Boldglen Limited

Boldglen Limited Medway Swale

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Boldglen Limited Medway and Swale is a domiciliary care service providing personal care to people living in their own homes. The service also provided personal care to people living in flats within an extra care housing scheme in the borough of Swale. Not everyone who used the service received personal care. The Care Quality Commission (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 providing personal care to approximately 177 people at the time of the inspection.

People's experience of using this service and what we found
There continued to be shortfalls in the service provided to people.

Individual risks were not always assessed and managed to keep people safe. People could not be sure their prescribed medicines were always managed in a safe way. When people had accidents and incidents, appropriate reports had not been completed which meant action had not been taken to review and reassess people's care needs and medical professionals had not been informed.

People could not be assured new staff were adequately checked to ensure they were suitable to work with people to keep them safe. We found no evidence that people had been harmed however, systems were either not robust enough to demonstrate staff recruitment was effectively managed. Staff had not always been allocated travel time to enable them to travel between care calls, this meant people received late care calls and staff were rushed to get to their next care call. One person told us, their staff member frequently finished their care call early.

Although initial assessments were undertaken with people before they received a service, the information gathered was not always used to develop a care plan where needed. Care plans were in place. However, care plans were inconsistent and did not always detail the relevant information staff would need to meet people's assessed care and health needs.

Records were not always accurate, complete or contemporaneous. Although there had been audits and checks of the service completed, these were not robust. This meant the management team were not always aware of concerns, changes in health or medicines issues, which led to delays in action being taken where needed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff had received training to make sure they had the skills to meet people's specific care needs. Staff told us they felt well supported by the management team.

Most people and relatives gave us positive feedback about their care and support. They told us, "They are all wonderful and see to my needs well"; "I have a regular male carer, who has become more of a friend. Knows me well"; "I am very happy with my carers"; "They are excellent" and "They phone me and ask how things are by way of feedback and I told them I am very happy with them." One relative and one person raised some concerns in their feedback which we reported to the registered manager so that the management team could address these.

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 rating at the last inspection was requires improvement (published 23 October 2019) and there were breaches of regulation 9,11,12,17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection to show what they would do and when they would improve by. We met with the registered manager on 31 October 2019 to discuss the repeated rating of requires improvement and set out expectations as well as listened to their planned improvements.

At this inspection we found the provider had made some improvements by ensuring that staff received training and support to carry out their roles safely and consent and capacity had been improved. However, the provider requires further improvement in medicines management, risk assessment, safe recruitment practice, effective staff deployment, effective assessment and care planning and effective quality monitoring.

Why we inspected
CQC have introduced targeted inspections to follow up on requirement actions, warning notices or to check specific concerns. They do not look at the entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of the key question.

We undertook this targeted inspection to check whether the Warning Notices and Requirement actions we previously served in relation to Regulation 9, 11, 12, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Boldglen Limited Medway Swale on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of 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 identified a new breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to effective deployment of staff. Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan for 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?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Boldglen Limited Medway Swale

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.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notices in relation to Regulation 9 Person-centred care, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also checked whether the provider had taken action to address requirement actions in relation to Regulation 11 Need for consent and Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by three inspectors, two of whom attended the service and one who worked off-site. Two Experts by Experience spoke with people 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. This service also provides care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care service.

The service had a manager registered with CQC. 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
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. Announcing the inspection enabled us to check if any staff at the service were positive or had symptoms of coronavirus (COVID-19) and to discuss arrangements for the inspection and PPE required. Inspection activity started on 7 October 2020 and ended on 22 October 2020 when we had a feedback video call with the registered manager. We visited the office location on 7 October 2020. Calls with people and relatives were made on 08 and 09 October 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commission the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had not received any concerns about the service.

We used the information the provider gave us during their emergency support framework (ESF) call. The ESF has been developed by CQC to gain an understanding from providers of how the COVID-19 pandemic has affected the service. The ESF is a supportive conversation to share information and review help and support the service may need.

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 eight people who used the service and 15 relatives about their experience of the care provided. We spoke with 10 members of staff including care staff, assessors, coordinators, the registered manager and the nominated individual. 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 eight people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, risk assessments and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about safe care and treatment and the requirement action served about recruitment and good governance. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At the last inspection in August 2019, the provider failed to robustly assess the risks relating to the health, safety and welfare of people. 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, the provider had not met the warning notice and was still in breach of Regulation 12.

● At this inspection, risks to people had not always been identified to ensure staff had the guidance necessary to follow a specific plan to prevent harm. There was inconsistent risk assessment practice across the service. Some people were prescribed blood thinning medicines which meant that they were at increased risks of excessive bleeding if injured and would need immediate medical attention if they fell or banged their head. No risk assessments were in place to detail safe ways of working with some people.
● Risk assessments were not always in place where people had health conditions, which carried potentially serious or fatal risks. For example, when people were diagnosed with diabetes, angina or epilepsy.
● Assessors had carried out COVID-19 risk assessments with people, some of these were clear and detailed about the risks that COVID-19 presented to the individual because of their underlying health conditions. However, others were basic and lacked detail for staff to follow. However, staff confirmed they wore personal protective equipment when providing care.

Individual risks relating to the health, safety and welfare of people had not been robustly assessed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team had carried out COVID-19 risk assessments with staff to ensure individual circumstances for each staff member and health conditions had been reviewed and assessed. Staff had access to personal protective equipment and had been provided with tests when required.
● People told us they had been involved in the risk assessment process. Comments included, "Well I am currently housebound and self-isolating with this COVID but we talk about this and the risks on a regular

basis and decided in my condition I stay in" ; "They know I am a little unsteady and the risks moving around, so they ensure there are no trip hazards and that I have a walker to safely get about" and "I can get about alright but we plan the risks of me being alone in the shower, which I will not have without help."

Using medicines safely

At the last inspection in August 2019 the provider failed to manage medicines safely. 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, the provider had not met the warning notice and was still in breach of Regulation 12.

● At this inspection, medicines were not well managed. Records showed that one person lacked capacity to administer their own medicines and staff should do this as part of care calls. Staff were not always doing this and records showed they were leaving medicines out for the person to take at a later time. Records showed the person was then forgetting to take the medicines and the medicines were found the next day by staff. This this meant the person went without their prescribed medicines. Staff had not sought medical advice about the missed doses and had not reported this to the office. Medicines administration records (MAR charts) did not always reflect that medicines were left out or not given by staff.
● Medicines that should not be given at the same time as food or other medicines, such as medicines which are used to control under active thyroids had not been identified on the MAR. Staff confirmed they gave the medicines at the same time as meals and drinks and not before food as detailed on the patient information leaflet. We spoke with the registered manager and they took advice from the pharmacists and made changes to people's care plans and risk assessments to prevent this from happening again in the future.
● Medicines records were not up to date. One person's care plan stated they self-administered all their medicines. However, the daily care records completed by staff at each care call showed that they were administering medicines such as transdermal patches.
● Medicines side effects sheets were in place in people's care files to act as a reminder for staff. However, medicines side effects sheets were not in place for all the medicines people were prescribed. For example, one person's care file was missing side effects sheets for four different medicines. They also had a side effect sheet in place for one medicine that they were not prescribed. This meant that staff did not have up to date information about people's medicines to enable them to support them safely.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Learning lessons when things go wrong

At the last inspection in August 2019 the provider failed to make complete, accurate and contemporaneous records. 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, the provider had not met the warning notice and was still in breach of Regulation 17.

● At this inspection, we identified a continued failure to record accidents and incidents. One person's

records for August 2020 showed that they had fallen or had seizures three times in the month. No accident or incident forms had been completed, healthcare advice had not been sought and office staff were unaware of the incidents. This meant that lessons could not be learnt and risks to people's safety had not been reviewed and assessed in a timely manner, which put people at increased risk of harm.

The failure to make complete, accurate and contemporaneous records was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Staffing and recruitment.

At the last inspection in August 2019 a robust approach was not taken to recruitment to make sure only suitable staff were employed to provide care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of Regulation 19.

● At this inspection we continued to find that staff were not recruited safely. The registered manager submitted three staff files which we reviewed. All three showed gaps in staff employment history. These gaps had not been addressed and recorded. We informed the registered manager of our concerns. They updated CQC during the inspection with explanations of the gaps. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that a full employment history is required.
● References had not been consistently obtained from the most recent employer. There was no information on the staff files to record why these had not been obtained. We raised this with the registered manager who provided CQC with an explanation.
● One staff file did not have photographic proof of identity. Another staff file had a driving licence photocard, however the address differed from that which the applicant gave on the application form. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that proof of identity including a recent photograph is required. We informed the registered manager of these concerns. During the inspection they responded with their explanations, CQC did not receive clarification of why recruitment policy and regulation had not been followed.
● None of the above shortfalls had been identified during either the recruitment process or through any audits.

A robust approach to recruitment was not taken make sure only suitable staff were employed to provide care. This was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) criminal record checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

At the last inspection we recommended the provider reviewed how to effectively deploy staff to enable them to carry out their duties to meet people's care and support needs and update their travel time practice accordingly.

● At this inspection some staff told us their calls had allocated travel time between their community care calls whilst others did not. We reviewed staff rotas and found travel time was not always allocated where staff were required to travel between people's homes. Some staff continued to have no travel time allocated on their staffing rotas to enable them to travel between each care call. For example, a staff member had a

care call from 08:30 until 09:00 and the next care call was at 09:00. One staff rota we viewed showed three care calls in one day with no travel time allocated. Another staff member had nine care calls in one day with no travel time allocated. This meant that staff would be running late for all their care visits during the day and people would not be receiving their care at the time they had been assessed for. Care records evidenced that people had not received shortened care visits, however they showed that the care visits were at different times to the times they had been assessed to received them. One person told us, "My carer always rushes. My call is for half an hour, but she goes sometimes after 20 minutes." The registered manager told us on 22 October 2020 that they had rectified this issue and all travel times were now rostered. We will follow this up and check for improvement at the next inspection.

● Some care calls were scheduled too close together without consideration for the person's assessed needs. For example, one person required one staff member to support them three times a day (morning, lunchtime and late afternoon) with meals as well as personal care tasks. The staffing rota showed that the morning call was scheduled for 10:15am until 11:00am, the lunchtime care call was scheduled for 11:15am until 11:45am which meant that they only had 15 minutes between their breakfast and lunch. The person's care records showed many care visits that were half an hour between breakfast and lunch. The registered manager told us that the COVID-19 pandemic had not affected the service's ability to provide care and support, had not caused staffing shortages or caused delays to travel.

Failure to deploy staff effectively to meet people's assessed needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us they received care and support from consistent staff. Comments included, "We have had support for our relative for the past five years. Her care is just at the weekends as she has respite care on weekdays. She usually gets the same carers each week as she does get if she gets a new carer. The ones we get are all very nice and really understand her needs"; "They are always on time. In 2019 our relative had a fall before the carer arrived, she called an ambulance and rang the office to inform us. She stayed with our relative until it was all sorted" and "We have been using the service for about the past two years. My relative gets four visits each day. We now have a consistent group of carers."

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notices we previously served about person-centred care and staffing. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the last inspection in August 2019, the provider failed to ensure people's care documents were accurately recorded in order to provide consistent care that met people's 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 and the provider was still in breach of Regulation 9.

● At this inspection, we found that some assessments had improved. However, the assessment process across the service was inconsistent. Assessments undertaken with people before they received a service had not always been used to develop a care plan. This meant that staff had no guidance about how to meet people's assessed needs. This put people at increased risk of harm, particularly when they had a medical emergency. We have reported more about how the lack of assessments and care plans impacted people in the responsive section of this report. The registered manager told us during on 22 October 2020 that they had addressed the issues with staff responsible for assessing people's needs and improvements had been made. We will follow this up and check for improvement at the next inspection.

Registered persons had failed to carry out an effective assessment of the needs of people to plan their care. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At this inspection the assessment process was more robust, it checked people's details such as marital status, religion, gender, nationality and ethnicity. Assessments of oral health had taken place.
● The assessment process also evidenced that consideration had been made to how many staff would need to support the person and how much support they needed in relation to tasks. This was recorded on a dependency tool.

Staff support: induction, training, skills and experience

At the last inspection in August 2019 the provider failed to provide staff suitable training to enable them to

carry out their roles safely. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made and the provider was no longer in breach of Regulation 18.

● Since the last inspection changes had been made to training process and on-line training had been introduced. Staff told us they were allocated a number of courses to complete each month. Staff spoke positively about changes. They said, "Training has really improved. I have recently done manual handling, health and safety, first aid, safeguarding, equality and diversity, teeth, feet and skin" and, "The training is online now. It is good because I can watch the video part and then go out and do my calls. Then I can come back and answer the questions then do the test. It works well for me. We get given certain courses to do over a three-week period."
● Staff spoke knowledgeably about the people they supported and told us about signs and symptoms they would look for which may indicate a decline in their health. One member of staff spoke about training they had received from nurses to support a person with dressing a wound.
● Staff told us new care staff shadowed experienced staff which enabled them to get to know people, their routines and any specialist equipment used, such as a hoist. Staff said they regularly met their line manager for one to one supervision. They told us that during the pandemic these had been completed by video. Staff felt they were supported well by the office staff and management team. They said they contacted the office if they had any concerns about a person's health and that action was taken. For example, if a person needed to be referred to health care professionals.
● People told us that most staff had the skills and experience to carry out their role. Comments included, "Our carers are so helpful and approachable which makes our life so much better. Nothing is too much trouble and we always have a chat and a laugh"; "They know how to do my care well. I am confident with them all"; "Skills are excellent, they even put my commode at the side of my bed for night time" and "They found that ulcer on my leg I was not aware of. Very well trained and skilled in my opinion."

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 the last inspection in August 2019, the provider failed to provide care with consent from the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made and the provider was no longer in breach of Regulation 11.

● At this inspection, we found staff responsible for carrying out assessments had awareness of the MCA process to ensure that decision making was decision specific for each person. They had carried out MCA assessments to determine whether a person lacked capacity which detailed the decision-making process.
● It was not always clear from the mental capacity assessments who else had been involved in the decision-making process when it had been determined that a person lacked capacity to consent to a particular decision such as relatives or healthcare professionals. This is an area for improvement.
● People had signed their assessment and care plan records where they were able to and had consented to care and support.
● Most people and relatives told us they made their own choices and decisions about their care. Comments included, "They always make sure that they offer her choices, not just one, which is thoughtful and they listen to what she says which is critical for her wellbeing"; "They always respect her choice and make sure that is what she gets"; "They always take time to explain things. The girls always involve me in my care and make sure I am happy with what they are doing" and "They come and ask how I am and ask what I want doing first. They won't do anything without talking to me." One person reported that a staff member does not always respect their wishes. We reported their concerns to the registered manager who agreed to investigate and resolve the concerns.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about person-centred care. We will assess all of the key question at the next comprehensive inspection of the service.

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

At the last inspection in August 2019 the provider failed to ensure people's care documents provided all the information needed to provide consistent care that met their needs and preferences. 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 and the provider was still in breach of Regulation 9.

● At this inspection we found that care plans were inconsistent across the service. Some had vastly improved. They were detailed and clear about the assessed needs and how staff should meet them. However, others lacked important information individual to the person.
● One person lived with a number of health conditions including epilepsy, chronic obstructive pulmonary disease (COPD), Parkinson's disease, angina and asthma. The person's assessment had identified these health conditions; however, the care plan did not provide guidance for staff on how to support these needs. This meant staff working with the person may not aware of how each of the health conditions affected the person's life. Information was not in place to describe what staff should do should in the event of deterioration. The person's care records identified that they had a number of seizures and they had been found on the floor. Staff had not understood because of the lack of planning what action they should take to alert medical professionals and the management team that the person's health had deteriorated.
● People who had diabetes had care plans in place to detail the person's condition and how it affected them as an individual and what staff should do if they suffered a diabetic emergency, such as hypoglycaemia where the level of sugar in the blood drops too low. One person's care plan stated that they should receive their morning care call not later than 08:30am due to their diabetes. Care records showed that the person's care calls had taken place frequently at later times including 09:00am, 09:10am and 09:40am. There was no explanation for these late calls. This showed that the person's assessed needs had not been met.
● Some people were prescribed blood thinning medicines to manage their health conditions. Care plans did not detail what action staff should take should someone taking this type of medicine have a fall or injury. One person's care record showed that they had been found on the floor a number of times. Staff had not

sought further advice and guidance from their managers and no medical attention had been sought to gain healthcare advice.

● One person had been assessed by the speech and language therapist (SALT) because they had a several medical conditions which affected their swallowing function. The SALT report was found within their care file at the office. However, the very specific guidance for staff (such as being alert and upright when eating and drinking and for 30 mins after, minimise distractions during mealtimes, turn off tv, minimise talking when eating) in relation to assistance with meals was not included in the person's care plan. This meant staff did not have all the information and guidance about how to support the person safely. The registered manager told us on 22 October 2020 they had rectified this issue. We will follow this up and check for improvement at the next inspection.

The failure to adequately plan people's care and treatment was a continued breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us they were involved in developing the care plan and reviewing these. Comments included, "I personally do that with them, and it is checked every six months to check things are all in order. I have a copy of it here"; "They assess my care plan every so often with myself"; "I do this with them, and it is due for review shortly"; "We and our relative were all involved in the planning for her care which was really valuable to us. Things have worked out really well" and "They come and sit and go through and do it with me. My wife is not able to but also due to my condition I have a close neighbour who also comes in to explain things. It is here and all alright."

● At this inspection, people's oral health care support needs were clearly documented within their care plans and staff were knowledgeable about the importance of maintaining people's oral health. Care records showed that staff were supporting people where required with maintaining good oral hygiene. Life histories were now in place within many people's care plans, these showed information about what and who was important to them to give a holistic view of the person. Staff knew people well.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about good governance. We will assess all of the key question at the next comprehensive inspection of the service.

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

At the last inspection in August 2019, the provider failed to have effective systems in place to check the quality and safety of the service. 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 and the provider was still in breach of Regulation 17.

● At this inspection, audits were not robust and were unclear. For example, shortfalls were identified in three people's care records in May 2020. These included concerns about a person's medicines being left in an egg cup for them to take later, a person being given alcohol in the morning, staff leaving medicines and concerns about the time between a person's morning and lunchtime call. The June audit noted these serious concerns had not been addressed. The July audit noted 'All checked and completed'. There was no information to note how these concerns had been addressed and the action was not taken in a timely manner which may have left people at risk.
● Audits of care records had not identified areas of concern that had been recorded by staff such as records of falls and seizures. Therefore, the service had missed an opportunity to address the issues in a timely manner.
● Medicines audits had failed to identify that medicines had not always been given and that medicines were being left out for a person who was deemed not to have capacity to take their medicines safely themselves.
● Audits of recruitment records had not identified that recruitment procedures and records were not robust.
● Although registered persons had taken action to address the shortfalls identified at the last inspection, further action was required to address the continued breaches of regulations and new breaches of regulations relating to risk management, medicines management, recruitment of staff, staff deployment, assessments and care planning.

Systems to monitor the quality and safety of the service were not robust enough to identify areas that were in need of improvement. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a registered manager at the service who had oversight of the day to day running of the service.
● Staff meetings between the office staff group had continued to take place regularly to enable staff to discuss important information. The management team had also used group chat messages and computer software to ensure effective communication and to ensure all staff got information at the same time. Staff felt the office staff and management team were approachable. One staff member said, "If I had any concerns, I would report them to [registered manager], she is very approachable."
● Notifications of incidents that required reporting to CQC had not always been sent in a timely manner. During the inspection process the local authority made CQC aware of a safeguarding concern related to missed medicines which had occurred on 08 October 2020. CQC had not received a notification of alleged abuse in relation to this incident. We discussed this with the registered manager on 22 October 2020 and they said they would ensure this was completed. CQC received the notification on 22 October 2020. This is an area for improvement.

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 Registered persons had failed to carry out an effective assessment of the needs of people to adequately plan people's care and treatment. Regulation 9 (Person centred care)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Registered persons had failed to ensure that a robust approach to recruitment was taken to ensure only suitable staff were employed to provide care. Regulation 19

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Registered persons had failed to deploy staff effectively to meet people's assessed needs. Regulation 18

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 Registered persons had failed to ensure individual risks relating to the health, safety and welfare of people had been robustly assessed. Registered persons had also failed to take appropriate actions to ensure medicines are managed in a safe way. Regulation 12

The enforcement action we took:

We imposed a condition on the registered providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons had failed to ensure records were complete, accurate and contemporaneous and failed to ensure systems to monitor the quality and safety of the service were robust. Regulation 17

The enforcement action we took:

We imposed a condition on the registered providers registration.