Compare Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Compare Care provides personal care for people in their own homes, most of whom were older people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of this inspection the service was providing personal care to 19 people.

People's experience of using this service and what we found
People had mixed experiences of the service. Most people spoke highly of the care and described caring staff but some people's service had been disrupted due to staffing difficulties. Some people had not received the visits they needed and this had an impact on people's safety, dignity and their confidence in the reliability of the service. One relative described how visits had been missed and commented that staff rotas were not well managed. Another relative said, "The rotas are not well managed, the staff have told me they have three clients at the same time so how are they supposed to do that?"

Systems for managing medicines were not always robust. Some people had not received their visits and consequently their prescribed medicines had not been administered by staff. Records for monitoring administration of medicines were not consistently accurate and this meant the registered manager could not be assured that people were receiving their medicines safely.

Staff told us they were concerned about the current staffing difficulties and management issues at the service. One staff member told us, "The clients are not getting calls that they are supposed to because there's not enough staff."

Systems for planning and monitoring care visits were not consistently managed. There were not always enough staff to cover all the visits and management of the service was inadequate. The provider was also the registered manager of the service. They were responsible for planning and monitoring care, training and managing staff and driving the improvements required following the last inspection. The lack of effective systems and management support meant they had failed to make the required improvements and the standard of service had continued to decline.

Staff had not receiving the training, support and guidance they needed to provide safe and effective care. Some staff were undertaking tasks for which they had not been trained and assessed as competent, this had put people at risk of harm. Staff were not all clear about current guidance for COVID-19 and when PPE, including masks, should be worn. Management oversight and governance arrangements had not been effective in identifying these shortfalls.

An electronic monitoring system was in place to support the delivery of the service. Staff had not received sufficient training and support in how to use the system. This meant that records were incomplete,

inaccurate and did not provide a true reflection of the care provided.

Risk assessments and care plans were not comprehensive or personalised. There had been minimal impact for people because staff knew them well and understood their needs. However, when new or unfamiliar staff attended care visits, they did not have all the information they needed to provide care safely or in a personalised way.

People and relatives spoke highly of their regular care staff who they described as kind and caring. One person said, "As far as we are concerned, they do a grand job and we are happy with them." Other comments included, "I am happy and have confidence in them," and, "I think they([staff]) are self - motivated because they love what they are doing."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported 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 21 September 2021), and there were continued breaches of regulations. We issued warning notices to the provider requiring them to make improvements. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and poor management of the service. A decision was made for us to inspect and examine those risks and to follow-up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections 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 continued breaches in relation to management of medicines, management of risks, record keeping and management oversight and governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Compare 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 team consisted of two inspectors and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own 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 registered manager would be in the office to support the inspection.

Inspection activity started on 20 October 2021 and ended on 22 October 2021. We visited the office location on 20 October 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection including the provider's action plan. We sought feedback from the local authority. 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
People were not always able to speak with us directly by telephone, so we spoke with relatives of seven people about their experience of the care provided. We spoke with four members of staff and the registered manager.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at 12 staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service, including policies, procedures and systems for planning care visits, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the provider's electronic monitoring system, we contacted two professionals who had contact with the service. We raised a safeguarding alert due to concerns we found relating to three people and asked the provider for immediate assurances about 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.

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

Assessing risk, safety monitoring and management; Using medicines safely
At the last inspection medicines were not managed safely and risks to people were not always identified, assessed and mitigated. This was a continued breach of regulation 12(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued requiring the provider to comply with the regulation by 29 September 2021.

The provider had not implemented their action plan. They said staffing issues had made it difficult to complete the actions. Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12.

- Medicines were not always managed safely.
- Some people had not received their prescribed medicines. A relative told us, "There has been the odd occasion when they have forgotten the medicines all together. Once recently, and I'm not sure if this has happened before."
- A staff member told us they were concerned about one person who they believed had not received their planned visits. This meant they may not have received their prescribed medicines for managing epilepsy. We checked the provider's electronic monitoring system and found no records of the visits being completed for this person on two mornings. The registered manager told us that the person had a family member who was likely to have supported the person with their medicines but there had been no action taken to check if this had happened. This meant the person had been exposed to risk of harm.
- The electronic system included Medicine Administration Record (MAR) charts. Staff were not always completing these records when they administered medicines and there were numerous gaps in multiple MAR charts. For example, the MAR chart for one person had been fully completed on only two days during the month of September. Daily records for the person showed on some days staff had noted that recorded medicines had been given, but did not identify which medicines and doses had been administered or any that had not. This meant that it was not evident if people had received all their medicines as prescribed or if staff had failed to document their actions. Inconsistent use of the electronic monitoring system meant that the registered manager could not be assured that people had received their visits and that they medicine had been administered.
- Staff had received training in administration of medicines, but assessments to determine their competency had not been undertaken. This meant the registered manager could not be assured that staff managed medicines consistently and safely. During the inspection the registered manager arranged for staff who regularly administered medicines, to receive a competency assessment.
- Risks to people were not always identified, assessed, monitored and managed.
- A person who needed support to move around had developed a pressure wound. The care plan for this

person did not identify risks to skin integrity or give clear guidance to staff about the care required, including who was responsible for dressing the wound. A care worker told us that a nurse visited to manage wound care but that on regular occasions they had taken on this task themselves. They also described training other care workers in this task. The staff member had not been trained and assessed as competent to complete this task. This meant the person had been exposed to risk of harm.

● A person was receiving all their food and fluids through a percutaneous endoscopic gastrostomy (PEG). This is a feeding tube that passes through the abdomen directly into the stomach. National Institute for Health and Care Excellence (NICE) guidance recommends staff should have received appropriate training to use the PEG system. The registered manager told us that staff were not involved in this aspect of the person's care. However, a staff member described how they ensured the person was hydrated by providing fluids via the PEG tube. This staff member had not been trained and assessed as competent to undertake this task. This meant the person had been exposed to risk of harm.

● Risk assessments lacked detail and did not identify the level of risk for people. For example, one person's care plan identified that they had epilepsy. They were prescribed medicine to manage this condition. There was no assessment to determine the level of risk for the person, including if they did not receive their medication as prescribed. There was no guidance for staff about how to recognise a deterioration in the person's condition or how to support them in the event of a seizure. This meant that staff did not have the information they needed to support the person's safety. Medication records had not been completed accurately and some scheduled visits had been missed. This meant the person had been exposed to risk of harm.

● Risk assessments had not always been completed or updated. This meant that staff did not have all the information they needed. For example, some people needed support with moving around but manual handling risk assessments had not always been completed. One person used a wheelchair and needed support with personal care tasks. There was no manual handling risk assessment and care plan to guide staff in how to support the person safely.

There was a failure to ensure that medicines were managed safely and that risks to people were assessed, monitored and managed. This was a continued breach of Regulation 12(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We raised safeguarding alerts for people who had been exposed to risk of harm. The registered manager provided us with assurances that immediate actions had been taken to ensure people's safety.

Preventing and controlling infection

● We were not assured that staff were always following safe infection control procedures because some staff were not using PPE effectively.

● Staff told us they were not always wearing masks when providing care to people. One staff member said, "Some clients don't like masks and we are not using the mask at their request."

● Most relatives told us that staff were not always wearing masks. One said, "They don't always wear masks now, but they always wear gloves." Another relative told us staff were not wearing masks now but that "They did during the pandemic."

● Risk assessments to determine people's individual needs and risks associated with COVID-19 had not been undertaken in line with current government guidance. This meant that the provider could not be assured that people and staff were protected from risks.

● Staff had access to PPE and the registered manager said they delivered anything that staff needed.

● We were not assured that the provider's infection prevention and control policy was up to date or that changes had been communicated to staff. Some staff were not clear about their responsibilities following changes to government guidance in August 2021. One staff member said, "I'm not always sure if I should be wearing a mask or not now, it (guidance) keeps changing." The provider had not undertaken risks

assessments to determine when staff should be using appropriate PPE, including masks inline with current government guidance.
● The registered manager said that staff were taking regular lateral flow tests to check their COVID status. They explained that staff were only required to inform him if they had a positive test and then a PCR test would be taken and the staff member would isolate in line with current guidance. However, there was no system in place for the registered manager to assure themselves that all staff were regularly taking lateral flow tests to confirm their COVID-19 status.

The failure to assess risks associated with COVID-19 for people and staff, and to ensure staff had clear guidance about what PPE they should be using. This contributes to a breach of Regulation 12(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment;
● There were not sufficient, staff to ensure all care visits were provided.
● Some people told us they were not receiving a consistent and reliable service. One person said, "There have been occasions where carers have not turned up at all." A relative told us, "The staff don't always get a rota. The second carer didn't turn up and I'd been up all night, so I was annoyed because it wasn't the first time this happened." Another relative said, "It's very rare that they don't turn up, but recently, in the last two months, it's getting worse."
● The registered manager told us there were not always enough staff because some full-time staff had recently left the service. This meant there had been difficulty in covering all the visits to people. The registered manager explained how they were actively recruiting to vacant posts including a care co-ordinator who would be responsible for planning visits to people. Until these positions were filled staff were being asked to take on additional visits and the registered manager was also covering some care visits and planning the rota.
● Staff told us recent weeks had been difficult and were aware of the staffing issues. All the staff we spoke with described a commitment to supporting the needs of people who relied on the service. One staff member said, "They are my priority, we all do our best to get calls covered."
● The electronic monitoring system showed when each visit had been completed. The registered manager said they were checking the system to ensure that calls had happened as planned. However, they were not able to identify all missed calls from this system at the time of the inspection and not all staff were using the electronic system consistently. This meant that the data was not reliable and it was difficult to be sure how many missed visits there had been.
● People told us they were usually informed of changes to the times of their visits because the care staff contacted them. One relative said, "We don't expect them (care staff) to be on time all the time, they generally let us know if they are going to be late." Some people were dissatisfied and described a disrupted service. Most people we spoke with were happy with their regular care workers and spoke positively about the service. They described reporting late or missed calls and receiving an apology and a quick response.

The lack of staff meant that people were not always receiving the reliable service that they should expect, and this had put some 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.

● There were safe systems in place for the recruitment of staff. Appropriate pre-employment checks were completed to help ensure staff were suitable to work with people.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At the last inspection the provider had not ensured that safeguarding processes operated effectively, and this was a breach of Regulation 13:(1) (2) (3) Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made some improvements and there was no longer a breach of Regulation 13. The provider's safeguarding policy reflected local arrangements and had been shared with staff. The registered manager and staff understood their responsibility to report safeguarding concerns. Updated safeguarding training had not yet been provided to staff, however the registered managed arranged for staff to undertake this training and provided evidence that this had commenced following the inspection.
However, practice was not yet embedded and sustained, and this remained an area that needed to improve.

● Most staff were able to describe how they would recognise abuse and knew how to report any concerns. One staff member was unsure and described undertaking investigations themselves, before reporting concerns to the manager. This meant that not all staff understood their responsibilities with regard to the provider's safeguarding policy.
● The registered manager told us that due to the recent difficulties with staffing levels they had not been able to arrange for safeguarding training to refresh and embed staff knowledge. However, they made arrangements for training for all staff to be completed immediately following this inspection.
● Systems for reporting incidents and concerns were not robust and did not support learning lessons when things went wrong.
● Information about incidents and concerns was not always recorded and reviewed. For example, when people had not received planned care visits the registered manager had not collated details. They were not able to identify how many visits had been missed, in what area, at what time. This meant that they could not fully assess the impact on people who relied on the service and necessary improvements had not been made.

Requires Improvement

Is the service effective?

Our findings

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

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

●Assessments of people's needs and choices lacked detail and did not include evidence based guidance.

●The provider had introduced an electronic care monitoring system and assessments and care plans had been transferred onto the new system. Assessments provided basic information but did not fully assess people's needs. For example, a person's medical conditions were listed but there was no assessment of the impact of these conditions, how they were managed or any risks to the person associated with these conditions. This meant that staff did not have all the information they needed to provide effective care.

● Staff described visiting people on a regular basis. This provided continuity and meant that staff knew people well and understood their needs. People confirmed that they had regular care staff. This meant that the lack of information within assessments and care plans had not had a negative impact for people who used the service. However, there was a risk that staff who were unfamiliar with people's care might be sent to cover visits and would not have the information they needed. This is an area of practice that needs to improve.

Staff support: induction, training, skills and experience

● Staff had received induction training when they joined the service and shadowed experienced care workers until they felt confident to provide care in the way people preferred.

● The registered manager described having regular contact with each staff member, either by telephone, social media messages or when delivering PPE or covering care visits. They explained that they used these opportunities to catch up with staff and check that they had all they needed. However, this informal support did not provide opportunities for discussions about personal development or assessment of practice and these conversations were not recorded.

● Staff told us they did not always feel well supported due to the problems with staffing levels. One staff member said, "We don't have time for supervision or reviews because the manager is covering calls." Another staff member said, "The shortage of staff is having an impact , everyone is feeling under pressure but it is worse for the manager and other things just have to drop- so we are not getting the usual level of support, but we can manage without."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

● Staff were working effectively with other agencies and supporting people with their health care and dietary needs.

● People and their relatives were confident that staff would recognise if a person was unwell and needed health care support. One relative said, "They do notice and would normally tell me. That's why regular carers are so important, they can see a deterioration."
● Appropriate referrals had been made and advice was sought from health care professionals. For example, an occupational therapist (OT) had provided guidance for staff in how to support a person with a hoist and sling. During the inspection we observed a positive discussion about the person's progress between the registered manager and the OT. The registered manager told us that the guidance from the OT would be added to the person's electronic care plan for staff to refer to.
● Staff were knowledgeable about people's needs and preferences with regard to food and drink. One staff member described encouraging a person to eat with snacks they enjoyed. A relative told us, "They do ask what (person's name) wants for lunch and they always get what (person's name) wants." Staff told us that people who received support with eating and drinking were given choices and their preferences were supported.
● A relative said that staff were consistent in supporting people to remain hydrated saying, "They always make sure there's a drink to hand and keep encouraging them to drink."

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.
● Staff demonstrated that they understood their responsibilities with regard to the MCA.
● People and their relatives explained how staff checked with people before providing care. One relative told us that staff always explained what they were going to do and said, "They always ask if they are ok with that. Even though it's the same task, they do still ask."
● Staff described their understanding of people's rights to make their own decisions. One staff member said, "We encourage people to make decisions themselves. If they don't have capacity then decisions might need to be made that are in their best interest."

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 comprehensive inspection on 20 October 2019 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; Respecting and promoting people's privacy, dignity and independence

- People were not always supported and treated well and their dignity had not always been maintained. We received mixed feedback about people's experiences.
- Some people were not receiving a consistent service and had late or missed visits. The lack of reliability had an impact on people's trust in the service. One relative said, "We have to build up trust and confidence with new carers."
- A staff member described how inconsistent staff had a negative impact on a person's dignity. They explained how the person had not felt comfortable with unfamiliar carers and had refused to let them help with their personal care. They said, "It had been two weeks and they were really glad to see me because I was a familiar face, they were very unhappy."
- A person needed support from two staff with moving around and their personal care needs. A staff member explained that not having enough staff had meant that the person had to wait an unacceptable time for their care. They told us, "As I was on my own, I couldn't support them until another carer arrived. It took a long time to find someone, but they came eventually." They described how waiting for their care needs to be met had a negative impact on the person's dignity.
- Most people we spoke with told us they were very happy with their regular care workers, with whom they had developed positive relationships. They told us, "They understand and are very sympathetic," and, "We have a team of four staff, they are very good and two are exceptional." Comments included that staff were "Considerate, patient and respectful." One relative described how a staff member had gone to the hospital to visit their relative and help them to shave. They told us, "Really they went above and beyond to do that."

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

- Some people's views were not always respected.
- One person had expressed a preference for female care workers. The registered manager described not being able to meet their request on a regular basis due to the staffing difficulties and due to the person's preferences. This meant that the person did not feel that their views were always respected and their service had been disrupted.
- A relative told us that they felt their relation's views were not always respected. They described how their relation had not felt comfortable with a particular staff member and said, "We asked that they not send them again, but they continued to do so until very recently."
- Where people had regular staff visiting they were positive about staff support. Comments included, "I think they do a sterling job. All the carers seem to be caring people." One relative told us, "They (staff) take their

time and don't pressure them," another relative said, "They are nice people and caring."

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 good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

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 provider had not fully implemented the AIS. Some people had communication needs due to sensory loss.
- Care plans included a communication assessment that identified people's sensory loss. For two people this had not been fully completed and there was no guidance for staff in how to meet either person's communication needs.
- A relative described how some staff were not aware of how to meet people's communication needs. They described this as a barrier to communication saying, "They are deaf and if they can't understand (the staff) then they will shut down." A second relative told us about their relative's needs, saying they were, "Totally deaf now, they just can't hear anything." The lack of guidance for staff meant that people were at risk of not being supported in a personalised way with their communication needs.
- Following the inspection we asked the registered manager about their understanding of AIS. They agreed that care plans did not identify and address people's communication needs saying, "It touches on it, but shallowly. It's a level of detail we were unaware of and an area we need to improve on going forward."
- There was no system in place to flag people's communication needs or to share this information to reduce barriers to accessing information. Failing to comply with AIS is an area of practice that needs to improve.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People usually received a personalised service from care staff who knew them well.
- People and their relatives told us that the regular care staff understood people's needs and were responsive to any changes in their needs. One relative said, "It's about building a relationship and the regular carers have done that."
- Staff described how well they knew people and their understanding of people's individual needs. One staff member said, "I only do visits for three people regularly. Occasionally I cover other visits, but usually I stick with my regular calls." This meant that staff had got to know people very well and were familiar with their care needs and preferences. One person told us, "They're like friends now, and they sit and have a chat." A relative described how regular carer staff had developed a strong bond with their loved one saying, "They all understand him."
- Staff told us they were able to support people's changing needs. One staff member told us, "If I need to stay longer I can, I would get paid for extra hours. There is lots of flexibility because we know people very

well."

● Relatives confirmed that staff were usually responsive when people needed additional support. One relative said, "I sometimes pop out and I feel confident that they would call or text me if needed." Another relative described how staff had waited until they returned so their loved one was not left alone following a fall. They told us, "I have confidence that if there was any issue they wouldn't just walk away."

● Records were not well personalised and did not always reflect the care that people were receiving. There was minimal impact for people because regular staff knew people well and understood their needs, but there was a risk that unfamiliar staff would not have all the information they needed to provide care in a personalised way. We have commented further on record keeping in the well led section of this report.

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

● People and their relatives were positive about the relationships that had developed with regular staff members. They told us how staff engaged with people and were aware of their interests. One relative said, "They know he likes horse racing and they will talk to him about that. Sometimes they go out for a walk with the wheelchair." Another relative described their regular care worker as having a good sense of humour, saying, "They talk about day to day things and they have a laugh together, that keeps them bright and cheerful."

Improving care quality in response to complaints or concerns

● The registered manager was responsive to people's complaints.

● People and their relatives knew how to make complaints and told us about the complaints they had raised. They said that the registered manager had responded quickly to address concerns for example when calls had been missed. One relative told us, "Once when the carer didn't turn up, I called the office and they immediately sent someone round."

End of life care and support

● The service was not supporting anyone with end of life care at the time of inspection. The registered manager advised if someone was nearing the end of their life staff would work with health care professionals to provide the support they needed.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A warning notice was issued requiring the provider to comply with the regulation by 29 September 2021.

At this inspection there had been a continued failure to improve and people had continued to be placed at risk of harm. The warning notice had not been met.

● Management systems were ineffective, risks to people had not been identified and managed. Staff were not always clear about their roles.
● The registered manager told us they completed a regular medicine audit and relied on records from the electronic monitoring system to oversee the quality and safety of the service. These systems had not been effective in identifying the risks and shortfalls found during the inspection.
●The registered manager had not been aware that some staff members were undertaking tasks beyond the boundaries of their role and for which they had not been trained. One staff member had been recording clear notes about the tasks they were completing on the electronic system but the registered manager told us they had not seen this and they were unaware that the staff member was completing a task that was not in the care plan.
● The registered manager said the electronic monitoring system was used by staff to record details of their visits including MAR charts. The medicine audit had not identified the lack of accurate recording on MAR charts that we found.
● Records were not kept consistently. This meant that records of people's care were not complete and accurate and could not be relied upon. Staff used their mobile phone to record on the electronic monitoring system. One staff member had not been keeping records of any visits since their mobile phone stopped working in August 2021. The staff member was unaware of the importance of maintaining accurate records and had failed to do so. Although the registered manager was aware of this situation, they had not taken action to ensure that paper records were in place until a new mobile phone could be arranged.
● People's care plans and risk assessments were also completed on the electronic system. These records were basic, task based, lacked personalisation and were not fully completed. This meant they did not reflect

the care that was provided and there was a risk that staff did not have all the information they needed to provide care safely. Following the inspection, we discussed these concerns with the registered manager. They described having previous care plans embedded within the electronic system and provided copies of these. However, these also lacked detail and were not well personalised.

● Systems for monitoring visits were inadequate and this meant that the registered manager could not be assured that people had always received their visits. The registered manager used a different system to plan staff rota's and visits to people. These did not always provide accurate information. For example, some rotas showed that a staff member had two visits to complete at the same time. The registered manager described how staff were able to adjust call times themselves because they knew people well. However, this meant there was no accurate record of when planned visits were due to take place.

● The electronic monitoring system was used by staff to record when they arrived and left a visit. However, this was not used consistently and there was not always a reliable record of when visits had happened.

● The registered manager told us that they would notice on the electronic system if a call had not happened. The lack of accurate recording meant this was not reliable. The registered manager said that people or their relatives would contact the office if a call was missed. This was not the case for everyone. One staff member described how two care visits had been missed during the week of the inspection but this had not been noticed by the registered manager and the person had not reported the missed calls to the office.

● We asked the registered manager to provide us with information about the number of missed visits in recent weeks but they were not able to provide this. This meant there was a lack of oversight and people were placed at potential risk of not receiving the care they needed.

● The lack of effective systems for monitoring quality and staff performance meant that there had been a continued failure to make improvements.

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

● The inconsistent leadership and a lack of management support meant staff were not always well supported.

● Staff described how the registered manager was regularly covering care visits because there were not enough staff. One staff member described the impact of this saying, "They can't always answer us quickly because they are providing care themselves."

● People and their relative's views on the management of the service were mixed.

● Some people told us the registered manager was very responsive, saying "He is just on the ball and knows what he is doing." When asked if the service was well run one relative told us, "Yes, absolutely and whole heartedly, (registered manager) is very good when issues arise."

● Other people expressed less positive views. One relative told us, "The rotas are messed up. I get the impression (registered manager) doesn't look after or manage the staff very well." Another person said, "The rota is not well managed. The carers have to manage it themselves."

● The registered manager confirmed that they had to cover care visits due to the current shortage of staff and that they were also completing rota planning for visits and dealing with other managerial tasks, including when on annual leave. This meant that they were not able to provide the level of support that they would want to staff and that planned improvements had not been implemented due to the current pressures.

● The registered manager confirmed that they were actively recruiting more staff, including a care co-ordinator to take on some of their workload and allow them to concentrate on making planned improvements to the service.

● The registered manager did not demonstrate that they fully understood the requirements of their role,

including the duty of candour. They had not submitted the required notification to CQC when staff shortages had affected the running of the service. The registered manager told us they were not confident in their understanding of the regulations and needed to improve their knowledge in this area.

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

- People, relatives and staff were not always proactively engaged and involved with the service.
- One person told us, "We don't have any communication from management. Only when I call them." Another commented, "Communication is not great and can just be a text message."
- People's equality characteristics were not always considered when planning their care. For example, risk assessments and care plans lacked the detail and guidance that staff needed to ensure effective communication with people who had sensory loss.
- Staff described having regular communication through texting or social media groups. This did not always provide an effective way to engage with staff. For example, the registered manager told us they had provided staff with current guidance about use of PPE on a social media application. However, staff remained unclear about current guidance and this shortfall had not been identified by the registered manager.
- Staff had not all engaged with the electronic monitoring system. The registered manager told us that some staff were reluctant or unsure about how to use the system. There had not been effective support, training and guidance for staff in how to use the system and this had resulted in inaccurate and inconsistent use. The registered manager said they had also not been able to access the training they needed and as a result were not confident in using some of the available functions that would have supported their oversight of the service.

There was a continued failure by the provider to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This had placed people at continued 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.

Working in partnership with others

- Staff described positive working relationships with other agencies. A staff member described working with a district nurse, another explained how a manual handling assessment had been completed with an occupational therapist.
- Some people were receiving care from more than one provider and staff worked together to ensure people received an effective service.
- Relatives of people spoke highly of the staff and how they involved them with care. One relative said, "They are a good team and that what makes it work."