Fen Homecare Ltd

Fen Homecare

Inspection report

Pegasus House
Pembroke Avenue, Waterbeach
Cambridge
Cambridgeshire
CB25 9PY

Tel: 01353968165
Website: fenhomecare.co.uk

Date of inspection visit:
23 June 2022
25 July 2022

Date of publication:
06 September 2022

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
Fen Homecare is a domiciliary care agency providing personal care to people in their own homes. The service provides support to people living with dementia as well as other physical and mental health needs.

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 our inspection there were 70 people using the service who received the regulated activity of personal care.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not support anyone with a learning disability or an autistic person. The manager was still reviewing with the provider if they intended to continue or to remove the group 'learning disabilities' and 'autism' from their registration. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is currently registered as a specialist service for this population group.

Right Support:
People's rights to choose were not always upheld and people were supported by staff who had not received training about consent or understood how to promote choice and independence.

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.

One person's right to choose to self-administer medicines was not supported. People's mental capacity had been assumed instead of exploring if the issue was a language barrier rather than comprehension.

People were supported by staff who were working unsafe shift patterns and long hours. Rotas were not managed in ways that meant sufficient numbers of staff to ensure breaks and safe ways of working.

People were supported with their medicines but the records for medicines did not always reflect safe medicines management and administration.

Right Care:
People told us language barriers between themselves and staff sometimes meant they struggled to make their wishes known as staff could not always understand them verbally or through written instruction.

Information was not always in formats people could understand which meant they were reliant on relatives to translate information about their care.

People told us staff were kind and caring and treated them nicely. Staff understood how to promote people's dignity and privacy.

Right Culture:
People were supported by staff who had not had the appropriate checks on their suitability for the role. Staff did not all understand how to recognise or report abuse and safeguard people they were supporting.

Person centred approaches were not promoted by the manager and staff team. People's care was not monitored for the quality and standards of care provided. Checks on staff knowledge and skills were not made, to ensure they could meet people's needs.

People were not supported to lead empowered lives and identify clear goals to promote their independence and ensure care was personalised. Staff did not evaluate the quality of support provided to people, involving the person, their families and other professionals as appropriate.

The provider did not ensure a complaints system was in place to enable people to voice concerns that were then investigated with outcomes clearly recorded. The provider did not have systems in place to ensure they acted openly and notified all concerned when something went wrong.

We have made recommendations about improving monitoring of safeguarding concerns and openly managing significant events ensuring a duty of candour is upheld.

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

Rating at last inspection
This service was registered with us on 6 May 2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part due to concerns received about staffing, governance and recruitment practices. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive 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 monitor the service and will take further action if needed.

We have identified breaches in relation to recruitment practices, staff training and support, consent, complaints, person-centred care and quality assurance systems and management of the service at this inspection.

We issued warning notices to the provider in response to a breach of regulation 17 (good governance) and regulation 19 (fit and proper persons employed). We have imposed a timescale for the required improvements to be completed.

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

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 of 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

Fen Homecare

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by one inspector 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. There was a manager currently in post who was in the process of applying to the CQC to become registered.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 June 2022 and ended on 25 July 2022. We visited the location's office on 23 June 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority,

Healthwatch England and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people and five of the relatives to seek their views about the care. We spoke with five professionals who are involved with the service. We spoke to seven staff members including the manager, office staff and support staff. We reviewed four people's care records and six staff files. We also reviewed various quality assurance documents and policies.

After the inspection
We continued to clarify information and request further documentation from the manager. We worked with other agencies and professionals to assess the risks to people in relation to recruitment and rota management. CQC continue to work with other agencies in regard to these concerns to ensure people are safe.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment

- The provider did not have systems in place to ensure safe and robust recruitment checks of staff members to ensure they were suitable for their role.
- We found a number of gaps in their recruitment records. This included incomplete interview records, missing identification documents and references. A lack of evidence of the right to work in the UK, unexplored gaps in employment history and missing Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The lack of thorough checks prior to staff being recruited put people at serious risk or the potential of this. This was because the provider had not assured themselves that staff were of good character and had the correct skills and knowledge to make them suitable for their roles.

The provider had not ensured robust recruitment systems to ensure staff were fit to be employed. This was a breach of regulation 19(1)(2)(3)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded during the inspection. They submitted further evidence that meant some of the missing documentation was put in place. However, this did not cover all gaps and one staff member still had no evidence of references, identification and DBS. All staff continued to have significant unexplored gaps in their employment history.

Staffing and recruitment (continued)

- The manager had not ensured there were sufficient numbers of staff on shift. This resulted in unsafe shift patterns. Rotas showed three staff members had worked for 53 days without a day off. Staff also worked very long days with minimal breaks and little to no travel time included in the planning of the rota.
- There were no systems in place for the monitoring of late or missed care visits that did not rely on the staff member or person themselves calling the manager to tell them. The manager told us they planned to introduce an electronic monitoring system, but this had been planned since February 2022 and had still not been implemented.
- People gave us mixed feedback about care visit times. Some people told us staff were on time and had never missed a care visit. Other people told us staff were often either late or left early and were always busy, resulting in people feeling rushed. For example, one person told us, "[Staff] come on time and they don't rush away, they stop the full hour." Another person said, "My only niggle is timekeeping really. [Staff] can be very late by a half an hour but up to an hour."
- One relative whose family member was receiving end of life care, told us how staff were often late by more

than an hour and when they called the office, the manager was not aware the staff had not arrived. This was particularly distressing for a person at the end of their life and their relatives who were reliant on good, timely care.

The provider did not implement effective and safe rota management to ensure there were sufficient numbers of staff on shift that enabled safe and timely care visits for people. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

● The manager had not fully assessed all risks to people. There were no risk assessments in place for people who used a catheter bag. There was lack of guidance for staff about how to care for catheter equipment or how to identify early signs of infection.

● People with diabetes and had no risk assessment or care plan in place for this. There was no information for staff about how to identify early signs of a person's blood glucose levels being too high or too low. Staff we spoke with told us they did not know what this might look like so would not know when to call for emergency medical support. This put people at serious risk of illness as there was the high risk of this occurring.

● Medicines management was not always safe. The provider had arranged for staff to receive training for medicines administration and there was evidence that some staff had been assessed for competency in practice. However, not all staff had evidence of competency checks and evidence of medicine administration records (MAR) were blank.

● Not all people required support with their medicines. Care records were, for some people, unclear as to whether the person, their relatives or the staff were responsible for the ordering and administration of their medicines. Where people required support with creams only, there was no chart to guide staff as to where to apply the cream.

● The manager did monthly audits of medicines; however these had failed to identify the concerns we found during the inspection. The lack of effective medicines administration and management put people at risk of not having their medicines as prescribed by some staff who had not been deemed competent to do this.

● There was no evidence of learning lessons when things went wrong. Staff told us they did discuss with the manager when they had made a mistake. Staff said this was more the manager telling them what they had done wrong rather than supporting them to reflect on lessons to be learnt and how they could work differently in the future.

● This prevented a learning culture and limited staff's ability to be able to reflect on what could be done differently next time. This was because there was no formal process for learning.

The provider had not ensured risks to people had been fully assessed appropriately and did not provide sufficient guidance for staff about how to manage the risks safely. There were no effective records and systems in place to ensure safe management and administration of medicines for people. Lessons had not been learnt or shared to improve practice or systems. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where risks to people had been assessed, the manager had made the correct referrals to relevant external professional such as district nurses (DN's) or occupational therapists (OT's) had been made. This helped to ensure people had the right equipment and nursing care where required.

Systems and processes to safeguard people from the risk of abuse

● The manager had not identified the vulnerability of, and conflict of interest for one person who was being

supported by their relatives as self-employed staff members. They had not put measures in place to ensure the person could easily speak up if concerned about their care or other safeguarding measures.
● Staff were recording incidents and accidents. However, there was no monitoring system in place to ensure the manager was aware of these. There were also no systems to check any safeguarding incidents had been reported to the appropriate organisations. The manager reported concerns they were aware of to the local authority but not to the CQC.
● Despite our findings, people told us they felt safe, this was mainly due to having continuity of care staff. One person told us, "[Staff] all know what to do. They are very kind to me. I do feel safe with them." Another person said, "I do feel safe with [staff]. They are very good in what they do for me."

We recommend the provider consider current guidance on safeguarding people and take action to implement robust systems for identifying, reporting and monitoring safeguarding concerns.

Preventing and controlling infection
● Staff were using Personal Protective Equipment (PPE) effectively and safely.
● The manager ensured processes were in place to reduce the risk of infection and the spread of COVID-19. Staff took part in regular testing and told us they had received training in how to safely use (PPE) such as gloves, aprons and masks.
● People told us staff usually wore their PPE, washed their hands regularly and cleaned the environment before finishing. One person said, "[Staff] all wear their gloves and masks all the time, very reassuring." Where staff had not worn PPE, people said they raised it with staff, or the manager and it was resolved quickly.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- The manager did not ensure that staff had the required training for their roles. Staff were given one face to face day of training, which covered 17 different areas of health and social care topics. This did not include safeguarding or the Mental Capacity Act 2005. Most staff we spoke with were not able to tell us about different types of abuse or how they would identify, report or record it.
- New staff without previous care experience or qualifications were not all supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- The manager had completed some checks of competency for staff for medicines. The provider had conducted a check of competency for one staff member who did not have previous care experience. This occurred on the same day they attended the training course to absorb 17 topics. Checks were recorded in a way that did not evidence how the staff member was competent.
- There was no evidence of staff having received an induction or supervision to support their understanding of people's needs, safe working practices and professional development. Staff told us they did not have supervision but had shadowed other staff and was asked to speak to the manager when they had made a mistake.

The provider did not ensure staff were suitably trained, supervised and supported to develop the skills and knowledge required to fulfil their role. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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

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

We checked whether the service was working within the principles of the MCA.

● Staff knowledge about the principles of consent and the Mental Capacity Act 2005 (MCA) was mixed and limited. Some staff told us they had not received any training in this. Other staff told us they had but could not remember what the content was and could not tell us what this meant. One staff member was able to explain the basic principles of consent and the MCA.
● People had consent to care forms in place but whether or not they had the mental capacity to make the decision was at times unclear. For example, one person's care plan said they had the mental capacity to make their day to day decisions about their care but yet their daughter had signed their consent to care form without explanation about why.
● Another person's care plan said they had the mental capacity to understand their medicines and had been self-administering medicines. This was later changed to staff administering. However, the record for this change was suggested by their daughter and referred to social services by Fen Homecare. This was without any recorded consultation for the change with the person. No assessment of their mental capacity in the area of their medicines or evidence of a best interest process having been followed. The decision was contrary to what the person stated in their care records they wished to happen.

The provider had not ensured people's mental capacity had been properly assessed where required and people's rights in relation to restrictive practices were not upheld. Records were unclear and did not show how the principles of the Mental Capacity Act 2005 had been followed. This was a breach of regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Not all people required staff to support them with eating and drinking. Where people did require support, this was not always provided safely. The manager told us that no-one currently being supported required a special diet or had choking risks.
● We saw complaints from relatives where frozen food had been presented to their family member because staff had not correctly understood the instruction for cooking it. This was reported to happen a number of times and relatives reported their family member becoming ill. Records showed the provider had given staff members additional training on food hygiene.
● People told us they felt staff were often unable to read the instructions in recipes for people's favourite meals due to language barriers. People and relatives told us this meant staff often just gave people ready meals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The manager had assured assessments of people's needs were in place. However, for some people this was information and comments from external professional's assessments of people's needs prior to starting with the service. There was no evidence of the manager reviewing this and conducting their own assessments to ensure the information was still relevant.
● The information from internal and external professional assessments had been used to inform people's care delivery but some aspects of assessing risk had been missed. People were aware of the content of their care plans and mainly agreed it met their needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access various health appointments where required or speak to health professionals on their behalf.
● The manager made regular referrals to community nurses or occupational therapist and chased these up

to ensure equipment and assessments took place as soon as possible. Staff understood the need to follow health professional advice to better support people's needs.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People overall told us, they thought the staff were kind and caring and treated them well. One person said, "I know them all (staff), they are very nice to me, well exceptionally nice really. They couldn't be kinder." Another person told us, "I have regular [staff] and that makes a difference, they all talk to me and we have a laugh. They suit my personality and that's such a good thing."
- Some people felt there were language barriers that prevented effectively communicating between themselves and staff what their preferences were or what they needed. One person told us, "The language barrier makes it a bit hard but it's OK once they have been here a while, I know most of the [staff]. I don't know who is coming and it changes quite a bit, but I do know them." A relative said, "[Staff] are lovely to [my family member] but sometimes their English isn't so good and they don't know [my family member's] accent."
- Language used by staff in daily notes did not always promote respect and equality and was institutionalised such as the term 'patients' and described tasks only, rather than including how a person was feeling that day.

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

- There was evidence of regular contact with people and their relatives to accept feedback about their care or when concerns had been raised. This did not go on to record the outcomes and only occurred when people and relatives reported an issue to the office staff. There was no evidence of the manager actively seeking people's views about their care.
- However, some people told us they were involved in verbal reviews and other people had a clear understanding of the content of their care plan and were happy about this. One person told us, "[Staff] are coming out next week to review my folder and talk to me about things, they do that quite often." Another person said, "I have a care plan and there was a review a while ago, I don't remember any feedback forms or anything." There was no documented evidence of formal reviews of care having taken place. This meant it would be difficult to consider progress and other changes without something to compare subsequent reviews to.

Respecting and promoting people's privacy, dignity and independence

- The manager and staff team understood how to ensure privacy was upheld. They delivered care in ways that generally promoted people's dignity. However, at times people told us they felt rushed by staff. One person told us, "[Staff] are all in a bit of a rush." Another person said, "Well [staff] are very quick, some just take 20 minutes and they are gone."

● Staff we spoke with were not able to demonstrate an understanding of how they could promote people's independence. One staff member spoke about asking people what they wanted but not how they could encourage the person to do more for themselves where it was possible.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The service did not have evidence of a formal complaints' procedure in place. However, people told us they could report any concerns and staff would resolve these very quickly. One person told us, "There was one [staff member] my [relative] didn't like in the house and they rang [the manager] and it was changed, there was no problem with that." Another person said, "I can ring [staff] at the office and discuss things and they are very responsive, no problems with that."
- Records showed evidence of regular contact with people and relatives who gave feedback about the quality of care, call times, meals and staff. We could see initial responses and actions agreed to be taken but no evidence of outcomes or how this information had been used to improve quality and performance.

The provider had failed to ensure there was a system in place for identifying, receiving, recording, handling and responding to complaints. This was a breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; End of life care and support; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care plans and assessments did review communication needs. The manager told us there was no-one being supported who required information in different formats. However, at least one person did not speak English. There had been no attempt to translate their care plan to their preferred language to help them understand it, despite employing staff who had the skills to do so. The person was therefore relatives on their relative to translate for them. This was a missed opportunity to support the person's independence as there were staff employed who spoke this language and could support with translating writing information to be shared.
- The manager and staff team were not aware of the accessible information standard but told us they would alter the formats of information to support people's communication needs.
- Staff did not understand what personalised care meant when we spoke to them. However, their personal values ensured people received care in a way they would be happy for a family member of their own to be supported, ensuring a personalised approach in practice.

● Feedback from people and relatives about person centred care was mixed but mostly positive. They told us care was delivered in ways that met their needs and preferences with the exception of time keeping. They told us they could easily change aspects of their care if they mentioned it to the staff or manager. One person told us, "I get continuity of [care staff] and I get to know them, and they know me very well and that's so important." Another person said, "[Staff] are a bit pushed for time sometimes, they can be away in a quarter of an hour when they should be here half an hour."
● People's care plans did not document their wishes for meeting their care or cultural needs at the end of their life. Records did not document the additional care needs and sensitivities specific to providing end of life care.
● Staff told us they were supporting people at the end of their life but had not yet received training in this area.

The provider had not ensured systems and records were set up in ways that promoted person centred approaches particularly in relation to communication needs and end of life care. This had resulted in some care and timing of care visits not being delivered in ways that met people's needs. This was a breach of regulation 9(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, feedback from people and relatives about the care being delivered was mixed. One relative told us, "It's end of life care now for [my family member] and I want to do as much myself whilst I can and [staff] have been very helpful about that. [Staff] are on time and very nice to [my family member]. [Staff] are very caring and I do feel [my family member] is safe with them."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The manager did not have a good understanding of the requirements and responsibilities of their role. For example, they had no systems in place for reviewing and analysing incidents and accidents and so patterns of poor practice were not identified or improved. There was no action or improvement plan in place and the manager did not feel this was their responsibility to create one.
- The manager understood the need to report notifiable events to the CQC and other agencies without delay. They also understood the importance of sharing outcomes with those involved and staff to learn from them and ensure open communication.
- However, this had not always occurred. We found a number of concerns that were recorded in people's record of contact that while, reported to the safeguarding teams or local authority, had not been reported to the CQC. One professional we spoke with told us the manager had not always reported missed care visits.
- The provider had no recorded input into the service and we found no evidence of any audits or other systems in place to enable the provider to have an oversight of the service and identify issues for improvement and assure themselves of the quality of care provided. The provider had been made aware of these same issues over 12 months previously by other external professionals but had not made the necessary changes and improvements.
- The manager did not have any effective monitoring systems or procedures in place, except for the auditing of medicines and people's daily notes. These audits had not identified the concerns found in relation to medicines, risk management or inconsistent of care visit times or durations.
- The manager and provider had both failed to identify the numerous concerns we found during the inspection including lack of staff supervisions, no systems for monitoring late or missed care visits. There were no checks in place for staff training or to monitor and review the competency of staff skill and knowledge to fulfil their roles.
- The manager did not understand the legislative requirements. Nor did they keep up to date with changes to best practice and government guidance such as the Right support, right care, right culture policy or the accessible information standard. They also had not followed CQC's Quality of Life tool used by inspectors to measure quality of services where the provider stated they specialise in supporting people with learning disabilities or autism.
- The manager was reviewing with the provider whether it is appropriate to continue to have the specialist band of 'learning disabilities and autism' on their services' registration. This was because they were not currently supporting anyone in this group of people and have previously not been able to meet the needs of people in this group. They have not yet confirmed if they intend to remove this from their registration.

Therefore, this means CQC will continue to inspect them against this statutory guidance in addition to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff struggled to understand their legal responsibilities in relation to safeguarding, the MCA and care and treatment.

● Staff were not supported to continually reflect, learn and develop their skills. Staff were not supported to manage their time to ensure their own well-being and safety. For example working an average of 10.5 hours a day, in some cases more, with minimal breaks and no day off in a 53 days period.

● There was no evidence that any lessons learnt had been identified from concerns raised in March 2021 and February 2022 and no action had been taken to implement new practices and improve the quality of care.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service and staff. The provider had failed to have systems in place for the effective planning and monitoring of care visits. The provider did not have any systems in place for monitoring the quality of care provision. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The manager did not always understand how to promote a personalised approach to care that meant staff understood about the impact of people's health conditions and how to reduce risks. The manager was unaware of the principles of the Right support, right care, right culture policy which support people's rights to choose and dignity in care.

● The manager ensured consultation processes about the care being delivered occurred but this was inconsistent in the application and recording of content and outcomes.

● Despite our findings, most people told us they were happy with the care received except for the issue of consistency of care visit times and not staying for the required duration.

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 manager understood their need to be open with people when something went wrong. Records did show how staff apologised to people following concerns being raised.

● However, the provider did not make sure there were systems in place to evidence clear investigation outcomes and responses to people in a way that fully promoted transparency.

We recommend the provider review regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with a view to updating their systems and practices to promote openness and clear recording of outcomes for notifiable events.

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

● The manager listened to people and relatives when they called to provide feedback. However, this was inconsistent, relied on people giving feedback and did not record outcomes.

● People told us they had contact in various forms and could speak up if required. One person told us, "[Staff] ring every now and then to check and ask questions so I don't get a form." Another person said, "I don't remember feedback forms but [staff] do ask you a lot of questions when they come."

● Not everyone knew who the manager was even though they had been in post since February 2022.

● Staff told us they felt they could approach the manager but had not been asked for their views about the

service or the care provided.

Working in partnership with others

● The manager worked with health professionals to arrange for any equipment and medicines to be put into place.

● Professionals we spoke with told us they had no current concerns with the service but when they had visited over the last 12 months, they had found similar concerns. These were in relation to poor recruitment practices, staff supervisions, inductions, appraisals and team meetings not in place or not recorded. They also found concerns about staff training. They felt the language used in documentation could be more personalised and missed care visits had not always been reported to them. These concerns had still not been addressed effectively at the time of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person Centred Care The provider had not ensured systems and records were set up in ways that promoted person centred approaches. This had resulted in some care and timing of care visits not being delivered in ways that met people's needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks to people had been fully assessed and appropriate and sufficient guidance for staff about how to manage the risks safely was not in place. The provider had no effective records and systems were in place to ensure the safe management and administration of medicines for people. The provider had not ensured safe and timely rota management.

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA RA Regulations 2014 Receiving and Acting on complaints The provider had failed to ensure there was a system in place for identifying, receiving, recording, handling and responding to complaints

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff were suitability trained, supervised and supported to develop the skills and knowledge required to fulfil their role.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance The provider did not have sufficient quality assurance, auditing and monitoring systems in place to enable oversight and effective management of the quality of the service provided. The provider had failed to have systems in place for the effective planning and monitoring of care visits. Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service and staff.

The enforcement action we took:

We have issued the provider with a warning notice to enforce improvement within a specified timescale.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured robust recruitment systems to ensure staff were fit to be employed.

The enforcement action we took:

We have issued the provider with a warning notice to enforce improvement within a specified timescale.