South Essex Special Needs Housing Association Limited

Aveley House

Inspection report

Arcany Road
South Ockendon
Essex
RM15 5SX

Tel: 01708856444

Date of inspection visit:
08 September 2020
24 September 2020

Date of publication:
10 November 2020

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
Aveley House is a domiciliary care agency providing personal care to approximately 375 people in their own homes. At the time of inspection, the provider was unable to confirm the exact number of people being supported. The service covers a wide geographic area in Essex, including Castle Point, Rochford, Basildon, Basildon North, Brentwood, Harlow and Epping.

CQC only inspects services 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
Safe and effective systems were not in place to ensure people received support as required. Safeguarding processes were not effective and people were at potential risk of harm due to the poor management of safeguarding concerns. People experienced late, missed or shortened calls, which impacted on their care and did not ensure their needs were met. There was no plan in place for extreme or sudden staff shortages.

The risk to staff and people using the service from COVID-19 had not been adequately assessed or measures put in place to reduce the risk. Staff did not have access to adequate and sufficient Personal Protective Equipment (PPE) to ensure people were protected from the risk of infection. Where incidents occurred, there was a lack of oversight and lessons were not learnt to reduce the risk of the incident re-occurring.

Although some staff told us they received supervision, these were not recorded, and staff meetings were not regularly held. Training was overdue in a number of areas, including on mental capacity. Staff had not received effective training in the management of risk relating to COVID-19. Staff were not seen to be fully supported, for example through a lack of COVID-19 risk assessments for those staff who may have underlying health conditions.

Although some people using the service and their relatives said staff were caring and kind, our findings did not always suggest a consistently caring service. This includes the risk of harm due to late, missed or shortened visits. People were asked for their views on the service through quality monitoring visits and calls, however improvements to people's care were not always made as a result.

Management of the service was not cohesive. The provider failed to demonstrate openness and transparency at all levels of the organisation. The registered manager did not have full access to complaints, safeguarding concerns or the training syllabus to ensure that they had effective oversight of the service. The organisational structure was not followed, and reporting lines were unclear. Systems were disorganised and some records including staff files could not be found. The service was unable to demonstrate any analysis of themes and trends or how learning was shared with the staff team to ensure continuous improvement.

We have made a recommendation on the implementation of the Accessible Information Standard (AIS).

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.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 5 November 2019) and there was a breach of Regulation 17 (Good Governance). The provider completed an action plan to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to follow up on specific concerns we had received about the service. The inspection was prompted in part due to concerns about infection control practice, safeguarding processes, missed and late calls and concerns related to management of the service and wider systems. A decision was made for us to inspect and examine those risks.

We inspected and found further concerns which impacted on other areas of the quality and safety of care. We widened the scope of the inspection into a comprehensive inspection which included all of the key questions.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive, caring and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding service users from abuse and improper treatment, safe care and treatment, receiving and acting on complaints, fit and proper persons employed, staffing, good governance, notifications of events to the CQC and the duty of candour.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Aveley House

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 three inspectors and two assistant inspectors.

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

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 a short period of notice of the inspection. This was because we needed to be sure the provider's representative would be in the office to support the inspection.

Inspection activity started on 8 September 2020 and ended on 24 September 2020. We visited the office location on 8 September 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. We also formally requested further information to be sent to us by the provider, following concerns raised about the service.

During the inspection
We spoke with 18 people who used the service and six relatives about their experience of people's care. We spoke with 20 members of staff including the registered manager, locality managers, quality monitoring

officer, care coordinator, training manager and care workers. This also included the chairman of the company and 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 medication records and associated audits, six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to work with the local authority to gather feedback on ongoing safeguarding investigations.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
- The safeguarding policy was not detailed enough and did not include when and how to report concerns to the local authority. Staff, including senior members of staff, did not demonstrate an awareness of safeguarding processes or how to escalate and consult local authority safeguarding teams.
- Complaints were recorded which included safeguarding concerns but were not reported as such. Staff lacked understanding in following safeguarding procedures to ensure that people were kept safe.
- The management team could not demonstrate how they looked for themes and trends in safeguarding concerns about people using the service and how they mitigated the risk of re-occurrence where possible.

Systems and processes were not established and operating effectively to prevent potential abuse, placing people at risk of 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; Staffing and recruitment; Using medicines safely
- Risks associated with arranging and monitoring care calls were not managed effectively. We made a number of requests for up to date lists of people using the service, prior to the inspection and during it. However, the senior managers were unable to provide a complete and accurate list. Systems were not in place which allowed the provider to demonstrate who was receiving a service.
- There was no effective system in place to monitor that care visits were taking place. A staff member told us the electronic system was not accurate or effective, they said, "It hasn't worked out as well as we thought. The Global Positioning System (GPS) isn't as good as it should be. At this moment everyone is involved in monitoring late and missed calls by checking the system – we are on a learning curve. It has not given us a true picture."
- Where electronic systems were not being used effectively, a staff member told us that the service could only identify missed visits if people called to complain. Despite this being raised at the previous inspection and forming part of the service action plan, this had not resulted in improvements being made.
- People did not always receive their calls in full or on time. Rotas had no travel time and no breaks included, so did not accurately reflect how long staff were spending providing care. One care worker told us, "I move the calls around a bit to make it easier. It's okay as long as it gets done." Another care worker told us, "We do change it around quite a bit, as the call times might be wrong or not follow with medication times properly." No risks had been considered on what impact this may have for people's assessed care needs and relied on care staff making their own ad-hoc decisions about who to visit and when. We saw an incident record for a person living with diabetes who had required urgent medical assistance following a missed lunch call which had not been identified by the service.
- Ten people using the service or their relatives reported that calls were either late or did not last for the

entire time the person had been assessed to receive. One person told us that care workers only stayed for half of the allocated time at every visit, and frequently called to see if they would like to cancel a visit scheduled during the day. One person told us, "The carers are not always on time and they never call and tell me if they are going to be late, so I just lay here waiting."

● The service did not effectively monitor missed and late calls which placed people at risk of not receiving they care they required. A log of missed calls was in place although this was not up to date, with the last entry recorded in May 2020. The service was not following its policy on recording missed visits.

● Because there was a lack of robust systems in place to demonstrate how many people and care visits were needed, it was not possible for the provider to demonstrate that they had sufficient staff on duty at any one time. There was no information on how many hours some staff completed. For example, one rota reviewed showed a care worker with 29 visits scheduled in from 6.01am to 10.30pm with no travel time or breaks.

● The provider had not considered the risk posed to and by staff who are related working together unsupervised. A complaint had been received by the service about poor care delivery by care workers with an existing personal relationship. However, there were no risk assessments or policy which monitored this practice by recognising risks and mitigating them. One staff member told us, "There are lots of families that work together – I think this causes problems."

● There were no systems for effectively monitoring people's medication and ensuring this was safe and mitigating risks.

● One person told us that their relative was currently supporting them to take their medication, but they were, "Concerned whether the care company will be able to administer [medication] with the erratic times they visit."

● We looked at the Medication Administration Records (MAR) and associated audits for four people. We found gaps in three of these records. We discussed this with the registered manager who did not know the reason for the gaps. They explained that the care worker would have been called and that it would have been recorded as an incident. The gaps in the MAR had not been picked up on the audits and any reason behind them was not recorded.

Preventing and controlling infection

● People and staff were not protected from the risk of infections, including COVID-19.

● Care workers told us that they were not supplied with hand sanitiser by the provider. One care worker told us, "We don't get hand sanitiser. If we want to use it, we have to get our own." Environmental risk assessments had not been carried out for people's homes, and the steps care workers ought to take if running water, soap and disposable towels to dry hands were not available. A care worker told us, "No extra measures have been undertaken in service user's homes to reduce the risk of infection."

● Care workers told us that they did not have an adequate supply of appropriate quality Personal Protective Equipment (PPE). One told us, "Disposable masks are given. They sometimes give you some, normally I wear my own mask because theirs aren't adequate. I don't get given enough, I get some, then none, it varies. I have to wear my cloth mask that I use to go to the shops."

● People using the service and their relatives told us staff did not always wear PPE when undertaking visits to them at their homes. One person told us, "Staff don't always wear the aprons, really only when they know someone is coming to watch them. They [care workers] have always got gloves on and they now wear the masks. I've never seen them wash their hands when they come in. Maybe they do, maybe they don't." Another person said, "Staff wear gloves and aprons but no masks, they can if they want to wash their hands, but they don't." One person asked for guidance from the CQC as to whether care workers are required to wear masks, telling us that, "Some do wear them and some don't, and they have been challenged. It's hard to always ask them to put them on". We were also told that one person had experienced care workers using the same pair of gloves for both personal care and food preparation.

● There was no COVID-19 protocol in place for staff to follow should someone they were supporting have

suspected or confirmed COVID-19. One care worker told us, "First thing, I would call the family and let them know, and I would call the office. I don't know if there are any protocols. The office would tell us what to do at the time."

● There was no procedure on display for staff members or visitors to the office or any advice given on how to prevent the spread of COVID-19 or how to protect people and staff. When inspectors arrived at Aveley House there was no sign-in book for track and trace purposes and no verbal explanation of COVID-19 procedures. One care worker told us, "No risk assessments are done. We have no temperature taking either. I work in another care facility and they take your temperature regularly, but these [Aveley House] don't. They haven't really spoken to me about COVID."

People who use services were not protected against the risk of harm, including risks associated with missed and late visits, medicines management and unsafe infection control practice. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some recruitment checks had been completed on new staff before they joined the service to check their suitability or competence to work with vulnerable people, however these were not always complete. Despite this having been included on the provider's action plan following last inspection, three newly recruited staff members had gaps in their employment, or their stated employment history did not match with references on file, and there was no evidence this had been explored at interview.

Recruitment procedures were not established and operated effectively to ensure that staff recruited were able to provide care and treatment appropriate to their role. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There were no arrangements for ensuring learning from incidents and for when things went wrong. Opportunities for improving and mitigating risks were not taken.

● There was no evidence to demonstrate learning from safeguarding concerns or of action taken to prevent re-occurrence and keep people safe. There was a log in place to monitor outcomes, but this not link to any systems for sharing and learning with staff.

● The accident and incident log for the service was reviewed. Of the 20 incident records seen, although the immediate action taken was recorded, 15 did not have any preventative measures set out such as ensuring visits were not missed or updating risk assessments and care plans.

Requires Improvement

Is the service effective?

Our findings

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

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

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

- Some people told us they were able to discuss their care with staff. Staff were unable to demonstrate regular review of people's care in line with best practice and legislation. This included review of the impact of COVID-19 on the care delivery.
- There was a lack of organisation to ensure that people had choice of carers where possible. For example, people told us they did not always know who was coming, if they were new or if they understood their care needs.
- Although some computer systems were in place to help plan and monitor care, these were not effective or reliable.

Staff support: induction, training, skills and experience

- Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Care workers told us that they had received limited or no training for COVID-19. One told us, "No, I haven't had any additional PPE training. I wear gloves, apron and mask. No, I haven't been shown anything around putting PPE on or taking it off, or what order it should be done in." Another care worker told us that they "Just generally watch the news" for information on COVID-19.
- Staff received an induction upon joining the service and training was provided. Training records demonstrated that a significant amount of training was overdue for staff, including in areas such as understanding the Mental Capacity Act and dementia care. We identified serious concerns around staff knowledge and practice for safeguarding, and found that 72 members of staff were recorded as not having had up to date training on this topic, in line with the provider's own policy for frequency of training.
- At the last inspection, the training manager was not receiving supervision or a yearly appraisal and there was no evidence of face to face supervision being planned or carried out for the staff team. The provider stated in its action plan following that inspection that supervision would be carried out. However, there was no evidence that supervision was taking place. One care worker told us that despite working for Aveley House for a number of years, "I have not had a 1:1."
- Oversight of training, supervision and staff competency was sporadic. Some staff had spot checks and observations took place on staff practice, while others told us they had not. Some supervision records could not be found.
- Staff meetings were not regularly held. There were no formal minutes, so it was not clear what had been discussed, or how any information arising out of these meetings had been followed up to make improvements to the service. This meant the service could not demonstrate how it effectively

communicates with and supports staff, at all levels.

Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Aveley House provides support to people with their meals. One person told us, "They [Aveley House] ask me what I want to eat and drink and I get what I ask for. They can't make hot food because they only have half an hour, but they make soup sometimes."
● However, due to late and missed calls it was not demonstrated that support with meals was consistent. One person told us that they sometimes did not receive their tea time call until as late as 9.30pm.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We received information from professionals who raised concerns with the provider about improper use of PPE by care workers. Despite professional advice having been provided, poor practice in relation to PPE use continued. Response to a local authority quality audit was also not responded to or acted on promptly. Professionals had provided opportunities for support and guidance which were not then followed up and monitored by management to ensure improvements and consistent practice was being adhered to. This also included advice on moving and handling.

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.

● Whilst we did not receive feedback from people that they did not get a choice in relation to their care, 162 members of staff had MCA training that was overdue based on the provider's own policy, with some being due for refreshing as far back as 2017.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- Although some people said care workers were kind and caring, our findings did not suggest a consistently caring service due to missed and late calls and ineffective systems to keep people safe from risk of harm.
- People did not always feel they received a caring service. We received mixed comments from people using the service. One person told us that they enjoy conversations with care workers about varied subjects, such as television shows and horses. Another told us they feel, "Very grateful for they work that [the care workers] do." However, other comments described care provided as "slack" and "a bit slapdash". One person told us, "[Care workers] didn't introduce themselves when they came in, and they frightened me."
- People did not always feel that their assessed needs were met. One person's relative told us that they had had to install a camera in their relative's home to see whether they had received sufficient care and support, due to visits by care workers regularly being cut short. The relative told us they had also taken over some care that was previously provided by Aveley House to ensure that the personal care needs of their relative were being met. Another person told us, "No personal care in the evening is offered, no teeth brushing or hairbrush of a night time."
- The provider could not demonstrate that it had considered equality and diversity in relation to increased risks of contracting COVID-19.

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

- People were contacted for their views on the service and some changes were made as a result, for example, where one person had requested that their bed was changed during a visit, action was taken to ensure this happened. However, the service did not have effective systems in place for monitoring suggestions, requests and complaints made by people and their relatives, and acting upon them to improve people's experience of care.

Respecting and promoting people's privacy, dignity and independence

- Whilst most people felt their privacy and dignity was respected and staff were patient when providing care, people did not always feel this was the case and feedback was mixed. One person told us, "There are a couple of carers that are too quick for me and not always polite and I don't feel like they listen to me" but [care worker] is absolutely fantastic."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

● People's needs were not consistently met due to the service's lack of oversight of missed and late calls. This impacted on people's ability to have choice and control in relation to their care.

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.

● The registered manager told us that a care plan will be created considering the needs of people with sensory impairment with the involvement of family or other advocates when they join the service. However, no awareness of the AIS was demonstrated in the registered manager's response. One person told us, "My sight is not great so I don't like them to move things otherwise I can't always find it but some of the [care workers] do and I don't know which one does."

We recommend the service consults guidance to ensure people's needs are met in line with the AIS.

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

● Where possible, staff spent time with people to reduce the risk of isolation. One person told us, "I look forward to staff coming and they [the care workers] are good company as I don't really see many people. They sit and chat with me and make me a cup of tea if I don't want to get into my pyjamas."

Improving care quality in response to complaints or concerns

● Information on complaints and missed visits were limited and did not always include information on how future risk would be mitigated. One person had complained about poor moving and handling practice in April 2020. However, this complaint had been closed in June 2020, and the complaints log did not detail steps taken to reduce the risk of re-occurrence. A further incident had occurred in August 2020, leading to a safeguarding investigation.

● The complaints system was not open and transparent and did not always result in care being improved. Not all complaints that were received were fully investigated and acted upon or measures put in place to make improvements. One person told us, "Even though I've complained, they [Aveley House] say that the carers don't do anything wrong."

● The provider could not confirm or evidence that there was oversight by directors and the registered

manager of complaints made about the service. This meant that there was limited opportunity for complaints to be investigated by appropriately senior staff, analysed for themes and trends, and improvements made correspondingly.

There was no effective system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

End of life care and support

- The registered manager told us that, whilst there is no formal policy and procedure for end of life care, care workers follow the direction of specialist palliative care teams. The registered manager told us that at the time of inspection there were four people who care workers had identified as receiving end of life care due to the presence of palliative care teams or nurses during care visits. Training records did not show that staff received training on end of life care, death or bereavement.

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

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

- The service was not well-managed and not all people using the service received consistent positive outcomes as a result.
- There was not a positive, open culture within the service, and robust steps were not taken to drive improvement. The service had failed to meet many of the objectives within its action plan from the previous inspection. The chairman of the company told inspectors, "We are just papering over the cracks and then another one appears."
- Management were not working together effectively, sharing information and each having adequate oversight of all aspects of the service. Contradictory information was provided to us on a range of topics by different members of the management team.
- It was unclear from speaking with members of staff whether reporting lines and associated supervision responsibilities as set out in the Aveley House organisational chart were being followed. For example, the training manager told us that they did not have a line manager "as such" but went to the nominated individual and directors.
- Filing systems were poorly maintained, and the service could not provide us with documents relating to people's care and treatment upon request. There were some quality assurance and audit processes in place, but it was not demonstrated that they were robust or working effectively to ensure adequate oversight and the delivery of safe, high-quality care.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Policies and procedures did not provide the registered manager with overall responsibility for issues such as safeguarding, despite having a legal and regulatory responsibility.
- There was a lack of oversight to ensure that notifications were made to the CQC. The registered manager had not notified the CQC of events that occurred. Notifications are required by law to ensure the CQC can monitor the service and ensure people are receiving safe care. Of 20 entries of abuse or allegations of abuse logged in the service's safeguarding spreadsheet, only two had been notified to the CQC.

The provider had not submitted statutory notifications of abuse or allegations of abuse as required to the CQC without delay. This was a breach 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, which is their legal responsibility to be open and honest with people when something goes wrong.

● We requested the duty of candour policy for Aveley House. However, the document provided was not tailored to the service. The registered manager was not aware of a duty of candour policy being in place. It was not clearly recorded in the service's complaints log that people had received an apology from the service.

The provider did not promote a culture that encourages candour, openness and honesty at all levels. This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People told us that they would contact the office if they had a complaint, and some spot checks on the quality of care were taking place. However, there was no robust system for demonstrating how improvements had been made following feedback.

● Although some care workers told us that they felt supported by the management at Aveley House, others expressed concern around a lack of clarity around furlough and underlying health conditions or caring responsibilities during the pandemic. None of the care workers that we spoke with had received a COVID-19 risk assessment in relation to underlying health conditions or equality characteristics that might place them at increased risk of COVID-19. One care worker told us, "The office staff are quite rude both to staff and members of the public. They are very abrupt with people and whoever you speak to have the same attitude. The atmosphere - you can cut it with a knife." One relative we spoke to described office staff as being unapproachable.

Working in partnership with others

● The service worked with others, for example, district nurses, and the local authority safeguarding and quality improvement team. However, professional recommendations and advice were not always followed.

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 provider had not submitted statutory notifications of abuse or allegations of abuse as required to the CQC without delay Regulation 18 (Registration) (2) (e).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no effective system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (2).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that staff recruited were able to provide care and treatment appropriate to their role. Regulation 19 (2).

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not promote a culture that

encourages candour, openness and honesty at all levels.

Regulation 20 (1).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risk of harm, including risks associated with missed and late visits, medicines management and unsafe infection control practice. Regulation 12 (2) (a); (b); (g); (h).

The enforcement action we took:

We are imposing conditions on the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operating effectively to prevent potential abuse, placing people at risk of harm. Regulation 13 (2); (3).

The enforcement action we took:

We are imposing conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at risk of harm. Regulation 17 (2).

The enforcement action we took:

We are imposing conditions on the provider's registration.