Daily Care 4 U (Telford) Ltd

Glebe Centre

Inspection report

The Glebe Centre
Glebe Street, Wellington
Telford
Shropshire
TF1 1JP

Tel: 01952567813

Date of inspection visit:
12 June 2018
13 June 2018
14 June 2018
15 June 2018

Date of publication:
18 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection relates only to Daily Care 4 U (Telford) Ltd and does not in any way relate to other business/charities/providers who may be operating out of The Glebe Centre.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. At this inspection they were providing personal care for 53 people.

Daily Care 4 U had a registered manager in post who was present throughout this inspection. The registered manager was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service has not been previously inspected.

During this inspection we identified seven breaches of regulations. These were in relation to, not protecting people from the risk of abuse and ill-treatment, unsafe care and treatment of people, staff members not having the appropriate skills and support to meet people's needs, complaints not being recorded or responded to, people not having personalised care based on their individual needs, failure to make notifications of significant events occurring within the service and ineffective quality assurance systems to identify or drive improvements.

People were not safe from the risks of ill-treatment and abuse as the provider failed to recognise and respond to allegations which could potentially harm people. The provider failed to follow safe recruitment practices when employing staff members. People were at risk of harm when receiving assistance with their medicines as the provider had failed to train and subsequently assess staff members as competent when supporting people. People were at risk of harm in relation to their care and support needs as there was insufficient assessment or guidance provided to staff on how to safely support someone with their identified risks. Staff members did not always follow safe and effective infection prevention and control practices. People could not be assured staff would arrive on time as the provider had insufficient systems in place to monitor staff member's attendance.

People did not receive care that was effective and personalised to their individual needs and preferences. People were supported by staff members who did not have the appropriate training and assessment of their skills and abilities. Staff members did not receive appropriate support and guidance from the provider. New members of staff were not supported through a structured induction programme and were not equipped with the necessary skills to support people in their own homes. People could not be assured that their rights would be protected as the provider did not have effective systems in place or knowledge to meet the requirements of the Mental Capacity Act 2005. People were not supported to have maximum choice and

control of their lives. The policies and systems of support in Daily Care 4 U did not promote the involvement of people in decisions about their care needs. People received assistance with eating and drinking although staff members had not been informed of, or promoted, people's individual likes or dislikes.

People received an inconsistent experience regarding the approach from the staff who supported them. Some reported good and kind care whilst others did not. People did not have their protected characteristics recognised or respected by the provider. People were not always supported in a way that eased their anxiety or distress. People did have their privacy and dignity respected by staff members.

People were not consistently involved in developing their own care and support plans. People's care and support plans did not contain the necessary information to direct the assistance they needed. When changes occurred in people's personal and medical circumstances these plans were not reviewed to reflect these changes. People's individual preferences were not known by staff members who supported them. People were able to raise concerns but the provider did not follow their own policies for recording or investigating complaints. People could not be assured their concerns would be effectively addressed. People did not receive information regarding their care and support in a way they could access or understand as the provider failed to recognise people's individual communication needs.

The provider failed to keep themselves up to date with current practices in health and social care. There were insufficient quality monitoring checks completed to identify or respond to poor care practices. Policies and procedures were in place but these were not followed. People did not receive information regarding their care and treatment in a timely way. The provider did not follow their own policies and procedures when unsafe and abusive staff practice was raised with them. The provider failed to make the required notifications regarding significant events occurring in their service.

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.

People were not protected from the risks of harm or abuse. The provider failed to act when suspected abuse was reported to them. The provider failed to follow safe staff recruitment checks. People did not have individual assessments of risk associated with their care. People received support with medicines by staff who had not been trained or had their competency assessed as safe. The provider failed to record or investigate incident, accidents or near misses. Staff members did not consistently follow effective infection prevention and control procedures.

Is the service effective?

Inadequate

The service was not effective.

Staff members were not provided with the necessary training or support to effectively assist people with their care needs. People were not involved in decisions about their care or day to day choices. The provider did not understand or implement the principles of the Mental Capacity Act 2005. The provider's policies and procedures did not promote people's rights. People received support with their meals although their individual likes and dislikes were not promoted by staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently supported by staff in a kind and compassionate way. Staff members did not actively involve people in decisions about their care. People's protected characteristics were not understood or promoted by the provider. People had their privacy and dignity respected by staff members.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive support that was individual to their needs

or preferences. Staff did not have access to relevant information to support their understanding about people's specific assessed needs. Care and support plans were not reviewed when changes to people's needs occurred. People could not be confident that their complaints would be listened to, taken seriously or acted on. People did not have access to information in a format they could understand.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's governance was ineffective to assess, monitor or drive improvements to ensure people received a safe and effective service. People were not provided with information affecting their care in a timely way. The provider failed to make necessary notifications regarding significant events. The provider failed to act when poor or abusive practice was reported to them.

Glebe Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection relates only to Daily Care 4 U (Telford) Ltd and does not in any way relate to other business/charities/providers who may be operating out of The Glebe Centre.

The inspection activity started on 13 June 2018 and ended on 15 June 2018. It included telephone interviews with people who used the service and their relatives. We visited the office location on 13 June 2018, to see the registered manager and to review care records and policies and procedures. This was an announced comprehensive inspection completed by two inspectors and an expert by experience. An expert-by-experience is a person who had personal experience of using or caring for someone who uses this type of care service.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Before our inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health

and social care services.

We spoke with nine people, five relatives and the registered manager. We looked at the care and support plans for five people including assessments of risk and guidance for the use of medicines. We looked at any records of quality checks and incident and accident reports. We further confirmed the recruitment details of four staff members.

Inadequate

Is the service safe?

Our findings

People were not protected from the risk of harm or abuse. The provider did not have effective systems in place for responding to concerns of abuse that had been raised with them. They did not follow locally agreed protocols for the identification, reporting and investigation of abuse. For example, one relative told us about a serious allegation of financial abuse and exploitation regarding their family member and two staff members. They went on to say that this had been reported to the registered manager but they did nothing about the concerns. They acknowledged that the two members of staff did not work with their family member anymore but believed they still worked for Daily Care 4 U.

We asked the registered manager about this allegation. They told us they knew about the allegation but they failed to follow agreed protocols for reporting and responding to such allegations including contact with the local authority, the police and with the Care Quality Commission. The registered manager confirmed that no investigation regarding the conduct of the staff members took place. They confirmed that these two staff members continued to work for them and with people in their own homes. When asked why they had not reported this allegation of abuse as expected, the registered manager said, "You expect me to believe someone with dementia?" This demonstrated a clear lack of understanding regarding those most at risk of exploitation within their care. Following our inspection site visit we confirmed that the provider had now referred this matter to the local authority in order to keep people safe.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not follow safe recruitment processes when employing new staff members. As part of their recruitment process the provider completed a check with the Disclosure and Barring Service (DBS). The (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with others. Contained within the DBS disclosure are details of any relevant criminal convictions, cautions and warnings. Out of the four staff recruitment files we looked at we identified two staff members with previous convictions listed in the DBS disclosure.

When we asked the registered manager about these criminal convictions, they told us they did not follow these up with the staff members concerned or check whether or not these had been disclosed at the initial application stage. There was no exploration of the risks these staff members may pose to people, if any. The registered manager failed to consider this information as part of their recruitment process. They failed to undertake any assessment of risk regarding these individuals when allocating them to work in people's homes. The registered manager told us it was their policy to seek three references for new staff members. We saw this was inconsistently applied as part of their recruitment. For example, a staff member had one character reference with no previous work based reference or second character reference. There was no evidence of any additional checks made by the registered manager to assure themselves that this person was a fit and proper person to work with people in their own homes.

We saw that this policy of three references was inconsistently applied throughout the other staff files we

looked at. There was no analysis of the quality or the content of the references provided for staff members. The registered manager could not assure us that those in their employment were safe to support people.

The registered manager failed to follow their own systems for addressing unsafe staff behaviour. They had policies and procedures in place for responding to such concerns including disciplinary action and re-training if necessary. However, when concerns were raised with them they failed to enact these proceedings in order to keep people safe. For example; when a concern was raised with them regarding a staff member acting outside of their policies and procedures they failed to record, investigate or identify any corrective actions needed to address this. This staff member had continued to work with people in their homes without any direction or correction following the concerns being raised with the registered manager. This left people at risk of injury as the registered manager failed to address the concerns effectively.

These issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safe from the risks of harm associated with receiving care and support from Daily Care 4 U. Those we spoke with told us they were not aware of any environmental risk assessments to their property or any equipment they used. One relative said, "The (staff) are very good at helping me to move [relative's name]. I'm not sure if that would happen if, for whatever reason, I could not be there. The carers rely on my guidance. We were given a turning aid, but I was not shown how to use it. None of the carers so far know how to use it either. This seems like a real lack of basic training."

We looked at how Daily Care 4 U kept people safe when supporting them. We saw some generic risk assessments but these were poorly completed and contained generic information. For example, those we looked at informed staff members to be aware of slippery paths and poor lighting. There was no individual assessment of risk regarding people or their circumstances. The information needed to support people in case of emergency had not been completed. For example, the environmental risk assessments we looked at had sections regarding the identified location of the gas shut off, water stopcock and the electricity fuse box. None of this information was included in any of the assessments we looked at.

There were no individual assessments of risk informing staff how to support people safely. For example, those at risk of trips or falls. One person, who was at risk of falls, told us, "They (staff members) used to assist me in the shower but they don't anymore and I have a strip wash." In this instance there was no assessment of risk informing staff on how to support this person safely or any consideration on how to maintain their preferred method of personal care in a safe and supportive way. For example, advice and guidance on physical adaptations or referral for specialised adaptations to the person's property.

When information was provided it was inconsistent and contradictory. For example, we saw instructions to staff members not to use a hoist as a specialised assessment needed to be carried out. However, there was no instruction on how to support the person in the absence of this specialised piece of equipment. The recording information we saw indicated that staff members had used this hoist despite the instructions given. The registered manager told us the instruction not to use it was incorrect but had not amended it. We saw information informing staff members that a hoist sling was not the correct one. Again, the registered manager told us it was the right one and the documented concern was incorrect. However, there was no follow up assessment or clear instruction to staff members on how to safely support this person. This placed the person and staff at risk of harm.

There were no individual assessments of risk relating to other areas of people's lives including diet and nutrition, skin integrity or mobility. People were at risk of injury as there was a lack of appropriate

professional assessment and guidance to staff members on how to safely support people.

The registered manager did not record or act on any incidents, accidents or near misses reported or suspected. For example, we were told about a staff member's actions which resulted in the injury of someone using their services. The registered manager had not recorded this incident. They did not undertake any assessment of risk or investigate the incident to identify any learning. They failed to recognise any measures that may reduce the risk of reoccurrence or harm in the future. We asked the registered manager why they had not recorded this incident but they were not able to provide us with an explanation or rationale for the lack of action in this instance. We asked to look at Daily Care 4 U's' incident and accident records. These could not be produced. When asked further we were informed by the registered manager that they did not keep any record of incidents or accidents. This lack of process for recording and investigating incidents, accidents and near misses put people at the risk of harm as lessons were not learnt and measures were not identified to reduce the risk of incidents being repeated.

People did not receive safe help or support with their medicines. The registered manager could not assure us that staff members had been assessed as safe and knowledgeable to support people with their prescribed medicines. One person told us about an injury they had received because a staff member had not followed the safe storage and administration of their medicine. The registered manager told us they believed the staff member's previous employer had trained and assessed them as competent and as a result they did not think they needed to repeat this. The registered manager took no action in this instance to seek additional training or competency assessment for this staff member following this incident. This placed people at risk of harm as staff member's skills and abilities had not been assessed. The registered manager told us they did not routinely assess staff member's levels of competency for supporting people with their medicines. We raised these concerns with the registered manager and the Local Authority. Action was then taken to remove this risk until the Registered Manager could demonstrate staff members were safe to support people.

We looked at the medicine administration and recording (MAR's) charts for people. Those we looked at contained missed entries and inconsistent administration of medicines. For example, one person required a medicated patch to assist with pain control. The instruction to staff was for this to be given every Saturday. We saw that this was given more frequently. The registered manager told us it should be every three days not once a week as recorded in the instructions to staff members. When it was pointed out to them that in once instance there was a gap of five days they could not explain this.

We saw on other MAR's charts that there were large gaps when recording external creams for people. One person told us, "(Staff) did not complete my MAR sheets for 11 days, which is completely unacceptable."

We saw on one person's MAR's chart staff members were signing to say they had given the contents of the Dosette box. A Dosette Box is a plastic tray that separates medicines into individual compartments for different times of the day for each day of the week. Each box contains a full week's medication. There was no breakdown of what medicine this Dosette box contained or indication of what staff members were signing. There were no individual risk assessments for people's medicines or any recognised side effects for staff members to be vigilant towards.

The registered manager had not completed protocols or guidance for 'when required' medicines. For example, should someone require pain relief medicine there was no instruction regarding the dose or frequency. This put people at risk of not receiving their medicines as prescribed. We asked the registered manager about these gaps but they were unaware of them. They told us they did not regularly look at the MAR sheets to see if they were being completed as expected. There was no oversight of people's medicines

by the registered manager. There was no identification of gaps in staff members recording or action when errors were evident.

Staff members did not consistently follow effective infection prevention and control practice when supporting people in their own homes. We asked people about how staff members supported them with personal care. One person told us, "They don't always wear gloves." The registered manager did not carry out any spot checks with staff members to ensure they were following effective procedures to minimise the risk of infection when they supported people. This placed people at risk of contracting avoidable infections.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us differing opinions regarding the timeliness of staff members support. Some of those we spoke with told us staff arrived on time and stayed for the agreed amount of time when others told us staff were late and left early. One person said, "I get really anxious when staff do not arrive on time or if only one carer shows up when there should be two." Another person told us, "On one occasion the carers were so late that I decided to shower myself. I know this is silly because I fell over and hurt myself." We looked at the recording of call times for staff members at people's homes. This was a new system which the registered manager had yet to fully embed in to their working practice. The provider's policy stated that people would be informed if a call was more than 15 minutes late. However, when we spoke with the registered manager they told us that staff members did not routinely inform them that they were running late. They went on to say that usually the first they knew about it was when the client called them asking where the carer was.

The new carer calling system had the provision to alert the registered manager or senior carer if a staff member had not arrived at a person's home at the time expected. However, when we spoke with the registered manager they told us this is reliant on someone looking at the computer screen. If no one had logged into the system then these alerts went unnoticed. The registered manager had not fully implemented this system or trained themselves in its operational capacity. This put people at risk of receiving late calls as there was no effective oversight.

Inadequate

Is the service effective?

Our findings

People did not receive care and support from a trained and competent staff team. One person told us, "One inexperienced staff accidentally stood on my catheter tube. They were very inexperienced and was really embarrassed by what they did. I did not feel confident with their help and the manager switched them from my rota when I requested this. I felt they had not had any adequate training for their care role." Some of the staff records we looked at could not evidence that they had received training essential to their role. For example, safe moving and handling, administration of medicines or safeguarding people.

We asked the registered manager to provide us with a breakdown of the training their staff members had received since being in their employment. The registered manager was unable to provide this information. There was no identification of individual staff members training, when they had completed it, when it was due to expire or any additional training they may require to effectively support people. The registered manager told us that staff members new to their role did not follow a structured induction process. When asked why staff members did not complete an induction the registered manager said, "We have lost our way with this a bit."

The registered manager told us that they did not have a structured programme of staff training. They did access on-line training and some training with a local provider representation body but this process was ad-hoc. They did not encourage or support new staff members through recognised qualifications in adult social care. They did tell us that some staff were completing a diploma in care but not the care certificate. The Care Certificate is a nationally recognised training programme aimed at training staff to recognise the standards of care required of them.

The registered manager did not undertake any assessment of individual staff members competency before allowing them to work with people in their own homes. This put people at risk of being supported by staff who did not have the skills, training or level of competency needed to effectively meet their needs.

Staff members were not supported in their role by an effective management team. The registered manager told us they completed supervisions with some staff. A supervision is a one-on-one discussion with a senior staff member. It is during these discussions that issues relating to their employment and those they support can be had. Areas of concerns can be raised and actions identified to increase staff members skills and confidence. The supervision sessions the registered manager had completed were not consistently applied to the whole staff team. They could not provide a rationale for why some staff had received supervision whilst others had not. They told us, "We haven't done them for some time."

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

People were not supported to have choice and to retain control over their lives by those supporting them. The individual assessment of care and support did not demonstrate the involvement of the person or anyone close to them. Those we spoke with gave us differing thoughts about their assessment of need. The

majority of those we spoke with did not know if they had a care plan or if they had been asked what help they needed or wanted. Individual preferences were not recorded and there was no assessment of the person's ability to make decisions for themselves. The provider was supporting people who were living with dementia. However, there was a lack of understanding on how this, or any other cognitive impairment or condition, could potentially impact on the person's decision making. There was a lack of understanding of the principles of best interest decision making. Because the registered manager failed to assess or record people's personal preferences these could not be included as part of any future best interest decision making should it be required. The provider did not have effective systems in place to involve people in decisions affecting their care.

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. The provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general. The provider's policies and procedures were not followed meaning that people did not have maximum control over their lives. At this inspection the provider could not assure us that people's human rights were being maintained.

People told us they were assisted by staff members with their meal preparation and with fluids. Some told us they were supported with ready meals and others with meals staff members prepared. However, there was a lack of recognition for people's individual preferences or choices. There was a lack of people's cultural needs or personal preferences by those supporting them. Opportunities to expand staff members learning regarding cultural preferences or personal tastes was not promoted. This lack of staff member's understanding was cemented in this instance by a registered manager who promoted and agreed with this approach. People were at risk of losing personal and cultural identity.

People had access to healthcare services when they needed it at their or their family member's instigation. These included GP and district nurses. One person told us, "Following an accident I got the GP to give me some treatment." The provider's lack of effective recording could not evidence whether they or the person sought the additional assistance in this instance. The care and support plans we looked at did not provide guidance to staff members on how to respond to health emergencies.

As part of the provider's initial assessment of people's needs the physical environment was considered but not individually or consistently applied. There was little information available to them or staff members on how the physical environment could be maximised or adapted to best meet their needs.

Requires Improvement

Is the service caring?

Our findings

People described differing experiences with the staff members supporting them. One relative told us, "Some (staff) adore [relative's name] and they think a great deal of them too. They are kind and considerate. They are truly genuine carers, unlike some of the other staff. Some staff are too rushed and brusque. They are not suited to their roles." One person told us, "I am really pleased with the help I get. They (staff) make my life easier." Another relative described how staff members would discuss aspects of their lives which caused upset and distress to their relative. They told us they don't expect carers should be telling their family member about their monetary problems or stress in their lives. Another person said, "Staff are ok. The ones I know anyway. Sometimes we get new ones in and they know nothing about me. However, I do have a regular one [staff member's name]. They are fantastic. A real angel. I have them most of the time and they are a little ray of light." Another relative said, "We get regular staff and they are nice people." This meant that people did not receive a consistent approach from staff members when they were being supported. There was a lack of managerial oversight to ensure the care people experienced was kind and compassionate.

People were not asked about any religious or spiritual faiths or beliefs as part of their assessments of care from Daily Care 4 U. We asked the registered manager how they assess and support people and staff regarding their protected characteristics. This included people's ethnicity, religion, sexuality, disability etc. However, the registered manager was not able to describe to us how they were meeting such needs for people. The care and support plans we looked at did not contain information on how staff members could support people with these aspects of their lives. This lack of awareness of people's protected characteristics placed them at risk of not having these met by those supporting them.

People were not always supported in a way that reduced levels of anxiety and apprehension. For example, one person told us that they required two staff members to assist them in the shower. They would become anxious if only one staff member turned up as they would not know at what time the other staff member would be there to assist them. They went on to tell us that the other staff member would turn up and support them but they were never reassured regarding the timeliness of this staff member, which heightened their anxiety.

People were not involved in decisions regarding their care and support. In instances where the provider was aware of individual's preferences these were not supported by the staff who assisted them. For example, when people expressed their likes regarding food options these were disregarded as staff members lacked the skills to provide the person with what they desired. As a result, the options presented to people were limited to what the staff members were comfortable in providing. We asked the registered manager what they could do to promote people's choices and decisions regarding such aspects of their lives. However, they were unable to identify any effective strategies for promoting individual's choices or decisions. People were asked if they had any preferences regarding a male or female care worker. Those we spoke with told us they were happy with the gender of the staff member supporting them.

People told us their privacy and dignity was respected by the staff members supporting them. Those we spoke with believed they were treated in a way that supported their privacy and respected their dignity. One

person said, "I live alone but they (staff) still close the door when I am having a wash."
People told us they were encouraged to do what they could with the assistance of staff members which assisted in promoting their independence. However, as people's individual levels of ability and needs were not recorded they received an inconsistent approach from the staff members supporting them. People's individual aspirations and goals regarding their personal care were not recorded. People were not encouraged to identify or achieve improvements in their lives which could potentially increase their independence.

We saw information which was confidential to the individual was kept securely in the office and only accessed by those with authority to do so.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was individual and responsive to their needs. One person said, "I don't think anyone ever came out and spoke with me about my care." Another person said, "I don't know if I have a care plan or not. They (staff) write in a folder but I have no idea what is in there. I guess they are just signing in and out." One relative told us they were involved in planning their family members care. However, this had consisted of them taking the initiative and telling Daily Care 4 U what they required as they didn't feel they had been asked what help their family member needed.

The care and support plans we looked at were minimal in content and did not provide the information staff members required to be responsive to people's needs. For example, we saw one person had recently started to receive care and support from Daily Care 4 U. This included several calls per day. Despite being supported for 13 days there were no instructions for staff members on how to support them. The little information that was there was inaccurate and contradictory. For example, we saw in one person's care and support plan the hoist sling was the wrong size and should not be used. However, the registered manager told us it was but it just hadn't been recorded as being the correct one. Staff members were not provided with the information they needed in order to respond to this person's needs leaving them at risk of receiving inappropriate care. We spoke with the registered manager about this and they told us, "I need to concentrate now on getting these assessments completed."

The registered manager told us, "Our services are well organized so that they meet service user's needs. This means that people get the care they need and also they are listened to and have their rights and diverse circumstances respected." However, we did not find this when talking with people or looking at their care and support plans. For example, we asked the registered manager about understanding and promoting people's protected characteristics as part of the Equalities Act 2010. This included, but was not limited to, sexual orientation. We explored aspects of their assessment which could potentially include lesbian, gay, bisexual, and transgender related elements to people's care and support. The registered manager said, "Why would we ask such a thing." This lack of awareness or willingness to discuss essential aspects of people's lives put people at risk of not having their needs met in a way they required. People's diverse needs and protected characteristics were not respected or understood by those directing the care and support to them.

People did not have individual assessments regarding their communication and information needs. One relative told us, "Some staff have difficulty talking with my relative because they have dementia. It is clear that some staff communicate with them very effectively, but one carer did not have a clue. I doubt if they had had any training in this area." The registered manager did not know about the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. As a result, the registered manager had failed to include this in the assessments of need they completed for people.

At this inspection Daily Care 4 U was providing support for those experiencing hearing loss, sight loss and also those living with dementia. These people did not have assessments of their needs regarding their

communication as directed by the Accessible Information Standard. This meant people supported by Daily Care 4 U with a disability or sensory impairment were not given information in a way they could understand.

We looked at one person's records and asked the registered manager to tell us about the person's preferences for meals. They told us, "[Person's name] likes spicy foods, like samosas. But we don't know what to do with these so we make them a sandwich instead."

This was a breach of Regulation 9: Person-centred care, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they had the information they needed should they need to express a concern or make a complaint. Those we spoke with told us they would contact the office. However, people did not feel confident their complaint would be effectively addressed. One person said, "The carers and office staff fail to notify me if somebody is going to be late. So I have to ring them and demand the arrival of a carer. Last evening the carer had not arrived by 10.20pm. The manager did not have a clue who was supposed to be coming, but eventually I got an 'emergency' carer to help me take my medication and get me to bed. I am completely dependent on the carers to do this with me. The manager is always very apologetic, but the problem keeps happening."

We asked to look at the complaints and compliments file or book. The registered manager told us they did not have one. We explored what they did when they received a complaint. They told us the complaints they usually received were in relation to late calls. However, they had no process in place to record or investigate these complaints. They did not have a system in place to monitor any trends resulting from complaints and failed to identify pro-active strategies to minimise the risk of repetition. Although the provider had policies in place to respond to complaints, these were not followed by the registered manager. This meant people could not be confident that their complaint would be listened to, taken seriously or acted on.

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

At this inspection Daily Care 4 U was not supporting anyone at the end of life or who was receiving palliative care and support. We confirmed with the registered manager that they did not have the assessment or care planning systems in place to support anyone who was approaching the end of their life. The registered manager confirmed with us that those working for Daily Care 4 U did not have the training, skills or experience to support such care needs.

Inadequate

Is the service well-led?

Our findings

At this inspection there was a registered manager in post. The registered manager was also the registered provider. The registered manager did not fully understand the requirements of their registration. The registered manager had not appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. At this inspection we identified that safeguarding concerns and allegations had been raised with the registered manager regarding two staff members. The registered manager failed to act on these concerns and failed to notify us. The registered manager was also informed about a staff member not working in accordance with Daily Care 4 U's policies and procedures. This resulted in injury to a person requiring medical treatment. The registered manager did not consider or make a notification to us.

This was a breach of Regulation 18 (Registration) Notification of other incidents, Regulations 2009.

The registered manager did not have effective quality monitoring systems in place to identify and improve the services they provided to people. We did see some quality checks which had been completed with people but these contained minimal information and did not identify any areas for improvement. The registered manager did not have a current system in place for completing 'spot checks' or anything similar to satisfy themselves that people were receiving a quality service from staff members. One relative told us, "[Registered manager's name] would learn a great deal if they took the trouble to do spot checks. I don't think they do that because I think they are reluctant to come face-to-face with the people they are supposed to support." The registered manager did not identify any of the issues we found as part of this inspection as being an area for concern. However, when we spoke with them about these issues they said that they recognised they had "Taken their eye off the ball."

The registered manager failed to follow their policies and procedures for addressing unsafe staff behaviour. For example, when it was raised with them that the behaviours of their staff members could potentially put people at the risk of abuse or the risk of harm they failed to record, pass-on or act in order to keep people safe.

People were not routinely informed about changes to the organisation which impacted on the care and support they received. For example, people had raised concerns that the phone number they were provided with to contact Daily Care 4 U's office no longer worked. The registered manager told us this was because the building where they are located changed the phone numbers. Despite Daily Care 4 U being informed prior to the change of numbers, they failed to communicate this in a timely way to those receiving support or to family members. This resulted in people not being able to contact Daily Care 4 U when they needed to, leading to anxiety and concern for some.

We asked the registered manager how they kept themselves up to date with best practice and changes with adult social care. They told us they received news letters from The CQC and Health and Safety Executive. However, when we explored this they went on to say that they didn't actually read them. The registered manager did not have a structure in place to keep themselves informed about best practice in health and

social care. For example, they did not understand that the Accessible Information Standard became Law in 2016, or how to assess and respond to people's diverse needs or protected characteristics. They did tell us they were part of a provider representative organisation and that they would consider contacting them in order to keep better informed about changes in the future.

We looked at the values and principles underpinning Daily Care 4 U's services. Daily Care 4 U provided information to us that stated, "Promise to deliver a first-class service with cost and give value for your money in mind." They went on to say they, "Understand that cost effective care is a valuable component in the care of a loved one. That is why we offer highly competitive prices whilst still giving a level of service that is second to none." However, at this inspection we could not support the assertions made or evidence that the care and support experiences of people and their family members reflected these values.

People gave us differing experiences about contact with the registered manager. Some of those we spoke with told us they had met them and that they see them regularly whilst others said they had never met them. One relative described Daily Care 4 U as "A shambles, with no systems or organisation." One person told us, "The manager is really helpful to us." People did not receive a consistent experience when in contact with the registered manager. This put people at risk of not having their concerns or queries answered consistently.

The registered manager had links with other healthcare professionals and support systems in the local community. This included those responsible for specialist assessment. For example, occupational therapists who undertake assessments to help people to carry out everyday activities which are essential for health and wellbeing. However, owing to inconsistencies in the record keeping and care planning the registered manager could not accurately identify to us when such referrals had been made and the outcome of any recommendations.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to make the required notifications regarding significant events occurring in their service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive support that was individual to their needs or preferences. Staff did not have access to relevant information to support their understanding about people's specific assessed needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm in relation to their care and support needs as there was insufficient assessment or guidance provided to staff on how to safely support someone with their identified risks. Staff members did not always follow safe and effective infection prevention and control practices.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safe from the risks of ill-

treatment and abuse as the provider failed to recognise and respond to allegations which could potentially harm people.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not follow their own policies for recording or investigating complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient quality monitoring checks completed to identify or respond to poor care practices.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were supported by staff members who did not have the appropriate training and assessment of their skills and abilities. Staff members did not receive appropriate support and guidance from the provider. New members of staff were not supported through a structured induction programme and were not equipped with the necessary skills to support people in their own homes

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to follow safe recruitment practices when employing staff members.

The enforcement action we took:

We issued the provider with an urgent notice of decision and asked them to complete an action plan infirming us how they are going to meet the regulation.