Omega Integrated 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?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Omega Integrated Care Limited is a home care agency for adults including people living with dementia. At the start of our inspection the service was providing care to seven people. At the end of our inspection this had reduced to three people. All people using the service received support with personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People did not benefit from a well-led service. We received mixed feedback from people and their relatives about the management of the service. This ranged from serious concerns about staff training and conduct including the registered manager's own abilities and professionalism, to positive feedback about the registered manager's supportive approach and a staff member's punctuality.

We found effective systems were not established or operated to monitor the quality and safety of the service, manage risks, or safeguard people from avoidable harm. Medicines were not safely managed to ensure people always received their medicine as prescribed.

People were not always supported by trained or experienced staff. The provider failed to ensure appropriate recruitment checks were completed to check staff were of good character, prior to their employment.

People were not supported to have maximum choice and control of their lives and staff did not always support them in their best interests; the policies and systems in the service did not consistently support good practice.

People did not experience holistic assessments or reviews of their needs. Care plans did not always provide appropriate guidance for staff to meet people's health, nutrition and hydration needs, or their end of life wishes. Care plans did not clearly identify what support people needed and what they could do for themselves.

We received both positive and negative feedback from people and relatives about whether staff protected people's dignity and treated them with respect. For example, one person told us a staff member was caring and good company. However, other feedback included "[staff] social skills are not good" and staff were not "compassionate".

We found complaints were not well managed and people did not receive information about their rights or how to complain. The service did not notify the Care Quality Commission of certain events as required. This meant we could not check the service took appropriate action to anticipate and respond to concerns and risks to people.

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

Rating at last inspection
This service was registered with us on 8 April 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the service in relation to missed care visits which put people's safety at risk. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the further details in all domains of this full report.

The provider did not take appropriate action to effectively address concerns or mitigate risks to people that were identified by inspectors.

Enforcement
We have identified breaches in relation to the provider's governance, the management of risks and protection from abuse, how people are supported to meet their nutritional needs and treated with respect. Breaches were also identified in relation to people's needs and preferences being assessed and reviewed, fit and proper staff employed and sufficient numbers of suitably trained staff. Other breaches include, staff use of equipment, management of complaints and notifying the Care Quality Commission of certain events.

We had serious concerns about the impact of poor risk management, governance and staffing upon people's safety. Therefore, during our inspection, 25 November 2021, we decided to impose urgent conditions upon the service. These conditions restricted the service from providing care to new people, without our permission. We also imposed conditions upon the service to provide us with evidence about actions taken to improve people's safety. The service did not submit evidence within the set timeframes and evidence submitted was insufficient to comply with conditions. We took this into consideration as part of our inspection."
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
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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 six 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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Omega Integrated 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 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. However, our visit to the registered office was postponed for eight days because the registered manager was not able to assist with the inspection as planned.

Inspection activity started on 3 November 2021 and ended on 14 December 2021. We visited the office location on 11 and 12 November 2021 and 6 December 2021.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with four members of staff including two care workers, the assistant manager and the registered manager who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and two people's medicines records. We looked at one staff member's records in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed. Several documents we asked to look at were not accessible or made available to us by the registered manager during our inspection.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted one health professional involved with people's care but did not receive any feedback. We liaised with the commissioning authority and local safeguarding authority to monitor people's safety.

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 for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Effective safeguarding systems were not established to protect people from the risks of abuse and harm. The service did not have access to a current safeguarding policy and procedure because they had not paid the fees to the policy provider. This was because the service decided to purchase policies rather than write their own. This meant staff did not have access to appropriate guidance or knowledge about how to respond to concerns of neglect and abuse.
• Staff we spoke with were not aware of the role of the local safeguarding authority in reporting concerns of abuse. One staff member did not have any knowledge about the different types of abuse. The registered manager told us they checked staff safeguarding knowledge in supervisions and discussions, but they could not produce any documentary evidence to support this.
• The registered manager told us they were aware it is a requirement to report concerns of abuse to the local safeguarding authority. However, they failed to do so in relation to instances of missed visits affecting five people on 22, 23 and 24 October of this year.
• During our inspection we found safeguarding concerns in relation to the management and administration of medicines and a person's fall and injury. These incidents were not identified by the registered manager as potential safeguarding concerns. We reported these concerns to the local safeguarding authority.
• After our inspection the registered manager sent us a retrospective lessons learnt register. However, this failed to identify what the service could have done better to safeguard people from similar future events, such as a robust risk assessment of a person's mobility needs. It failed to acknowledge the missed care visits as a lessons learnt event or what service improvements were needed to safeguard people from reoccurrences.

Systems were not in place to protect people from the risks of abuse and harm. 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.

Assessing risk, safety monitoring and management
• The service had not identified or mitigated risks which put people at increased risk of harm. One person's needs meant there were risks in relation to falls, moving and positioning, choking, medicines administration, post-surgery wound, skin integrity and pressure damage. However, no risk assessment was completed for this person or one other person. The registered manager told us this was because they did not have time, despite care being delivered for over a week in one case.
• The registered manager had not reviewed the risks to one person after they fell from their bed. A more suitable bed was arranged; however, no other hazards were identified in relation to the person's mobility or what staff should do to reduce the risk of falls.

• Risk assessments for two other people were poorly written and did not identify hazards or actions to reduce risk in relation to health conditions such as diabetes, or the use of catheters. One person's care plan contained a general reference to bed sores without further explanation. This meant staff did not have access to appropriate information to manage risk safely. A staff member told us they were not aware of any risks in relation to the person's skin integrity. The registered manager informed us the same person had pressure damage following their hospital admission, which had improved over time. However, this was not documented in their care plans or risk assessment.
• The service had not identified or mitigated fire hazards in relation to paraffin-based topical creams. Environmental risk assessments of people's homes were not completed.
• One person's care plan identified they had a 'memory issue' without further explanation. Their family member told us the person could become "confused" due to Alzheimer's Disease as well as their mental health needs. The service's risk assessment was not robust in relation to the person preparing and cooking food. For example, the risk assessment stated, 'There is no history burning food or forgetting food being prepared', which did not consider or anticipate the potential risk due to the person's needs.
• In response to urgent additional conditions placed on the service on 25 November 2021, the registered manager reviewed two people's risk assessments. However, this was not provided within the set timescale and the content of risk assessments remained inadequate. For example, catheter care was not in accordance with the catheter care policy and procedure in relation to the frequency that staff should replace parts of this medical equipment. Neither were the manufacturer's instructions referenced. A third person's risk assessment was not reviewed at all, as required by conditions placed on the service. We were concerned not enough action had been taken to improve people's safety.

Systems were either not in place or robust enough to effectively manage risks to people. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The service failed to complete relevant staff recruitment checks, as required. This put people at increased risk of harm from potentially unsuitable staff.
• The registered manager only gave us access to one staff member's recruitment records, which were not in accordance with requirements. For example, no employment references were obtained; only one character reference was sought and documented 11 months after the staff member's employment, with no evidence of verification.
• The same staff member's employment history was inaccurate and incomplete. Their Disclosure and Barring Service (DBS) check, dated 20 August 2021, was not gained prior to their employment in September 2020. The registered manager told us they had not used the DBS update service prior to this as they did not know how to use it. We asked to see the staff member's other recruitment records such as evidence of their start date, job role and job description. However, the registered manager told us these were not accessible.
• The registered manager failed to provide recruitment records for two other staff members, as requested by us on 16 November 2021. They also failed to retain employment records for three other staff members who they confirmed were employed in October 2021. The registered manager told us they had "deleted" these staff members' records at their request and was unable demonstrate they had completed recruitment checks for these staff.

Systems were either not in place or robust enough to ensure staff were suitable, which placed people at increased risk of harm. This was a breach of regulation 19 (Fit and proper staff employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service failed to make sure there were sufficient numbers of suitable staff to support people to stay

safe and meet their needs.
• The local authority made us aware that several visits for five people were missed in October 2021. The registered manager told us they felt this was a contractual issue due to less hours being commissioned than initially agreed. The registered manager confirmed with us this resulted in staff refusing to attend agreed visits on 22, 23 and 24 October 2021. They told us agency staff were too expensive to cover staff, which mean there was no effective staffing contingency plan.
• We found the service did not have any suitable staff to deliver care to three current people in the event of planned or unplanned absence by the staff member responsible for delivering their care. The registered manager told us they may be able to cover. However, they acknowledged that people preferred female staff. We were also concerned about whether this was a viable contingency plan because of the registered manager's ill-health.
• Agreed care visit times and duration were not consistently recorded in people's care plans. One person's daily report showed visit start times were inconsistent in the morning up to one hour; and up to nearly two hours for the evening visit during the month of October 2021.
• In response to urgent additional conditions placed on the service on 25 November 2021, the registered manager reviewed their staffing contingency plan which included plans to recruit female staff. However, this plan was not provided within the set timescale and when we checked during our site visit on 6 December 2021, no viable candidates had been identified. The registered manager told us information for potential candidates was two to three months old. Also, they had no internal resource to support them with the recruitment selection process.

The service failed to employ or deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet all other regulatory requirements. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We received feedback from other people and relatives the staff member responsible for delivering their care was punctual and visits were not missed.

Using medicines safely
• The service failed to establish or follow effective systems to safely manage and administer medicines.
• The registered manager initially told us care workers were not responsible for administering any people's medicines and therefore no medicines records were completed. We found that to be factually inaccurate. For example, a care worker advised us they were responsible for crushing and administering a person's medicines for pain relief as well as antibiotics. We found the service was also responsible for getting medicines out of blister packets and prompting two other people to take their medicine.
• The service had not completed a medicines list or medicines administration record (MAR) for one person to ensure medicines were given according to the prescriber's directions, another person's medicines list was inaccurate. This was against national guidance for care providers managing medicines in the community.
• There was no information about whether it was safe for staff to crush medicines for one person, or how to promote their safety in relation to safe storage and administration of thickener powder for drinks. Another person's care plan failed to include any information about the name or directions for a prescribed topical cream, applied by staff.
• There was no explanation or actions taken in response to omitted medicines we found in relation to two people.
• None of these concerns had been identified or acted upon by the registered manager to improve people's safety.
• Staff we spoke with did not know the treatment purposes of medicines. This meant they did not have enough knowledge about the person's medicines to identify and act upon potential concerns.
• In response to urgent additional conditions placed on the service on 25 November 2021, the registered

manager reviewed a person's care plan. However, the updated care plan was not provided with the set timescale and failed to list or name the prescribed topical cream and did not state what the cream was used to treat, other than 'cream to address various health issues', which was insufficient. It also failed to provide staff with guidance about time-sensitive medicines.

The service failed to administer or manage medicines safely, which put people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• The service failed to effectively mitigate COVID-19 risks to people. There were no risk assessment to identify whether people were at an increased risk of COVID-19 or what staff needed to be aware of and/or do to reduce risk.
• The registered manager told us they were unaware of government guidance in relation to weekly COVID-19 'PCR' (laboratory) testing for homecare staff and 'Live-in' care workers. These were not being completed by staff to reduce risk of COVID-19 transmission from staff to people.
• The registered manager told us staff could take their own rapid lateral flow device (LFD) test, however, there was no monitoring system in place to check the frequency or the result of these tests.
• In response to urgent additional conditions placed on the service on 25 November 2021, the registered manager provided a retrospective log of LFD test strip ID numbers and corresponding negative results from 20 October to 5 December 2021. However, this was not provided within the set timescale and no information was provided about how the registered manager checked results or whether these were registered and reported centrally, in accordance with government guidance.
• When we announced our inspection the registered manager informed us they had COVID-19 symptoms and tested positive using an LFD test the day before, as a reason to postpone our inspection. They later denied the LFD test was positive, rather said it was unclear. However, we were concerned the registered manager had delivered care to a person for three consecutive days when they were unwell with symptoms of respiratory infection, due to the risk of transmission.
• Prior to our inspection we received information of concern that staff did not wear Protective Personal Equipment (PPE) during a care visit.
• The provider's policies and procedures did not detail how staff should use PPE in accordance with government guidance. The registered manager told us they had not been able to access PPE, however we found they had not taken timely action to address this prior to our inspection. The registered manager told us they purchased PPE privately, but failed to provide evidence that staff were using the appropriate type of PPE such as masks.

Systems were not in place to effectively risk assess, detect or control the spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We received other feedback from people and their relative that a staff member always wore PPE and managed hygiene well.

Inadequate

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

• The service failed to carry out effective initial or ongoing assessments of people's needs or preferences for care and treatment.

• The registered manager told us they and their assistant manager completed an initial assessment for one person prior to care starting. However, they could not find recorded notes of this and said they did not have enough time to receive feedback from the person's relative or write a care plan before care was delivered for two days before ceasing. The registered manager showed us hand-written notes in their diary for another person and said care plans and risk assessments were not created for staff to follow due to lack of time.

• Written notes for the same person's initial assessment contained very limited information. For example, there was no reference or information about the person's diagnosis of Alzheimer's Disease, sensory needs, emotional needs, medical conditions, allergies, communication needs, or diverse needs including protected characteristics such as religion and sexual orientation.

• Another person's care plan did not identify their Alzheimer's Disease or mental health needs or any guidance about how staff should meet their needs. A staff member told us, "I don't really know about [the person's] diagnosis. They are independent and takes medication on their own." Information in the person's care plan was contradictory as it stated the person was 'independent' in taking their medicines and in another section stated they needed staff 'prompting' to take their medicine.

• In response to urgent additional conditions place on the service on 25 November 2021, the registered manager reviewed two people's care plans. However, this was not provided to us within the set timeframe and the content of the care plans remained poor. For example, there continued to be no information about one person's diagnosis or how staff should meet their needs in relation to this.

People's needs were not adequately assessed. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

• The registered manager did not ensure staff were trained and competent to deliver people's care safely. They told us they had not completed staff competency assessments for any areas of training and/or care delivered.

• The provider had not arranged an appropriate mandatory training pathway to meet people's needs. For example, no initial or ongoing training was in place for medicines administration, moving and handling, diabetes awareness, dementia training.

• The registered manager lacked knowledge about their responsibilities to ensure initial and ongoing training was in place to meet people's needs. There was total reliance on staff only completing 15 standards of the Care Certificate, which did not include areas such as medicines or practical moving and handling. The Care Certificate is a set of national minimum standards for staff new to care. Staff were signed-off as completing the Care Certificate by the contracted trainer after completing 80% pass rate, without any workplace observations by the registered manager. This was not in line with national Skills for Care guidance.
• We received information of concern that one staff member delivered care unsupervised without any previous training or experience on one occasion, whereas the registered manager told us they were always supervised by another staff member. We also found the other staff member was new to care and lacked medicines administration training or moving and positioning training from a qualified practitioner.
• The registered manager told us they supervised staff "on the job", however, they did not keep records of supervisions or personal development plans to provide evidence of this.
• In response to our urgent additional conditions place on the service on 25 November 2021, the registered manager submitted an updated staff training matrix. However, this was not provided within the set timeframe and did not consider competency assessments by the service or face to face training arrangements, such as moving and handling practical training. The training matrix did not include whether catheter care awareness was needed for staff; no training analysis was provided.

Staff did not receive appropriate training or supervision to enable them to carry out the duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• The service failed to take appropriate action to ensure people's nutritional and hydration needs were identified, understood and consistently met.
• We found limited information contained in one person's initial assessment about their nutritional and hydration needs. For example, the provider's assessment noted that 'level two thickener 2 scoops for 200ml' was required, however there was no reference to the required texture of solid foods. A staff member told us the person required "level 2 pureed food" and said, "I had to physically feed [the person] with pureed food". This was not in accordance with International Dysphagia Diet Standardisation Initiative (IDDSI) guidance which refers to pureed food as level 4 and not level 2. The lack of appropriate guidance about the required texture of food meant the person was at increased risk of choking.
• We received information of concern the same staff member did not know about modified diets and had to do their own research about how to puree foods and thicken fluids. The person's initial assessment did not refer to guidance from a dietitian or a speech and language therapist for swallowing. This meant staff did not have appropriate guidance to follow to meet the person's needs.
• The same person's daily care report task list stated, "Add thickener to drink – tap water" with no further instructions. This was ticked in the 'AM' column for 5, 6 and 7 November 2021 of the daily report, which indicated the person was not offered or did not drink in the afternoon or evening. No drinks or meals were ticked on 8 November 2021 and there was a handwritten note at the bottom of the report stating, "breakfast prepared not taken." There was no further explanation about actions taken. We were concerned the person's nutritional and hydration needs were not adequately assessed or met.

People's nutritional and hydration needs of were not always met. This was a breach of regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

• The service failed to ensure equipment and premises were properly used by staff; and failed to ensure standards of hygiene were consistently maintained.
• Staff had not received any training in how to properly use equipment such as slide sheets to assist one person. We received information of concern a staff member did not know how to use this equipment properly, which resulted in the person appearing uncomfortable. Also, that the registered manager had suggested staff lift the person up and down the stairs in their home using a wheelchair. There was no evidence this was carried out by staff, however, this suggestion was an improper use of equipment and posed an increased risk of harm to the person and staff members.
• We also received information of concern that tasks such as washing up was not completed by staff, uneaten food was left out in the kitchen and toilets were left unclean. There was no reference to equipment or cleaning task responsibilities in the persons' initial assessment or in their daily reports.
• Another person's care plan failed to include information about a pressure cushion, which the registered manager told us staff were responsible for pumping-up. The registered manager told us they had searched the equipment online to find out how to use it and what it was for, however, they could not show us evidence of this or recall where they found information or that it was from a reputable source. There was no guidance about how to use the equipment in the person's care plan or reference to the manufacturer's guidance.

The service did no ensure premises or equipment were properly or hygienically used by staff. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

• The service failed to demonstrate how people's consent to care was sought, or how the Mental Capacity Act 2005 was applied where people lacked mental capacity to consent.
• People's consent to care was not captured in any of their care records. One person had signed their care plan. However, there was no reference to whether this meant they consented to the care service. The provider's Mental Capacity Act (MCA) 2005 policy and procedure did not include how the service intended to capture and document people's consent.
• Two updated care plans provided no explanation about why people were not involved in their review, or whether their consent had been sought.
• Where a lasting power of attorney was identified in one case, the service did not include how this was verified, or specify whether this was for health and welfare and/or finance and property. The person's care plan did not make any reference to a mental capacity assessment or best interest decision. The registered manager failed to implement the provider's Mental Capacity Act (MCA) 2005 policy and procedure, which stated they were responsible for undertaking mental capacity assessments and following the MCA best interest checklist.
• The registered manager had not explored whether another person met the criteria for a mental capacity

assessment to consent to care. Information we received from the registered manager and the person's family member about their Alzheimer's Disease, health conditions and communication difficulties, indicated they may have fluctuating mental capacity.

The service failed to capture people's consent to care or act in accordance with the Mental Capacity Act (MCA) 2005 where people lacked capacity. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

• We received information of concern about the way the registered manager and staff members conducted themselves in a person's home. Feedback also included that staff members left the person's curtains open and lights on during the night, which did not protect their privacy or promote their comfort. The same person received undignified care from a staff member, because they did not know how to provide personal care or use equipment to ensure their dignity and comfort. The registered manager disputed the concerns raised. The local safeguarding authority confirmed with us they were taking action to investigate.

• One person told the care provided by staff was not "Compassionate" and another staff member had been "Rude" to them on occasion.

• People's care plans did not identify whether they preferred a particular gender of care worker to deliver their care. The registered manager told us that people currently using the service preferred female staff. However, the registered manager said that either they or other male care workers would deliver the personal care in the event that staff cover was needed. This was contrary to service users' preferences.

• The service provided updated care plans for two people, which continued to fail to address their preferences and whether male staff were an acceptable alternative.

• After our site visits, the service sent us completed satisfaction questionnaires for two people. One of these questionnaires identified a person did not feel staff protected their dignity or treated them with respect. The registered manager failed to include how they intended to address this.

• We found people's care plans and care reports were task focused. They did not provide information about actions taken by staff in response to concerns about emotional distress or physical pain. For example, one person's daily report stated they had 'back pain' with no further information. Another entry said, "had a lovely chat after calming down', with no details about the person was upset about. This showed a lack of caring and compassion in relation to the persons general demeanour.

• The provider information return (PIR), highlighted a person's complaint, which included "Client said that carer does not respect [their] dog by not writing the name of the dog in the daily task sheet". The PIR feedback noted, "However, it was addressed that the dog should be called by its name." We found the care plan and daily task sheet were not updated in accordance with the person's wishes.

People were not always 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.

• Other people and relatives provided positive feedback about how staff treated them. For example, a

relative said "One carer is good which is an improvement on the previous provider" and described the staff member as "Bubbly and open".
• One person told us they got on well with their care worker and said, "I shall miss them when I don't need them". Another person told us the registered manager was "Lovely" and "Polite".

Supporting people to express their views and be involved in making decisions about their care
• We received feedback from five different sources that people and/or their relatives had not received copies of initial assessments or care plans.
• A person's relative told us a, "Young male care worker new to the job" had carried-out a person's initial assessment, who advised them they would receive the care agreement by email the following morning. However, no information was provided. We received other information that a male care worker had carried out another person's initial assessment, which "Only took half an hour" and "Not many questions were asked" and copies of the assessment and care plan were not provided.
• A staff member told us they had carried out an initial assessment alone for one person, whose name they could not recall. During our inspection the registered manager told us they led all initial assessments, because other care workers did not yet hold the necessary skills or experience to do so. We were concerned the staff member's lack of experience and the absence of providing copies of assessments and care plans, meant people were not supported appropriately to express their views and be involved in making decisions about their care.

People were not always supported to collaborate with their own assessments and care plans. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; 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.
• One person informed us their vision was "not very good". Their care plan also documented this. However, there was no information about how the service met the person's needs. A staff member told us the person did not have any issues with their vision. This meant the service failed to identify and meet the person's communication needs in accordance with NHS Accessible Information Standards.
• People's care plans did not always reflect their needs or preferences. The care plan template did not include areas such as background information about service users, sexual orientation or sensory needs. There were sections entitled 'religion and culture' and 'hobbies' with subtitles 'what I can do for myself', 'what I need help with'. However, information recorded in these areas was limited and incoherent. For example, religious information for one person stated, 'What I can do myself: Christian and Buddhism'. No information was recorded under the subtitle of 'How staff can support me'.
• One person told us the service did not meet their companionship needs which was important to them. Their care plan did not identify potential social isolation or how staff should support the person with this, apart from 'be polite and respectful', which was insufficient for staff to know how to meet their social needs.
• The initial assessment for one person did not identify end of life wishes or palliative care needs. The registered manager told us the person's needs changed rapidly after their initial assessment due to deteriorating health. However, there was no record of a review of their needs to assess whether the service was able to provide appropriate care and support.
• There was no information about whether the same person required palliative oral care, to keep their mouth moistened for comfort.
• We received information of concern the registered manager provided unsatisfactory advice about options in relation to a suitable bed or other equipment that may support the person's comfort at the end of their life. Instead of referring and liaising with the hospital or community team they advised them to self-fund a bed and stated, "time was more important than money". This advice was inappropriate and caused the family member confusion about where to access appropriate support in a timely manner.

People's care plans did not always capture their needs and preferences. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The service failed to establish and operate effectively an accessible system for managing complaints.
• We received consistent feedback from people and their family members that they had not received any literature from the service about the complaints policy and procedure, or about their rights to escalate concerns if they were unsatisfied with the registered manager's response to complaints.
• The registered manager confirmed they did not provide printed information about their complaints or safeguarding procedures as it was too expensive to print this information. Instead they showed us business cards with their mobile telephone number which was given to people. This was insufficient to ensure people understood their rights and how to raise complaints or safeguarding concerns.
• We requested evidence of complaints records, investigations and outcomes, which the registered manager failed to provide. The complaints policy was last reviewed in 13 June 2019 and was due for review after 12 months, which had not been completed. The complaints policy contained out-of-date information as it identified an ex-employee as the main point of contact for the receipt, investigation and management of complaints.
• During our inspection you told us a person no longer required your care services due to being admitted to a hospice. We received contradictory information of concern that serious concerns about the care provided resulted in the service being stopped for an alternative care provider. We were concerned the registered manager failed to disclose the concerns to us, or how they intended to investigate and act upon concerns in accordance with the complaints policy and procedure.

The service did not establish an accessible complaints procedure and people's complaints were not always appropriately acted upon. This was a breach of regulation 16 (Receiving and Acting Upon Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service had investigated one complaint earlier in the year in response to several concerns raised by a person about a staff member. We received feedback from the person that the care provided had improved as result of actions taken by the registered manager. However, as reported upon in the 'Caring' domain of this report, we found the service had not fully implemented agreed outcomes.

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; Continuous learning and improving care

- The service failed to establish or effectively operate systems to assess, monitor and improve the quality and safety of the service, or to mitigate the risks to people.
- No checks or audits were completed by the registered manager. For example, they had not checked, identified or acted upon medicines administration record concerns to make improvements. There was no systematic audit of recruitment procedures and Disclosure and Barring checks, of incident reporting or training processes or staff attendance and competencies, in accordance with the safeguarding policy and procedure to safeguard people.
- The registered manager did not always have the relevant knowledge or training required to understand their responsibilities or to comply with regulations. They referred to CQC requirements as a "mere formality" and a "tick box" exercise. This showed their disregard for the regulations as a condition of their registration in order meet fundamental standards of care.
- The registered manager was unaware of the requirement to seek the full employment history of prospective staff, or the requirement to maintain staff employment records. This showed they did not understand how to apply data protection legislation as staff records were deleted at the request of ex-employees. The registered manager failed to keep up-to-date with relevant national guidance, such as PCR testing for staff.
- The provider failed to maintain accurate, complete and contemporaneous records in respect of people, persons employed or the management of regulated activities. Access to relevant records and information was a consistent obstacle throughout our inspection for reasons described, as well as due to the lack of resource, technology and equipment.
- The service failed to establish an effective business continuity plan. It did not address how the service would respond to a sudden loss of staff through COVID-19 self-isolation or management cover in the event of the registered manager's ill-health and/or absence. Information about managing an 'Outbreak of infection among staff' did not comply with government guidance in relation to self-isolation.
- The service failed to display their public and employer's liability insurance at their registered office.
- In response to our urgent additional conditions placed on the service on 25 November 2021, the registered manager provided us with a statement about their quality assurance processes. However, this failed to provide specific information about how the service planned to implement checks and audits. There was no schedule or timeframe for implementation, neither was there consideration of risk priorities. The registered manager also submitted a COVID-19 testing policy and procedure, however this failed to consider the testing requirements for live-in staff. The registered manager provided evidence they had recently invested in

software to improve records. However, we were concerned this would not solve issues with the poor content of care plans, risk assessments or management procedures.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
• We were concerned the registered manager provided conflicting information throughout our inspection, which raised concerns about their openness, transparency and ability to foster an open culture within the service. For example, the registered manage was given opportunities to disclose information to us about incidents, such as a person's fall and they failed to do so. Information provided by the registered manager throughout the inspection was consistently ambiguous and meant inspectors needed to revisit queries to gain a clear answer.
• Although there was no evidence that incidents met the duty of candour threshold, the registered manager did not demonstrate knowledge of this regulation or their legal responsibilities.

Robust systems were not established or operated to monitor risks to people or the quality and safety of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service failed to notify the Care Quality Commission (CQC) without delay of specific incidents as required. For example, we were not notified in relation to missed care visits. The registered manager told us missed visits occurred because they had an insufficient number of staff. This met the criteria for events which prevent the provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements. Missed care visits had the potential to increase the risk of harm to service users due to neglect as a safeguarding concern. This was also reportable to CQC but was not completed by the service.
• The service delayed notifying us about a person's fall. We were concerned the fall may meet the safeguarding threshold as the registered manager told us this occurred due to a lack of suitable equipment. The service also failed to document a risk assessment in relation to the person's needs prior to or following this incident. The registered manager did not seek advice or report this incident to the local safeguarding authority.

The service failed to notify CQC about certain events. This was a breach of Regulation 18 (Notification of other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• At the time of our inspection the service did not have a system for gaining people's and/or their representatives' feedback to improve the service. In response to our inspection the registered manager sent people satisfaction surveys and provided us with two completed versions. One person's feedback indicated they were generally satisfied with care provided, however they answered 'no' to whether they felt the care worker communication with them respectfully, 'no' to whether they staff treated them with dignity and 'no' to whether they were involved in their care plan. No explanation was provided about how the service intended to respond and act upon feedback received to improve the service provided.
• The registered manager was not able to provide evidence about how relevant information was shared with staff or how they gained staff feedback. Staff told us they received support from the registered manager, however, there were no records to demonstrate staff supervisions or what topics were discussed.
• The registered manager told us there had been a breakdown in communication and partnership working with the local authority in response to changes in commissioned hours. There was no evidence the

registered manager was taking steps to improve partnership working; they continued to blame the commissioning authority for a loss of work.

The service had not acted upon feedback from relevant persons to make improvements to the service provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

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 service failed to notify the Care Quality Commission of certain events, as required.