Goldcrest Healthcare Service Limited

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Inspection report

Unit 1
Red Lion Court, Alexandra Road
Hounslow
Middlesex
TW3 1JS

Tel: 02085714402

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Goldcrest Healthcare Services Limited is a domiciliary care service providing personal care and support for people in their own homes. At the time of the inspection the service provided support for 44 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not always have risk management plans to provide care workers with appropriate guidance to manage identified risks.

There was a process for the administration of medicines but the provider did not always ensure this process was followed, so that information was provided and recorded to ensure medicines were administered as intended.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

People's care records did not always provide accurate information relating to the care and support they needed, so staff did not always have all the information they needed to care for people. People's wishes in relation to how they would like their end of life care provided were not recorded.

Audits were carried out to check the quality of the service, but these did not always identify where improvements were needed. People told us they felt safe when they were supported by care workers in their own home. The provider had a recruitment process to ensure care workers had the appropriate skills and knowledge to provide care in a safe manner. Effective infection control processes were in place.

An assessment of a person's support needs was carried out before any care package started. Staff felt they were supported by their manager. Care workers completed a range of training and had regular supervision.

People told us the care workers that visited them were kind, caring and respected their privacy and dignity. Care plans identified people's religious and cultural wishes and how to support the person so their needs were met.

People's communication needs were identified in their care plans. There was a complaints process in place and people told us they knew what to do if they wished to raise any concerns.

The provider worked in partnership with other organisations. People using the service and care workers felt

the service was well led.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 31 October 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains requires improvement.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, need for consent, person centred care and good governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Goldcrest Healthcare Service Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector. An Expert by Experience carried out telephone interviews with people using the service and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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. At the time of the inspection the care and support manager was in the process of applying to take on the role of registered manager for the service to replace the existing registered manager was moving to another location owned by the provider.

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 6 May 2021 and ended on 17 May 2021. We visited the office location on 6 and

7 May 2021.

What we did before the inspection
We reviewed information we had received since the last inspection in September 2019. 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 of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and five relatives about their experience of the care provided. During the inspection we spoke with the care and support manager. We received feedback from 12 care workers. We reviewed a range of records which included the care plans for five people. We looked at the records for four care workers in relation to recruitment and 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. We looked at complaints records and training data.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider did not always ensure information was provided to ensure people received their medicines as intended. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• The provider had a process for the administration of medicines, but we found that when medicines were administered, they were not always recorded appropriately, information was not always provided for care workers and the level of support the person required was not clear.
• The care and support manager confirmed three people had their medicines administered by care workers. We reviewed the medicines administration records (MAR) for two people and they did not always include the dosage of the medicines and the frequency of administration.
• During the inspection we asked to see the MAR charts for the third person who had their medicines administered by the care workers. The care and support manager informed us these documents could not be located and, therefore, they could not demonstrate they had been checked to ensure the person's medicines had been administered as prescribed.
• We reviewed the care plans for two different people which indicated that care workers should prompt them to take their prescribed medicines. The records of the care provided which were completed by the care workers for one person indicated eye drops were administered and a cream was applied for the other person. The administration of these medicines was not referred to in the medicines risk assessment and there were no MAR charts in place providing guidance for care workers on how these should be administered.
• Also, the care workers repeatedly recorded that medicines were administered in the daily records of care when the care plans stated they should be prompted. It was not clear as to the level of support the person needed.
• The care and support manager told us four care workers had been assessed in relation to their competency to administer medicines which should be completed annually. The records indicated that two care workers were last assessed in 2019, one in January 2020 and there was no competency assessment on file for the fourth care worker. Therefore, the competency of the care workers to administer medicines had not been assessed in line with the provider's procedure.

We found no evidence that people had been harmed however, the provider did not always ensure information was provided and recorded to ensure people received their medicines as intended. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Relatives told us they felt care workers administered medicines as prescribed and in a safe way. One relative said, "Carers give [family member] their medication every time they call and do it well. No mistakes."
• Following the inspection the provider sent us examples of one person's MAR charts for March and April 2021 which were not available at the time of the inspection. These were of a different format to the ones reviewed during the inspection and now included the number of eye drops to be a administered.

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

At our last inspection we found people may not always receive safe care and treatment because the provider had not always identified or planned for risks to their safety and wellbeing. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• The care plans for two people indicated they had problems when swallowing. The records of both people stated their food should be cut into small pieces or softened, with the care plan for one person indicating the care workers were required to support them to eat their meals. There were no risk assessments in relation to the risk of choking and there was no guidance provided for care workers on how food should be prepared, for example what softened means and what to do if the person started to choke.
• The provider had not developed COVID-19 risk assessments or risk management plans for people receiving care and care workers. This meant the possible factors which could increase a person's risks if they developed COVID-19, for example medical conditions and ethnic background and actions required to reduce possible risks were not identified.
• The records of care for one person completed by care workers for each visit indicated they accompanied the person to attend a hospital appointment but there was no risk assessment to provide the care workers with guidance on how the support the person safely in the community. The person's care plan also identified they lived with mobility issues but there were no falls or moving and handling risk assessment in place.

We found no evidence that people had been harmed however, the provider did not always ensure information was provided to enable risks to be managed and mitigated. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People who were receiving support and relatives confirmed care workers wore personal protective equipment (PPE) when they provided care. One person said, "Yes, they wear face mask, gloves and apron every time. They also bring sanitiser with them" and a relative told us, "Carers always wear masks when they arrive then put on gloves and apron when they get inside. They also bring sanitiser with them."
• The care and support manager confirmed adequate supplies of PPE were available and they had installed PPE stations in people's homes for care workers to access.
• Care workers confirmed they had completed infection control training and COVID-19 guidance was

circulated to provide additional information.

Learning lessons when things go wrong

At our last inspection we found the system for reviewing incidents and accidents had not been followed to ensure learning took place and to identify actions to reduce risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• There was a procedure in place for the recording and investigation of incidents and accidents, but this was not always followed. When an incident had been recorded, we found that there was limited information about what had happened, and no record of any actions taken to reduce any identified risks.
• We saw one person had experienced a fall in February 2021 and the reason given for completing the form was 'repeated fall incidents' but there was no record of any action taken. The care and support manager confirmed the person had experienced another fall in November 2020, but an incident form could not be located. The person's falls risk assessment and care plan had not been updated to reflect the falls that had occurred.
• We found copies of messages from an electronic log system in the incident and accident folder which indicated that one person had experienced a fall in April 2021 and a second person had experienced two falls in March 2021. Incident forms had not been completed for these falls and the falls risk assessment and care plan had not been updated for the person who had experienced the two falls to reflect any changes in their risks.

This meant the provider could not ensure that the appropriate actions were in place to mitigate risks. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider had a recruitment procedure in place to identify the skills and knowledge of an applicant. We saw this included two references from recent employers, their employment history, records of the interview and notes from shadowing an experienced care worker.
• People confirmed care workers usually arrived on time and they stayed for the agreed length of time with some people saying the care workers sometimes stayed longer. Their comments included, "Yes, they arrive on time every time. They are very good. They have a 45-minute call and it's not enough. They do all sorts of extra work for me. They will do anything for me" and "Sometimes they are not on time, because [they] travel by buses, but usually [they are] on time. They do stay for 45 minutes and sometimes they stay longer."
• We reviewed the visit records for five people, and we saw the times the visits occurred were in line with the planned times and the visits were for the agreed length of time. Care workers confirmed they had enough travel time between visits and usually enough time to complete the care tasks during the visit, but some care workers told us they often felt rushed but always met the person's care needs.

Systems and processes to safeguard people from the risk of abuse
• People we spoke with told us they felt safe when they received support in their home. People's comments included, "I have carers once every day and they help me shower, get dressed and clean my commode for me. I have them for 45 minutes, they will do anything for me really. I feel very safe and the manager calls me to see how I am" and "The lady who helps me makes me feel very safe. She helps me shower and have a wash and get me dressed every day. She is really helpful."

• The provider had a system for responding to any concerns relating to the care and support provided. We reviewed the record of one safeguarding concern that had been raised in the previous year and this included information from the local authority, any actions, what had been learned and the outcome of the investigation carried out by the local authority.
• Care workers showed they understood how people should be protected from abuse.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

At our last inspection the provider could not ensure people's care was provided within the principles of the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

• The provider had a process in place for assessing if a person had the capacity to consent to their care, but this did not always reflect the principles of the MCA. We reviewed the records for two people and found mental capacity assessments had been completed which identified the person could not consent to aspects of their care. A best interests decision had been completed for each person, but it was generalised and did not reflect how a specific aspect of care would be provided in the best interests of the person.
• Two people who had been identified as not being able to consent to aspects of their care had risk assessments for the use of bed rails, but the mental capacity assessment did not include the use of bed rails. A best interests assessment had not been completed for either person in relation to the use of bed rails to ensure this was the least restrictive option whilst keeping the person safe..
• The records for one person identified a relative had a Lasting Power of Attorney (LPA) but the form to consent to care had been signed by another relative and it was not clear if this person had the legal authority to consent on the person's behalf. The care plan for another person had the form to consent to

care and the mental capacity assessment signed by a relative but there was no indication that relative had an LPA in place giving them legal authority to consent on the person's behalf. This meant the provider could not ensure the relative consenting to the person's care had the legal right to do so under the MCA. A Lasting Power of Attorney is a legal document that can be issued in relation to either property and financial affairs or health and welfare and legally enables a relative or representative to make decisions in the person's best interests as well as sign documents in areas identified in the LPA.
• The mental capacity assessment for one person indicated they could not communicate their decisions using speech, sign language or another form of communication but the care plan indicated that the person had no issues with communication. This meant the mental capacity assessment did not reflect an accurate assessment of the person's abilities.

This meant the provider could not ensure that the principles of the MCA were followed, and care was provided in the least restrictive manner. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care workers we contacted confirmed they had completed training in relation to the MCA and demonstrated an understanding of how it may affect the support they provided.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• An assessment of a person's support needs was completed before the care package started. We saw a 'baseline assessment of needs for daily living' was completed which identified the person's support needs in relation to personal care, nutrition, mobility, social isolation and communication.

Staff support: induction, training, skills and experience
• People told us they felt the care workers that visited them had received appropriate training to provide the support they needed. One person said, "I think [they are] well trained. [They are] very careful and don't leave me for a minute when I am getting dressed." A relative told us, "We are very satisfied with the service they provide. They can do the job well and really do care about my family member."
• Care workers undertook a range of training courses which had been identified as mandatory by the provider. These included moving and handling, health and safety and emergency first aid. The training records demonstrated that all care workers were up to date with their mandatory training and care workers we contacted confirmed they had completed regular refresher courses.
• We reviewed the supervision records for four care workers and we saw they had completed regular supervision meeting with their line manager and spot check visits were carried out to assess their skills and how they provided care.

Supporting people to eat and drink enough to maintain a balanced diet
• A relative commented on the support their family member received with their meals, "The carers do prepare food for [family member], not ready meals. We told them what [family member] likes and dislikes and although they cannot cook proper Indian food, they try their best with jars and pastes to do Indian food."
• People's care plans identified if the person required support with preparing food and/or with eating their meals.
• The care plans also identified if any family members were involved in purchasing and preparing meals.
• Care workers we contacted confirmed they had completed nutrition and hydration training as well as food safety training.

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

• People we spoke with told us they had been supported to access healthcare services with one relative commenting, "Carers do help [family member] contact GPs etc. Two weeks ago, [family member] was coughing badly and they contacted us to ask our opinion then suggested calling rapid response. Paramedics came straight away and put (Named) right."
• The care and support manager explained that, when required, referrals were made to relevant healthcare professionals for a person who did not have any family or friends to support them. They also told us that a contact list of organisations which could be of use to the person in providing additional support was included in the care plan folder in their home.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

• Although individual care workers were caring, the service was not always caring because we had identified a number of shortfalls in the way the care was provided during the previous inspection in September 2019 and we found similar issues during this inspection. Therefore, people may not have received the support they required to meet all their care needs. For example, people may have been placed at risk of poor care as risk management plans were still not always in place and medicines were not always managed appropriately.

• People told us they were happy with the care they received, and the care workers provided care in a kind and caring way. One person commented, "Yes, I am definitely happy with the support I get. They are very good." Relatives also confirmed they were happy with the care provided with one commenting, "Carers are very kind and caring to [family member]. We are very pleased with their work."

• People also confirmed that care workers treated them with respect as well as promoting their dignity and independence. Their comments included, "Yes, the care worker is always polite and when [they help] me, [they smile] at me and treat me like a person. [They make] me feel comfortable. [They are] kind and caring. I like [them] very much" and "I want to keep my independence as much as possible. I have a memory problem so like to get a prompt to take my medication, but I do everything else for myself."

• Care workers we contacted confirmed they respected people's privacy and dignity. Comments included, "I respect my client and help them with what they need to do for themselves" and "Respect their privacy and treat them as individual. I let them do what they can do themselves."

• We saw that some of the care plans we looked at identified the person's religious and cultural beliefs.

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

• People and relatives confirmed they had been involved in the planning of the care being provided. One person told us they were working with the service to increase the number of visits they received as their support needs had changed. A relative said, "We were involved in planning [family member's] care. The family met with the company to discuss what they needed, and they put it in place straight away."

• The care and support manager explained that when they were contacted by people receiving support or by relatives asking for guidance, they would signpost them to relevant organisations for example for home adaptations and financial support.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

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

At our last inspection the provider had not ensured the care plans contained detailed and up to date information to reflect how people wished their care to be provided and how to meet the person's care needs. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• People's care plans were not always person centred and did not always identify how people wanted their care provided. We saw one person's care plan section relating to washing and dressing stated, "I require assistance with hygiene, toileting, washing, dressing and change pad. I also require help getting up from the bed." This did not provide care workers with any information as to how the person wanted their care provided.
• Care plans did not always reflect the information recorded in other documents to demonstrate the person's current support needs. For example, we identified that one person had experienced a change in their support needs following a hospital admission in January 2021, but the person's care plan had not been updated to reflect the possible impact of this on how care should be provided.
• We reviewed the care plan for another person, and we saw a behaviour chart had been completed but the care plan did not indicate that the person experienced behaviour which could require additional support and that a chart should be completed.
• The records of care completed by care workers following each visit were not always person centred and were focused on the tasks completed and not he person's experience of their care.
• During the inspection we saw documents identified as end of life care plans. These documents did not always refer to the person's end of life wishes and used identical wording for different people. The information included on one care plan stated the person lived alone but they lived with their family. The documents did not reflect the person's wishes but stated they were 'fairly independent' when this was not always the case and for care workers to 'be attentive to [person's name] changing moods or any physical conditions and report to family and coordinators/managers.' There was no guidance as to how care workers should provide support to meet the person's wishes if their health deteriorated and they required care towards the end of their life.

This meant the provider had not ensured the care plans contained detailed and up to date information to

reflect how people's care should be provided and the person's wishes. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the care and support manager provided a copy of an end of life care plan for one person, but this document was not part of the care plan paperwork provided during the inspection.

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 care plans identified their communication needs. The person's care plan indicated if they had any hearing or visual impairments which could impact their ability to communicate and how care workers could support the person. The person's preferred language was also identified in the care plan.
• People we spoke with confirmed they could understand the information provided by the service relating to their care. Their comments included, "Yes, I have a file where everything is written down for me. I can read it very well" and "Yes, I have a file in my house, and they write everything up in it. I read it from time to time and it is easy to read."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were supported to maintain their family and community relationships to reduce the risk of social isolation.
• The initial assessment of the person's support needs, and their care plan identified who was important to the person, lived with them or regularly visited them.

Improving care quality in response to complaints or concerns
• People confirmed they knew how to raise any concerns with their comments including, "I have never needed to complain but if I did, I would ring the agency to talk about it." One relative told us, "We haven't had to make a complaint, but I would know how to do it."
• Care workers explained how they would respond if a person raised a concern with them, with one care worker telling us, "I deal with complaints by reporting to my manager or care coordinator, then record on daily care notes and write the complaint form and record on the care planner app as well."
• The provider had a complaints policy with a flow chart for the procedure in the complaints folder to provide guidance on the process.
• We reviewed the records for four complaints that had been received since the previous inspection. The records included information on the complaint, additional information identified during any investigations and the outcome with any action that have been taken.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider did not have a robust quality assurance process in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had a number of quality assurance checks in place, but these did not always provide adequate information to identify where improvements were needed, or when concerns were noted actions were not recorded to show where improvements had been made.
• Audits were carried out of the completed MAR charts which had been collected but we saw where issues had been identified actions had either not been recorded, or if they had there was no evidence these had been completed.
• The provider did not have processes in place to ensure when information was reported to the office the appropriate action was taken. For example, when incidents were reported to the office a process to ensure that information was recorded and acted upon was not in place. This meant appropriate action was not always taken to respond to any changing care needs.
• We saw some of the records of care provided during a visit completed by care workers had been audited but these audits did not always identify when care was provided which was not included in the care plan. outside of that . For example care workers had recorded in the care notes that they were administering eye drops which was not identified in the care plan. The audit of these records did not identify this to enable appropriate action to be taken to ensure the care was provide in a safe manner.
• The provider had not always mitigated risks to people's safety by ensuring risk management plans were in place, for example, in response to specific risks identified during people's care needs assessments including swallowing, COVID-19 and supporting a person to access the community. The provider's audits were not consistently effective as they had not identified these issues, meaning the provider was not able to address them.
• The provider did not ensure they complied with all regulatory requirements. During the inspection the care and support manager told us a concern had been referred to the local authority safeguarding team and had

been investigated in August 2020 but they had not sent the required notification. Providers are required to send the CQC a notification when a safeguarding concern is raised with the local authority in relation to a person receiving the regulated activity.
• A survey of people receiving support was last completed in 2019 but the service carried out quarterly quality monitoring calls to people. A form was completed for each call with the person's feedback, but this information had not been analysed to identify any areas of good practice or where concerns had been raised.
• A range of issues were identified at the inspection in 2019 which have been identified again during this inspection. The provider had failed to address these issues to ensure improvements were made and systems developed to ensure consistent, safe and appropriate care was provided.

This meant the provider had not ensured the quality assurance processes were robust enough to provide information to identify were improvement action was required. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care workers told us they were supported by their manager and that the service was well led. Their comments included, "I have a good relationship with all my clients and I don't always get issues, I have got enough support from the office and if I need help regarding my work or my skills I get it from my manager or the care coordinator" and "The management and office are supportive and they are always ready to help me through any problem or any issues that I have with my clients, they are understanding too."
• The care and support manager told us there was regular contact with people receiving support.
• There were clear roles and responsibilities identified for staff including care coordinators, administration and recruitment. The care and support manager explained there were defined roles and job descriptions which provided clear lines of responsibility for staff. The care and support manager confirmed they were in regular contact with care workers either in person, on the telephone or using a telephone app and this was confirmed by the care workers.
• The provider ensured people's cultural characteristics were identified and the care provided reflected their needs. For example, if a person spoke a specific language a care worker who also spoke the preferred language was allocated wherever possible. If a care worker identified specific cultural observances they would be allocated to appropriate care packages.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People we spoke with told us they felt the service was good. Their comments included, "I only know about the service I get, but that is very good" and "Yes, well run, 100% very good." Relatives also told us they felt the service was well led with their comments including, "We know who the manager is and all the staff in the office are really lovely people. I can't think what they do really well, because it is all good" and "Yes, it is well run. They do a good job."
• Care workers confirmed they read people's care plans regularly with them telling us, "On start of the care and once office tells me of changing the care plan" and "I read every time the care plan and risk assessment is ready if I'm starting a new client or if I have any concern regarding the client."

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
• People and relative we spoke with confirmed they knew how to contact the office if they had any concerns. One person told us, "Management are very good. They ring me from time to time to make sure I get the support I need. They ask if I am okay and if I feel safe. Just like a family."
• Notwithstanding the notification relating to a safeguarding which was not submitted, the care and support manager demonstrated a clear understanding of the responsibilities of informing the relevant organisations

when an issue occurs.
• There was a range of policies and procedures in place which would be regularly reviewed and updated when required. For example, the complaints policy included guidance which indicated when the person should be updated on the progress of the investigation and the outcome.
• The provider had a clear process in place to respond to complaints and concerns in a timely manner and how they would identify where improvements should be made. The complaints records included correspondence with the person who raised the complaint detailing the outcome.

Working in partnership with others
• The provider worked in partnership with other organisations. The care and support manager confirmed they attended the provider forum meeting organised by the local authority. They also had regular meetings with the local authority to review the care packages they funded. They also worked closely with other social care providers involved in providing care for people they also supported.

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 did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 as they did not ensure service users' mental capacity was assessed and recorded where they were unable to give consent. Regulation 11 (3)

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 risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1) (2)

The enforcement action we took:

We have issued a Warning Notice requiring the provider to comply with Regulation 12 by 20 August 2021.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider did not have appropriate checks in place to assess, monitor and mitigate the risks relating health, safety and welfare of services. Regulation 17 (1)(2)

The enforcement action we took:

We have issued a Warning Notice requiring the provider to comply with Regulation 17 by 20 August 2021.