Dutee4U Home Health Care Ltd

DuTee4u Home Healthcare

Inspection report

11 Moorcroft Close
Stoke-on-trent
ST6 3GB

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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

Dutee4U Healthcare Limited is a domiciliary care agency providing personal care to people in their own homes. 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. The service was supporting 21 people at the time of our inspection. 18 people were supported with their personal care.

People's experience of using this service and what we found
People who used Dutee4U Healthcare Limited did not receive a safe, effective, responsive or well led service. The provider was unable to demonstrate the safe and effective running of the service as records were either unavailable, conflicting or disorganised. People shared very mixed experiences of using the service.

Due to the lack of information provided to us, the provider could not demonstrate staff supported people to receive medicines safely and this placed people at risk of harm. Information was not available to support staff to administer safely and records were not accurate. Staff had not received training to administer medicines safely or had their competency checked.

People were not safeguarded from the risk of abuse because the provider could not demonstrate staff were either trained, or informed to recognise the potential signs of abuse. There was no evidence that incidents of potential abuse had been referred to the local authority safeguarding team or investigated adequately by the provider. The provider's poor documentation meant they could not demonstrate changes had been made to protect people from possible abuse.

People did not always have risks safely managed. Where concerns were identified it was not evident how these were safely reduced or eliminated.

The provider could not demonstrate staff had been recruited safely. Recruitment files seen were incomplete, illegible or inaccurate. We could not be assured who was currently employed by the provider or what checks had been made before employing them.

People did not always receive care and support at times agreed and this affected the quality of care provided and people's safety.

There was no evidence of people's capacity to make decisions being assessed by the provider when their needs changed or evidence of how the agency worked effectively with outside agencies, including health care professionals.

People's private information was not protected in line with data protection legislation.

The provider could not evidence they provided a responsive service. Care was not centred around individual

needs, despite care plans being very person centred. Where people had complained about the quality of the care, they received it was not always evident the provider had responded to ensure changes were made as a result.

The service was not well led. The provider had failed to notify appropriate agencies, including CQC of safeguarding concerns and they failed to provide us with information in a timely manner. Some information requested formally following the inspection was not provided. There was no evidence that people had been consulted about the ongoing care they received.

People were not supported to have maximum choice and control of their lives because call times did not always suit the individuals or offer degrees of flexibility. We had no evidence that staff supported people in the least restrictive way possible and sometimes decisions to support people in line with their best interests were not followed and not recorded.

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

This service was registered with us on 03 February 2020 and this is the first inspection.

Why we inspected
We carried out this inspection after we received concerns from an anonymous source and the local authority safeguarding team about the care and support delivered by the agency.

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

Enforcement.
We have identified breaches in relation to safe care and treatment, person centred care, safeguarding people from abuse, complaints, good governance (including lack of notifications and management concerns), staffing issues and also the safe recruitment of staff at this inspection.

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

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.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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**

DuTee4u Home Healthcare

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by one inspector.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we wanted to be sure the registered manager would be at the registered office to facilitate the inspection.

Inspection activity started on 24 March 2022 and ended on 04 April 2022. We visited the location's office on both of those dates.

What we did before the inspection
We reviewed information we had received about the service since their registration in October 2020. We asked the local authority and Healthwatch for any information they had which would aid our inspection. 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 that gathers and represents the views of the public about health and social care services in England. We reviewed information of concerns shared by the local authority safeguarding team and from an independent whistle-blower about the quality of the care provided.

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 used all this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service or their relatives about their experience of the care provided. We spoke with seven members of staff, including the registered manager, the director, the senior support worker and four support staff.

We reviewed a range of records. This included three people's care records and extracts from others. We looked at four extracts from staff files in relation to recruitment, training and supervision. We viewed a variety of records relating to the management of the service, including policies and procedures.

We sought clarification from the provider to validate evidence found. We did not always receive information required from the registered manager and on occasions information received was inaccurate.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this service. We have rated the safety of this service as inadequate. This meant people were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of abuse because the provider could not demonstrate staff were trained or informed to recognise the potential signs of abuse.
- In discussions staff were vague about what constituted abuse. One staff member told us they had never witnessed poor practice but could not share any examples as to what constituted poor practice. This meant they may not recognise abuse and or act accordingly to respond to it.
- The local authority safeguarding team told us that there had been six allegations of theft within the service. Four related to the same staff member. The provider had not acted to safeguard people following these allegations and their poor record keeping had meant police were unable to effectively fact find. This meant people who used the service had been exposed to potential abuse and or abusive practices and the provider had failed to safeguard them or mitigate future risks adequately.
- An incident where a person fell was simply recorded that they slipped. This incident was later referred to safeguarding by a relative because the staff member had allegedly left the person unattended.
- We received mixed feedback as to whether people felt they received safe support. Some people did feel safe. One person told us, "I feel safe I can definitely say that." Another said they were, "More or less safe, some staff are better than others." Some people however did not feel safe and this was mainly due to staff inexperience and unreliability (missed calls). One relative told us; "Twice they didn't turn up - not rang or anything. [My family member] is vulnerable and can't do anything for themselves." They told us they had reported this to the local authority. In relation to staff unreliability and inexperience one person told us, they had; "Lost all faith in them."

The provider failed to ensure people were protected from potential abuse as staff did not understand what constituted abuse and some care practices increased peoples risk of harm.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Due to the lack of information provided to us, the provider could not demonstrate staff supported people to receive medicines safely and this placed people who used the service at risk of harm.
- Staff told us they were required to administer medicines to some people who used the service and most said they had not received training or guidance as to how to do this safely. Their competency to support people with their medicines had not been assessed and assurances could not be made by the provider they were safe to support people.
- Records for administering medicines, including creams, were not appropriately completed on all

occasions to reflect safe administration. Care plans did not accurately reflect medicines administration requirements meaning there was a lack of guidance for staff to complete the tasks.
● Staff had not followed safe administration practices as they administered medicines for one person from a box made up by someone other than the pharmacist. They did not know this was inappropriate. This meant the person may receive the wrong medication and staff were not guided to check.
● The provider did not have systems in place to monitor the safe storage and administration of medicines meaning risks were not being identified or monitored to keep people safe. For examples, gaps in recording had not been identified or followed up. This meant action was not taken to address any mistakes immediately and thus reduce any impact on the person who used the service.
● Prescribed creams were documented on the medicine administration records seen but administration had not been signed. The registered manager told us this was because the creams had not been administered however in a daily record staff detailed, they had 'applied cream'. When, as required, medicines had been administered it had not been documented why there was no protocol to advise staff as to how and when they should give this.

The provider failed to ensure staff had the knowledge, skills and competence to safely support people to receive their medicines safely and records did not reflect safe administration.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● We saw that some risks were assessed and detailed on care plans. Where risks had been identified however it was not always documented how risks should be managed. For example, one person was identified as having a risk with their skin integrity. Plans said creams were required to reduce risks however there was no record of what cream or how and when it should be applied.
● Staff told us risk assessments were in place and on people's files. However, people and relatives told us staff did not always follow the guidance that the assessments identified. For example, one person had been identified as at risk taking their own medicines. The provider agreed with the person's relative to keep the medicines out of reach to reduce the risk of the person overdosing. This had not been formally documented and the person's relative told us that on occasion staff did not follow through on this requirement. This meant the risks were not being safely managed to protect the person.

The provider had failed to act on risks identified to protect people from harm.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There was no evidence to demonstrate staff had received training in relation to preventing and controlling infection.
● Feedback from people who used the service identified that certain staff did not wear a uniform. The provider told us uniforms were required. The lack of uniform could pose a risk of cross infection.
● People told us that most staff wore personal protective equipment (PPE) although some staff did not and this caused people anxiety.
● We were given mixed information about staff following government guidelines in relation to testing for COVID-19. Staff were unclear if they had regular testing. One staff member told us a person positive with COVID-19 was being supported by staff who were not testing and then supporting other people.

● A senior support worker told us staff were supposed to test weekly, but, "They didn't always do it." One staff member told us, "I have never done one – not needed to." Other staff said they did them every 3 to 4 months, then weekly and now less.
● There were no records of staff testing so the provider could not evidence they followed guidelines to keep people safe from the risks of contracting or spreading COVID-19.
● A staff member positive with COVID-19 was mixing with another staff member at the office location without wearing appropriate PPE and the one staff member administered medicines to people within the 5 day isolation period after infection with the virus.
● A number of people shared poor experiences of staff keeping areas clean and hygienic. One person said staff had used a sink to dispose of bodily waste and others said areas hadn't been cleaned after food preparation and dirty crockery had been left in the sink.

The provider failed to ensure staff followed safe infection control practise to ensure the risks of cross contamination were reduced.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Conflicting information was given about which staff were working for the service. Most of the people we spoke with told us they 'never 'knew who was coming to deliver their care and they often did not know what time to expect staff. They also said staff didn't stay the allocated amount of time. The staff rota was vague and not time specific. The record of staff hours worked was also vague. Some people told us staff did what was required but no more.
● The provider was unable to share accurate information to reflect their decision to employ a person with a prior criminal conviction. They could also not demonstrate how they made sure that the person was receiving adequate supervision when supporting people. As a result, people who used the service could have been placed at risk of harm.
● Staff recruitment files were incomplete which meant the provider could not demonstrate a robust and thorough recruitment process to safeguard people.
● A senior staff member told us some staff were on probation and should not work unsupported. People we spoke with said they had been supported by probationary staff working unsupported.
● Staff were working without checks being made with the Disclosure and Barring Service (DBS). The DBS is an agency that helps providers make safe recruitment decisions and checks are a legal requirement when appointing staff to work with vulnerable people. The provider did not have a process for assessing risks identified when the DBS identified concerns.
● We saw four staff files but none of them were complete. Other information such as references, were not always available, and two staff have told us they did not supply references. No checks were available on one staff file and we were told the staff member had taken the file for a legal appointment. (This staff member later said they he had not taken it.)
● Records were chaotic and information we requested to evidence the recruitment process was not provided. The manager could not provide us with a full staff list to reference.

The provider was unable to evidence safe recruitment practices, and this placed people who used the service at risk of receiving unsafe support.

This was a breach of Regulation 19 Fit and proper persons employed

● The registered manager told us that staff training was not up to date. They could not evidence what training had been done by staff as they had no records. People who used the service shared concerns about the skills and knowledge of some staff. For example, one relative told us a carer had not secured a person's catheter bag causing discomfort. Some staff told us they have not attended training to support catheter care.
● The registered manager told us rotas were destroyed after the week worked. This meant we could only see staff on duty for the week ahead. We were unable to corroborate shadowing opportunities of staff or whether they were working unsupervised.

Learning lessons when things go wrong
● Lessons were not learned when things went wrong. The registered manager had not recorded complaints or outcomes. Some people told us of reoccurring issues suggesting they were not acted upon.

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 of this service. We have rated the effectiveness of this service as Inadequate. There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

- People shared examples where the lack of staff knowledge, skills and training had negatively impacted upon the quality of the service they received.
- Staff files did not contain records of training. The provider told us that staff had completed the Care Certificate but could not evidence this and some staff told us they had not completed it. Other essential training such as safeguarding vulnerable people, managing medicines and moving and handling had also not been delivered to all staff. This meant the provider could not evidence staff were effectively trained to carry out their role.
- Staff had not received specialist training to help them understand people's health conditions. For example, one person had diabetes and one person was at risk of developing pressure areas. Without knowledge of these conditions, the provider could not ensure staff could deliver care and support effectively.
- Some staff told us they had not received an induction to the role but had gone straight out to support people alongside another worker. This meant they may not have received essential information such as guidance as to people's needs and preferences.
- Staff said they felt well supported informally but formal processes were not in place to do this. There were no records of known allegations of poor practice and no evidence that poor practice had been addressed. This meant staff may not have received appropriate support including formal monitoring and retraining when issues were identified.

Staff were not trained to safely carry out the roles they were employed to do. Lack of staff monitoring meant that poor practice affected people's quality of care.

This is a breach of Regulation 18 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager told us staff were involved in supporting people to meet their dietary needs. They told us that no one had a special or cultural dietary need.
- People were not always satisfied with the support they received at mealtimes. One person told us, "Staff are inexperienced in cooking and this limits choices." Another person told us, "Staff can't find food and so it goes off." This meant the lack of staff skills impacted on the quality of the 'meal' people received.
- Records detailed people's dietary needs but some people told us usually their 'meal' was a pre-prepared

sandwich.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

● The registered manager told us people's capacity to make decisions was assessed prior to them being supported by Dutee4U Healthcare Limited. This meant decisions about capacity had already been made. When one person's personal risks increased the provider could not evidence that safeguards had been made in the person's best interests to provide an audit trail for safe practice. Staff told us how they offered choices to people but did not reflect a more detailed understanding of mental capacity. Staff had not received training about the MCA meaning they may not understand the principles of the legislation.

Supporting people to live healthier lives, access healthcare services and support
● People received personal care from the provider and their health needs were met by other professional agencies. Care records made the distinction. The registered manager told us family members liaised between agencies when healthcare support was required. Relatives confirmed this.
● Staff did not support people to access health care services unless it was specified in the person's care plan. Staff were not currently supporting people to access healthcare. There was no detail in care plans to guide staff how to respond in an emergency, except to refer them to relatives who would support in such circumstances.

Staff working with other agencies to provide consistent, effective, timely care
● The provider told us how they had attended multi-agency meetings when required to discuss people's changing needs and agreed any changes to the person's support plan at this time. This meant they could offer continuity for the person. One person's relative told us how they had valued this support as it meant the person was supported to have their changing support needs met.
● Some relatives told us that they had requested reviews to look at increased care needs but this had not actioned. They told us they were still waiting. This meant the provider was not meeting everyone's expectations in relation to working with other agencies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans were detailed, and person centred. There was evidence that needs were assessed at the start of the service and times allocated to people to meet their assessed needs. For example, one person required medicine at a certain time and so care was arranged to fit around that time.
● Assessment information included consideration of any characteristics under the Equality Act 2010 such as age, religion, disability and sexual orientation. This meant care could be delivered in line with people's preferences and choices if the plans were followed.

Requires Improvement

Is the service caring?

Our findings

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

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

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

● People told us the majority of staff were polite and courteous. Some people said communication could sometimes be a problem. For example, one person told us that they requested a certain food item and was told it was not available. They later saw it in the fridge. Another person told us, "I've given up telling them to do things, they don't always listen but it's not a big deal."

● One person detailed very different experiences depending which staff member supported them. They told us, " Two are respectful and courteous, personal care is discreet. One just does their job, although never rude."

● One person told us. "They [the staff] don't all have the same degree of empathy." This meant some people were not always receiving a caring service.

● Some staff were described as kind and caring. Others were described as very reliable and efficient. However, some people said staff were inexperienced and so didn't meet their needs as they preferred.

● People thought that if they had consistency the care would be better. They told us because of this they didn't get opportunities to get to know staff and staff them. One person told us, "There are lots of different staff, you don't get used to anyone."

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

● Relatives told us they had initially involved in the planning of their family member's care and support. This meant care was personalised with input from the people who knew them best. Other than this people didn't think they had opportunities to share their views and experiences. When people expressed views, they were not always listened to. For example, two people felt they needed a review of their care as it was not currently reflective of their needs. Neither had had a review despite asking and chasing the request.

● Some people did not know who the management team were and this meant opportunities to informally share their views was limited.

● Despite the lack of review and monitoring some people felt staff provided their care how they wanted it. These people were able to share their needs and wishes. One person told us, "They support me how I want it done."

● Some relatives told us how they had to 'teach' staff how to deliver care and support in a way that best suited their family member. One person felt that this was the only way the information would be shared with staff.

Respecting and promoting people's privacy, dignity and independence

● Most people told us that staff respected their privacy and dignity when delivering personal care. One person told us they were supported with personal care by a female carer and this was their preference. One

staff member told us how they respected people's dignity and privacy saying people had the right to be treated this way.

● People said staff carried out the tasks requested of them. One person told us they directed their own care and some days they required more support than others. They said staff were responsive to this and this enabled the person to be as independent as possible when they were able.

● Information was stored securely in a locked office and care plans were readily available to the people they belonged to. Information sent to us was not password protected and some people we contacted had not been advised that their details had been shared with us. This meant people's personal information was not always protected.

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 of this service. We have rated this service as Inadequate: This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

● We were not confident that people could speak out if they had a concern about the service provided. Some people said they did not know who to approach and another person told us, "It's hard to speak out as they are family." This meant the provider had not created a culture where complaints were encouraged and acted upon to improve the service provided. There were no safeguards in place to make sure people were supported and supervised appropriately without a conflict of interests.

●The provider told us they had a complaints procedure, but there was no evidence this had been shared with people who used the service or staff. This meant it was not accessible to use in order to address issues or concerns.

●The registered manager told us they had received complaints but did not write them down so was unable to evidence a process or satisfactory outcomes for people. Despite this people shared details of complaints they had made and their outcomes.

● We received mixed feedback as to the effectiveness of the complaints process. One person had complained and was satisfied it was managed appropriately. One person told us they had raised complaints about the conduct of a staff member, and this was not managed effectively causing distress to the complainant.

● We were told by a senior staff member that other staff had raised concerns about a staff member. Again, these had not been actioned and the person was still working. This placed people at risk of poor care.

The provider did not always respond to complaints to people's satisfaction. Poor recording meant the provider was unable to document their response to concerns and complaints.

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

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

● The timings of calls did not reflect people's assessed needs. Staff told us how they routinely ran late, often very late, due to the number of calls and the geographic area.

● People told us they were unaware of how long their calls were planned to last despite the registered manager having care plans that were time specific.

● People told us staff did not stay long and left once tasks had been completed. One person told us how they would have liked staff to do additional tasks, but this was not something offered and staff left after they had finished the task that was documented. This meant care was task centred and not centred around the personal needs of people.

●Some people had requested a review as they considered their needs were not been currently met effectively. Reviews had not happened meaning people were no longer getting the support they felt they needed.

The provider had failed to ensure care was centred around individuals (for example, call times and call duration) and this meant care was task centred and not person centred.

This is a breach of Regulation 9 Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider failed to demonstrate how they could meet people's communication needs. They did not have information available in formats that were easy to read or understand. Some people told us they did not know who the managers were and had no contact details for them should they wish to contact them.
● Sometimes people felt that communication with staff was problematic because of a language barrier. This meant that people could not express their needs in a way the staff member understood.

End of life care and support
● According to the provider, they were not currently supporting people who were at the end of their life.
● Staff had not received training in order to support a person at this stage of their life and care plans did not detail any end of life wishes should their needs change.

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 of this service. We have rated this service as 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

- The registered manager had been ineffective in managing the service in order to keep people safe from harm. They did not have a good understanding of their role and responsibilities.
- They had failed to carry out checks on care provided and this left people at risk of harm. They had not ensured safe recruitment or training for staff, including themselves and this had left people vulnerable. They failed to share information when requested and on occasion provided false and inaccurate information.
- They had failed to inform us of incidents and were unaware of what the duty of candour was. The registered manager was also the nominated individual and so checks to the registered manager's competence and performance had not being monitored.
- Audits on the service provided had not been carried out. A senior staff member told us they were too busy covering calls to get this process started.
- Quality checks had not been carried out and people said they had not been asked if they were happy with the service provided. A high number of people were not satisfied. This lack of monitoring meant the registered manager was unaware of this issue relating to the quality of the service.
- The provider had recently identified concerns about lack of training and support for staff. They had taken action to instigate training. They were not however aware of the majority of the issues identified as part of the inspection process.

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

- People shared mixed views of the service they received and people who were dissatisfied shared a range of issues relating to the quality of the service provided. These concerns have been detailed throughout the report and some concerns were serious enough for us to take urgent action to make people safe.
- The provider did not create a culture where quality would be reviewed and improved in response to feedback. As the service expanded support was no longer person centred and could not always meet peoples assessed needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not have knowledge of their duty of candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

● As we liaised with social care professionals from the Clinical Commissioning Group and local authority contracts and safeguarding teams it became apparent that there were several concerns about the quality of this service. For example, missed calls and allegations of potential abuse, which we had not been informed of by the provider.

Poor management practices and the lack of monitoring and auditing processes meant that people were at risk of harm and unsafe practise. The provider had not created an open culture where people were listened to and improvements made as a result.

This is a breach of Regulation 17(1) good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider is required by law to inform us of incidents that have occurred in relation to the service provided. They had failed to do so. In a meeting with social care professionals we were advised there had been allegations of abuse within the agency. We had not been made aware of these.
● An accident resulting in hospital treatment had not been notified to us. We could not be confident that accidents or incidents had been identified and they had not been followed up as per the requirements of this regulation. This meant they were not being open and transparent and as a result people may have received unsafe care that was not investigated to reduce risks of reoccurrence.
The provider failed to notify us of incident and accidents as is their legal responsibility

This is a breach of Regulation 18, Notice of incident, Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider could not demonstrate people were engaged in the monitoring and review of their care following their initial assessments.
● When people had shared feedback, improvements had not been made as a result reflecting people were not actively listened to.

Continuous learning and improving care
● We saw how some issues had been investigated by the provider. However, there was no record of how these issues had been used to reduce the likelihood of reoccurrence. The provider had not evidenced they had learned from the issues or improved the service as a result. This meant people continued to receive poor, late or inappropriate care and support.

Working in partnership with others
● The provider could not evidence how joint working had improved people's quality of life and although records advised other agencies visited the people they supported, for example the district nurse. There was however no evidence of staff liaising with professionals to ensure continuity of care.

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 notify us of incident and accidents as is their legal responsibility

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure care was centred around individuals (for example, call times and call duration) and this meant care was task centred and not person centred.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not always respond to complaints to peoples satisfaction. Poor recording meant the provider was unable to document their response to concerns and complaints.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Poor recruitment and recording practices meant the provider could not demonstrate how people were recruited safely to ensure they were fit to support people who were potentially vulnerable

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not trained to safely carry out the roles they were employed to do. Lack of staff monitoring meant that poor practice affected people's quality of care.

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 failed to ensure staff had the knowledge, skills and competence to safely support people to receive their medicines safely and records did not reflect safe administration. The provider had failed to act on risks identified to protect people from harm The provider failed to ensure staff followed safe infection control practise to ensure the risks of cross contamination were reduced.

The enforcement action we took:

We issued an urgent condition to the provider's registration to protect people from immediate harm

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from potential abuse as staff did not understand what constituted abuse and some care practices increased peoples risk of harm.

The enforcement action we took:

We issued an urgent condition to the provider's registration to protect people from immediate harm

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Poor management practices and the lack of monitoring and auditing processes meant that people were at risk of harm and unsafe practise. The provider had not created an open culture where people were listened to and improvements made as a result

The enforcement action we took:

We issued an urgent condition to the provider's registration to protect people from immediate harm