amount of concerns people had raised with us during this inspection and concerns cited on the provider's quality assurance spread sheet. Where management completed audits, auditors only described the procedures and processes used to handle complaints instead of what action they had taken in response. Therefore, the provider would not have been able to analyse if complaints were dealt with satisfactorily and use any feedback to make further improvements.

This was a continued breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff knew about recording and reporting complaints and told us they were confident management would be appropriately responsive to concerns raised.

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 carers.

At our last inspection we recommended the service seek advice from a reputable source about meeting all five steps of the AIS to ensure all information presented is in a format people would be able to receive and understand. The provider did not make enough improvements.

● The provider did not always follow the Accessible Information Standards (AIS). Electronic care records did not always identify, flag, share and record people with learning disability's communication needs.
● For example, we only discovered a person had a learning disability when looking at the communication needs section in their electronic care plan. In this care plan section, staff had only documented the words, learning disability, as the person's communication needs. This meant there was a potential for the person to

not be able to communicate and understand staff consistently.

● We reviewed the person's electronic care plan in detail with a senior manager, who confirmed this was the only part of the care plan that referred to the person's learning disability. The provider updated the person's care record in response to our feedback by stating, 'they [the person] were known' to a local authority's learning disability team. We found, the concerns around their communication needs, had still not been addressed.

This was a continued breach of Regulation 9 (Person-centred care) 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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained 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

At out last inspection, the provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A). This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 of the Health and Social Care Act.

● Quality assurance systems used to assess, monitor, and improve service delivery were inadequate. The nominated individual and senior management did not have all the necessary skills and knowledge to become compliant with the regulations and associated legalisations. Therefore, they could not identify when systems and processes developed, to identify where quality and safety, were compromised.
● The service did not have a registered manager since August 2022. At the of our inspection, the operations director had submitted an application to become the registered manager for the service.
● From September 2022 until our inspection on 20 February 2023, the provider informed us monthly, they were ready to be re-inspected as they were confident they had made the necessary improvements. During this inspection, we found this was not the case.
● The provider's monitoring systems were ineffective. Audits undertaken by staff were descriptions of the provider's procedures and processes instead of evaluating what they did. Therefore, the provider would not have been able to determine the areas where further improvements would be required. As seen in audits of complaints, missed calls, home reviews and staff recruitment records, as examples.
● Records relating to care and support were not consistently accurate and fit for purpose. Audits had been ineffective in driving improvements in these areas. For example, an office staff completed a care plan audit on 14 February 2023, and a senior manager signed it off as complete. We found several inaccuracies in the care plan audit. It stated the person did not have epilepsy when they did, did not have legal power of attorney (LPoA) when a relative family member did, and the person received no support from outside agencies, when they did.
● We could not be confident care records reflected what people said they wanted and consented to. Senior staff failed to record people's involvement and views when conducting mental capacity assessments, home

reviews, or Best Interest meetings. Records showed staff members who completed various assessments, wrote them from their own perspective. Staff did not consistently document dates in care records. Therefore, we could not establish when checks, care reviews and meetings with people, happened.

● The nominated individual did not ensure staff's work practices reflected the principles and values of, Right Support, Right Care, and Right Culture. The provider failed to devise specific care plans relating to people with learning disabilities and people with dementia. This would have shown how these conditions impacted their everyday life and what action the service had taken in response.

●The provider had put in unrealistic targets for staff to complete training. The nominated individual and a senior manager stated that in addition to completing essential training courses, care staff had to complete 52 online courses between December 2022 and February 2023. When we probed further about how realistic this was, considering staff had a full work schedule, management responded the deadline for completion was really, for April 2023 instead. No structured plan was in place to show how the provider would assess staff's competencies for the relevant training, during this period.

● The provider and senior management failed to have completed training specific to their job roles, to ensure they could address the concerns found at our last inspection and to become compliant with the requirements of the Health and Social Care Act 2008 and associated legislation.

● From April 2021, CQC expect all health and social care services to only use training in restrictive practices from training providers who were certified and compliant with relevant training standards. We found the provider failed to do this.

This meant the provider still did not operate an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had installed a new electronic care planning and monitoring system. The newly developed electronic care plans were more person-centred.

At our last inspection we found the provider did not notify the CQC of certain incidents or event which have occurred during, or as a result of, the provision of care and support to people. This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations

● The provider failed to still notify us of incidents as they were legally required to do. They failed to notify us of an incident that involved the police, an allegation of abuse, where people sustained injuries resulting in hospitalisation and concerns raised about a person at risk of malnutrition.

●This demonstrated the nominated individual and senior management did not fully understand their legal responsibilities to report notifiable incidents to us and therefore failed to meet the requirements of this legislation. For example, informing people about the incident, in person by one or more representatives of the registered person, providing reasonable support, providing truthful information and having a written record.

This was a continued beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the Duty of Candour (DoC), which is their legal responsibility to be open and honest with people when something goes wrong

● At our last inspection, we found the provider failed to record and keep a copy of actions taken as required in the Duty of Candour regulation when a notifiable safety incident occurred. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of Regulation 20 of the Health and Social Care Act

● The provider had made improvements, but further improvements were required.
● Electronic care records showed letters of apology ("apology" means an expression of sorrow or regret in respect of a notifiable safety incident), were now sent to people and relatives when things went wrong.
● However, this was only one part of the legislation, and we found no records to show the provider had completed all other parts of DoC legislation.

This was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People's feedback about the service and care staff was positive about but they felt the main issues were around call timings and durations of visits, which impacted the care they received. People who raised these concerns with us, told us they did not feel listened to. Most of the people we spoke with said the provider did not ask them for feedback, but this was not the case for all. A person commented, "They (staff) turn up occasionally to ask how things are. I don't know why they do it because it has no effect."
● The provider did gather feedback from people and relatives about the quality of care provided.
● The provider put a new recording system to complete telephone calls to check the quality of care and support. Where people fed back concerns, there was insufficient information to show if actions taken in response, was to people's satisfaction. For example, two people had raised concerns about care staff timings on 5 January 2023 and 24 January 2023. Apart from staff stating they had spoke to specific care staff to ensure they arrive to the two person's home on time, there was no further information to show if the care staff were monitored to ensure they followed senior staff's instruction and how these feed back was used to improve the service.
● All staff spoke positively their job and training received. They all felt their induction, supervision and training prepared them for their role and responsibilities.
● Staff felt well supported by management, several mentioned and spoke highly of the field care supervisor who they described as really good and very supportive. Some spoke about recent improvements they had noticed, such as the electronic care system which they spoke highly of. They told us the office staff and management team were more respectful and pleasant to them when they called them for advice.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission about specified incidents without delay. Regulation 18 (1)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not notified the Commission about specified incidents without delay. Regulation 18 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure people were treated with dignity and respect. Regulation 10 (1).

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

	The provider failed work in accordance with Mental Capacity Act 2005 and its Code of Practice. Regulation 11 (1).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's established complaints system was ineffective in helping them to identify, handle, and respond to complaints. Regulation 16 (1).

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not work in accordance with all the requirements of the Duty of Candour. Regulation 20 (1).