Hands of Compassion Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hands of Compassion Care Ltd is a domiciliary care service providing personal care to six people at the time of the inspection. 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.

People's experience of using this service and what we found
Feedback about the service was mixed. Some relatives and people were positive about the service. However, others raised concerns such as staff attendance, consistency and the lack information in care plans.

The service was not well managed. The providers did not attend events to keep up to date with best practice and would benefit from doing so and from engaging in relevant learning. Systems and processes were not effective and had not always identified concerns and driven change. Communication needed to be improved and the provider had not sought feedback from people and their relatives.
Risk assessments were not always in place or did not contain the information staff needed to keep people safe. This meant there was a risk staff, particularly new staff, would not know how to support people safely. Good practice was not always followed, for example infection control needed to be improved. Medicines were not well managed, and the support provided to people with their medicines needed to improve.

Incident reporting and investigations were not effective, and the actions planned to reduce the risk of re-occurrence had not always been undertaken. The investigation of incidents had not included assessing if abuse had occurred. Staff training needed to be improved. Some staff had not always undertaken safeguarding training or training in medicine administration. Staff fed back that the induction could be improved, and they would have liked to have undertaken a longer period of shadowing before working alone.

Staff had not always been recruited safely as appropriate references had not always been sought in line with the providers own policies. Staff had missed calls which meant people were left without the support they expected. Staff did not always stay the full length of calls. The provider had recently made changes to the staffing to address this. However, at this inspection was not able to determine if this had been effective in reducing the risk that calls would be missed in future.

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. There was a lack of understanding of the principles of the Mental Capacity Act and there was no evidence decisions were made in line with these principles.

The providers had not worked in partnership with health professionals and had not always sought information on professional recommendations when they had been made.

Support to maintain people's dignity could be improved. Some language used in daily notes was not respectful. The provider had failed to identify this and provide staff with guidance to modify language used. There was a lack of information in care plans about what people could do independently for themselves. Staff had not always taken the time to sit and talk to people once tasks had been completed to support people to ask questions and express their views.

Care plans were not person centred and relatives and staff told us they needed to be improved. The complaints system was not effective and did not enable the provider to review trends. Where complaints had been made by relatives, they were not always happy with how they were responded to and concerns had arisen again.

Where people were supported with meals and drinks, they were happy with the support provided. People told us staff were kind and caring.

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 04/03/2019 and this is the first inspection.

Why we inspected
This was a planned inspection based on the date the service was registered.

Enforcement
We have identified breaches in relation to safe care, good governance, person centred care, consent, recruitment, staff training and managing safeguarding and complaints.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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 responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hands of Compassion Care Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

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

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 22/01/2020 and ended on 27/01/2020. We visited the office location on 23/01/2020.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the service registered. We used all of this information to plan our inspection.

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

We reviewed a range of records. This included three people's care records and two medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed updated documents sent to us by the provider.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely

● Medicine administration records (MARs) were hand written. MARs can be handwritten but need to be checked and countersigned by a second person to ensure they are accurate. This had not been done. Some MARS sheets did not have people's basic details on them including their name.

● MARS were not complete and there were unexplained gaps in records. For example, one person had a pain patch which needed to be removed after 12 hours. There were gaps where staff should have signed to say this had been removed. This meant the provider could not evidence medicines were administered as prescribed.

● Some people took 'as and when' medicines and there was no information for staff on the protocols for administering these. For example, how many doses could be given within 24 hours.

● Where people were supported with creams there were no body maps in place to show staff where to apply these. There were no records to show creams had been applied. After the inspection the provider sent an updated risk assessment for one person's medicines. This stated where creams could be applied but did not state the name of the cream. This meant there was a risk staff could apply the wrong cream.

Medicines were not always managed safely. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

● There were no risk assessments in place for one person. The person was at risk from falls and there was a lack of guidance for staff on how to support them safely. Risk assessments were put in place after the inspection. However, these were long and repetitive in some places and lacked details in other areas. For example, the mobility risk assessment said staff were to give minimal assistance during transfers from seating to standing but did not explain what this assistance was.

● Other people's risk assessments were not always in place when they needed to be. For example, there was no risk assessments for one person's catheter. After the inspection the provider sent us updated plans for catheter care. However, there continued to be information missing such as what the signs and symptoms of infection were and whether the person had a history of concerns relating to their catheter.

● Another person had a pressure sore and had equipment in place to relieve this. Their care plan stated they had no risks to skin integrity. This meant there was a lack of guidance for staff on how to mitigate risks to people's health and wellbeing. After the inspection the provider sent an updated care plan. However, there continued to be a lack of guidance about some equipment the person used to keep themselves safe. Information for staff was inconsistent about where pressure sores were and there was no body map to guide staff on where to apply barrier creams to prevent sores from occurring.

● Whilst existing staff were aware of some risks to people, there were areas where they were not. For

example, one person was diabetic. Staff did not always know what the signs and symptoms were if the person was to become unwell due to this health condition. There was no information on when the person last had ill health due to their diabetes or how often concerns arose. This meant staff might not identify and act on concerns.
● Staff had access to gloves and people said they used these. However, the provider told us they did not provide aprons for staff. Aprons are worn by staff to reduce the risk of infection transferring from person to person. During the inspection the provider said they would put these in place.

The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Incidents and accidents were not well managed. During November 2019 one person fell whilst care staff were present. During this visit they were being supported by one care worker and not two, as they should have been. The incident report lacked detail regarding this event. There were no details about how the fall occurred and what staff were doing at the time. The action planned to address this concern was to ensure two carers were present for all calls. However, records showed there were a number of occasions after this incident where the person's calls were undertaken by one care worker. This meant the provider had failed to ensure appropriate action was taken to keep people safe.

The provider had failed to do all that was reasonably possible to manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● There had been no safeguarding concerns recorded or reported by the service. The provider knew how to report concerns. However, the provider had not investigated how staff had supported one person to get up off the floor after an incident where they had fallen. This meant they had not investigated the incident to ensure that no abuse had occurred.
● There was a safeguarding policy in place. However, the policy didn't include information on the local area protocols.
● Most staff completed safeguarding training. However, some new staff said they had not yet completed this training and staff did not always know how to raise concerns outside of their organisation if they needed to do so.

The provider had failed to ensure that systems and processes were operated effectively to prevent the risk of abuse. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Recruitment was not carried out safely. One member of staff was missing a character reference. The other member of staff did not have an employment reference and had recently worked in a care home. We asked the provider if they had contacted the previous employer for a reference and they told us they had not. This meant they had not done everything reasonably possible to ensure staff were safe to work with vulnerable adults.

The provider had failed to ensure there was satisfactory evidence of conduct in previous social care

employment. This is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other employment checks had been completed. For example, Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.
● Some relatives we spoke to had concerns about staffing levels and feedback was not always positive. Some relatives told us staff had not always turned up to care calls. However, at the time of the inspection staffing levels had been increased and there was sufficient staff to provide the service as the provider had recently new staff.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff had not always completed medicine training before they supported people with medicines and there were no records of checks on staff competency. This meant the provider had not ensured staff were safe to administer medicines. Staff had also not completed training in supporting people with diabetes and one person had this condition.
- Staff had undertaken shadowing a more experienced member of staff prior to working alone. However, staff told us they did not always shadow for very long and they would benefit from changes to the induction. Comments included. "They could make the induction a bit better. I did one call shadowing." And, "The shadowing was fairly small, a couple of hours. It would have been better if the shadowing was longer and there was a bit more introduction."
- Staff training was online and included the Care Certificate. The Care Certificate is an identified set of standards which social care workers must adhere to in their daily working life. Some staff told us the training could be improved.
- Staff were supporting people with complex mobilities needs and at the time of the inspection they had not completed practical manual handling training. However, practical manual handling training had been arranged and staff confirmed they were planning to attend.
- Feedback from relatives was mixed about staff skills. One relative told us they were not confident staff had sufficient training. However, other relatives had no concerns.
- The providers worked alongside staff and was able to observe staff practice. Some staff had recorded supervisions. However, some staff said they had little contact with the providers and there were no records of staff being monitored or supported during their probation period.

The provider had failed to ensure that staff had the training and induction they needed to support people effectively. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff were not always aware of guidance from health professionals. One person had been assessed by an occupational therapist for support with their mobility. The person had a hoist in place, however, the provider told us care staff were not using this to support the person to mobilise as they were able to bear weight. The provider was not aware of any recommendations made by the occupational therapist. There was no evidence the provider had sought to contact the occupational therapist to seek this feedback. This meant there was a risk staff were not supporting the person in a safe way.

● People using the service accessed and arranged their own healthcare or had the support of relatives. Staff told us when people were unwell, they encouraged them to contact the GP. However, the lack of health information in people's care plans and gaps in training meant there was a risk that staff would not recognise when some people were unwell.

The provider had failed to do all that was reasonably possible manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was information for people to take with them if they went in to hospital if staff needed to call an ambulance, such as what medicines they were taking.

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

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

● There was a lack of understanding of the principles of the MCA. One person had bed rails in place. Staff noted in the daily notes the person had climbed over the rails and got out of bed and in future the bed rail needed to be all the way up. There was a risk staff were using the bed rail to prevent the person getting up when they chose to do so. This is a restriction to the person's liberty and there was no capacity assessment or best interest record in place to support this restriction.
● There were no recorded best interest meetings or capacity assessments for people at all. It was not clear how people had consented to their care. During the inspection we identified one person who needed support to make decisions. The person's care plan referred to a decision maker. However, there was no evidence in place to demonstrate anyone had the legal right though Power of Attorney to make health or care decisions on the person's behalf. A power of attorney is a legal document which gives a named person authority to make decisions on a person's behalf.

The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to starting the service people's needs were assessed. This assessment included information on people's needs such as communication, nutrition and hydration, personal care, health concerns and cultural and religious needs. However, these assessments were not always sufficiently detailed and were not always used to develop a detailed care plan, assess risks or ensure there were sufficient staffing levels. For example, one person had bed rails in place. There was no risk assessment in place for these to instruct care staff on how to prevent the persons limbs becoming trapped in the rails.
The provider had failed to sufficiently assess people's needs. This was a breach of Regulation 9 of The Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care was not always delivered in line with best practice. We asked the provider if they were aware of NICE guidance for administering medicine for people living in the community. The provider told us they were not aware of this guidance. NICE stands for National Institute for health and Care Excellence and they provide information on best practice for administering medicines.

Supporting people to eat and drink enough to maintain a balanced diet

● Not everyone using the service needed support with eating and drinking.

● Staff understood the importance of encouraging people to drink sufficient fluids.

● Where people needed this support, feedback was positive. Comments included, "Before my relatives had the support, they got dehydrated but they don't now. I am happy they make enough drinks and enough to eat." And, "[My relative is] always left with drinks and snacks to hand so happy with that side of things."

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.

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

- People and their relatives told us they were involved in developing the initial care plan. However, there was no evidence care plans had been reviewed or discussed with people after the initial assessment. One person's mobility needs had changed and there was no evidence the service had met with them or their relatives to discuss this change.
- Some care calls were shorter than planned which meant there was a risk staff did not spend time listening to people and answering any questions they may have about their care. One person's care plan stated they needed support with personal care and wanted social support to reduce the risk of isolation. However, staff did not always stay the full length of the call and one 30-minute call was only 13 minutes long.

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

- The provider had not ensured that people had been well treated. For example, systems to keep people safe from harm and protect them from risk were not robust and action to reduce missed calls had not been taken in a timely manner.
- Staff told us they knew how to protect people's dignity. For example, by ensuring they covered people with a towel when providing them with personal care. However, one relative told us this did not always happen and said, "I am not sure they do respect [my relatives] dignity."
- Some of the language used by care staff and the provider in people's daily notes was not appropriate. This demonstrated some staff and the provider did not always know how to respect people's dignity.
- Staff told us they encouraged people to do things for themselves and were able to give examples. However, care plans were basic and did not include guidance for staff on what people could do alone. This meant there was a risk new staff would not have this information and not encourage people to remain as independent as possible.

The provider had failed to ensure people with treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where people had needs relating to their protected characteristics under the Equalities Act 2010 such cultural and religious needs, staff provided this support. However, people were not asked if they wanted support with other protected characteristics such as sexual identity and gender identity. This meant there was a risk people would not be supported with these needs. However, this was added to care plans after the inspection. People had been provided with support with other protected characteristics. For example, to follow their religion where they wanted this.

● People and their relatives told us staff were kind. One relative said, "I think the staff are nice and kind. They do what they need to do and that makes it easier for me as I don't have to worry." One person said, "The staff are nice and treat me well, I am happy with the service."

Inadequate

Is the service responsive?

Our findings

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

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

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

- Care plans lacked person-centred information such as information on people's life history and likes and dislikes or how they wanted care to be provided. One relative said, "There is no real description on [my relative] and I don't think new care staff know about him." Some staff also told us they wanted to know more about people in the care plans. This meant there was a risk care was not person centred and delivered in line with people's preferences.
- There was a lack of information about people's health needs in care plans. For example, one person had a condition affecting their mental function. There was a lack of detail about how this affected the person and the support they may need. After the inspection the provider sent us an updated care plan which did not include any information on this condition.
- People using the service had family support. However, the provider had not discussed end of life with people or their relatives. This meant they had not offered people the opportunity to express any preferences for their care.
- There was a lack of consistency of staff, although this had improved recently. Comments included, "There has been a number of changes of staff coming around. All doing a good job, but I think [my relative] would like more consistency." And, "At the moment it is consistent, it has been erratic though and we have seen different staff. We don't know who is coming in advance though and don't meet staff before they come and provide care." This meant there was a risk staff would not know people prior to providing them with support. However, this had recently improved.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs had not been fully assessed. After the inspection the provider sent us two peoples care plans where this had been addressed.
- The provider had not acted make sure they were providing information in a suitable form and was not aware of the requirements of the AIS at the time of the inspection.

Care was not always person centred. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place. However, the provider told us this was not shared with people and their relatives.

● The provider had some records of complaints on their email and had responded to complaints. However, relatives told us they had complained but did not always feel satisfied with the outcome. One relative said, "When I complained, they are very polite, but you are left wondering if you have actually resolved anything. Yes, the concern had arisen again after I complained".

● There was no complaints log in place and no evidence complaints had been monitored for patterns or trends.

The provider had failed to operate an effective accessible system for receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; 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

- There were no documented audits available at the inspection and no documented action plans for improvement where issues had been identified. There was no evidence missing risk assessments had been identified. Gaps in medication administration records were discussed in a staff meeting in October 2019. However, we saw gaps in these records in November and December 2019. There was no plan in place on how the provider intended to prevent this concern from continuing to re-occur. There was no monitoring of call length or staff timekeeping and we identified a number of calls were shorter than planned. The provider failed to address this.
- The provider had identified some issues relating to missed calls but had not acted quickly enough to resolve these concerns. We looked at the providers records for missed calls in November 2019 and December 2019 and saw there was a significant number of missed calls. However, during this period of time the provider had increased the number of people they were supporting. The provider had not prioritised ensuring existing people's calls were covered.
- Staff were not well supported and communication and organisation at the service needed to be improved. Whilst there was enough staff to provide the service, there continued to be concerns where staff had not turned up to visits. The provider had not taken the action they needed to resolve these concerns. For example, staff told us the provider did not always send the rota far enough in advance and on some occasions were sent "less than 24 hours before the call". Staff said this had had an impact on the quality of the service as some staff had not turned up to calls because they did not have enough notice prior to the visit.
- There was a lack of oversight on staff performance. Although the provider had worked alongside some staff, this was to fill in gaps in the rota and was not specifically arranged to monitor staff practice. Spot checks and competency assessments had not been completed to ensure staff were undertaking tasks such as manual handling and medicine administration safely.
- There had been no incidents at the service which qualified as duty of candour incidents. A duty of candour incident is where an unintended or unexpected incident occurs which result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident. The provider understood their responsibilities under duty of candour. However, the systems to monitor incidents was not effective and the action taken to address concerns had not been effectively implemented.

The provider had failed to ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was aware of their responsibilities about reporting significant events to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Working in partnership with others

● The provider had not sought feedback from people, relatives or staff about the service. The provider had failed to consider if people or their relatives had any concerns or wanted to make any adjustments to their care. Relatives told the inspector they would have welcomed the opportunity to feed back their views and resolve any teething issues. Comments from relatives included, "The office have never called to ask if we are happy with the service. The communication is the difficult thing for us and the record keeping." And, "There has been no contact from the office to ask if everything is okay."

● Staff meetings were not frequent. The last meeting was in October 2019 and only two staff had attended. Some staff told us communication with the provider could be improved. One staff said, "I don't really talk to [the providers] to be fair."

●The provider did not demonstrate they worked in partnership with health and care professionals such as occupational therapists and GP's to improve people's care

● The provider, who was also the registered manager, was qualified in other professional areas. However, they had not undertaken any management qualifications in health and social care or attended any learning events. This had an impact on people's care as the provider was not up to date with best practice. For example, the provider was not aware of current best practice guidance for the administration of medicines.

The provider failed to seek and act on feedback from relevant persons. The provider had failed to improve their practice. This was 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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to sufficiently assess people's needs. Care was not always person centred.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people with treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that systems and processes were operated effectively to prevent the risk of abuse.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014

	Receiving and acting on complaints The provider had failed to operate an effective accessible system for receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure there was satisfactory evidence of conduct in previous social care employment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff had the training and induction they needed to support people effectively.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably possible manage and mitigate risks to people's health and safety. Medicines were not always managed safely.

The enforcement action we took:

We applied conditions to the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to seek and act on feedback from relevant persons. The provider had failed to ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services. The provider had failed to improve their practice.

The enforcement action we took:

We applied conditions to the providers registration.