Anndrew Ltd

Bluebird Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bluebird Care is a domiciliary care agency. At the time of our inspection, the service was supporting 24 people with personal care in their own home.

People's experience of using this service and what we found
Care plans did not provide sufficient guidance to staff. This provider did not have adequate oversight of what training staff had received. Therefore, there was a risk that people's needs may not be supported safely. Incidents that had occurred were not always responded to safely.

Medicines were not managed safely. There were no audits to identify these concerns. This had put people at risk of not receiving their medicines and having ill health.

Staff were not safely recruited, as they began work before references and police checks were returned. People reported that staff were often late to support them. Records showed that this punctuality was worsening on a monthly basis. People reported that this had resulted in them completing tasks themselves unsafely. This neglectful practice had not been resolved. There was a lack of oversight at the service, to ensure that people's needs were safely met. Staff followed safe infection control procedures.

The provider did not keep an accurate list of what training staff had received, so we could not be assured that staff were provided with the relevant skills to complete their roles. Health professionals were not always communicated with, and professional guidance was not always recorded for staff to follow. People told us that they had access to food and drinks of their choosing. People did not receive good quality end of life care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The ethos of the company was uncaring. We observed undignified language to describe people. Care visits were often late which left people anxious or completing tasks themselves unsafely. People told us that staff treated them in a caring way in their homes.

Care was not person centred. Expected national standards were not met, as people did not receive personalised care to meet their needs. Complaints were not always recorded, and themes were not analysed. Ongoing complaints of poor punctuality had not been resolved.

The service has been rated 'inadequate' for a second time. There has been a provider failure to oversee the quality of the service and drive improvements. The registered manager had left one month prior to our inspection, and it was not clear what improvement plan was in place. No new governance had been

completed in their absence. The provider is legally accountable for the safe running of the service. They had failed to oversee a safe and effective service. This has put people at long term risk of harm. A new manager was in position, and intended to become the registered manager. It is a legal requirement for the service to have a registered manager.

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 Inadequate (published 22 August 2019) and there were multiple breaches of regulation.

After the last inspection, we added a condition to the providers registration. This is a legal requirement. which the provider must follow. We requested that the provider sent monthly summaries of the action taken to improve the service. The provider sent us monthly summaries of the action taken. However, this inspection found that improvements had not been made as described.

At this inspection, not enough improvement had been made and the provider was still in breach of regulations. This service has been in Special Measures since 22 August 2019. The service remains in Special Measures.

Why we inspected
The inspection was prompted in part due to ongoing concerns received about medicines, staffing levels, staff training and overall governance. A decision was made for us to inspect sooner than originally planned and examine the risks in a comprehensive inspection.

We have found evidence that the provider needs to make improvements. Please see the report for full details.

Enforcement
The provider remains in breach of regulation 11 (consent), regulation 12 (safe care and treatment) and regulation 17 (Good Governance). At this inspection, we identified additional breaches of regulation 9 (person centred care) and regulation 19 (Fit and proper persons employed).

You can see what action we have asked the provider to take at the end of this full 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.

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led

Details are in our well led findings below.

Bluebird Care

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 completed by two inspectors

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

The service did not have a manager registered with the Care Quality Commission. The registered manager and provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been recently employed. They told us they intended to register.

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 manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used all of this information to plan our inspection.

During the inspection
On the 4 and 5 December, we visited the office location to review records related to the running of the service. This included records related to ten people's care needs. We also looked at four staff recruitment files and a variety of records relating to the management of the service.

On 9 December, we visited three people's homes to observe care being provided. On 11 December, we phoned people and relatives to discuss their experience of care provided. We spoke with six people who used the service and three relatives about their experience of the care provided. During the inspection, we spoke with six members of staff, the (recently recruited) manager and the provider.

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

Inadequate

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. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had 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 at this inspection and the provider was still in breach of regulation 12.

- Care plans and risk assessments did not provide enough guidance to staff. This put people at risk from harm. For example, a relative told us that a person was in pain if repositioned in a certain way. Records showed that a staff member had been corrected by other staff after attempting to reposition them this way. However, there was no written guidance to ensure that this painful repositioning did not occur again.
- Staff lacked knowledge on people's needs. For example, one person had a pressure sore. Staff were unsure of the severity of their injury and what setting their pressure relieving mattress should be at. There was no guidance available for staff. This increases the risk of further skin breakdown.
- There was a lack of recording, to ensure that people's needs were understood. For example, a staff member explained that a person had started shaking. The staff member was unsure if the symptom had started after a recent medicine change, or whether the medicine was prescribed to stop the shaking. There was no recording of when this symptom started, or evidence that professional advice had been sought. The lack of recording and staff knowledge put this person at risk of ill health.
- Time sensitive medicines were not managed safely at the service. Two people required medicine to be given at a specific time for their health condition. Staff were provided with no, or incorrect guidance on when this medicine was required. Records showed that these people's medicines were often given outside of the prescribed time, this puts them at risk of ill health.
- Staff did not always record that they had given people their medicines. For example, one person's medicine had been recorded as 'missed' for 25 days out of 30. There had been no investigation into whether the person had received their medicine or not.
- Where medicine errors had been highlighted staff had not always responded to keep the person safe. For example, one person had coughed and spat out their medicine. The medicine was disposed of. However medical advice had not been sought on whether staff should take other action considering the person had not received their prescribed medicine.
- Where incidents had occurred, these were not always documented. This meant that learning may not occur. For example, one-person experienced confusion. They had blocked themselves in a room with chairs. Staff had pushed the door open to support them. There was no detailed recording of this incident to ensure that it was learnt from. There was no guidance in place for staff to respond safely if this occurred again. A

staff member advised that they had not received training in challenging behaviour to support this person safely.
● Where incidents had occurred, there was no formal review of themes to ensure that incidents did not re-occur. For example, we identified two recorded medicine errors which had not been reported to the person's GP for advice. An analysis of incidents could have identified that safe processes were not being followed and ensure staff were made aware of expectations.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. 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
● Records showed us that staff were not safely recruited. Records showed three staff were working without references being received from a previous employer. Two staff had begun work before police had confirmed their safety to work in a DBS check . Therefore, the provider had not assured themselves that the staff were of good character and safe to work with people

The unsafe recruitment of staff is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Records showed that staff often arrived late to support people and this lateness had worsened each month. There were 63 late calls in September, 146 late calls in October, and 239 late calls in November 2019. People at the service required timely care calls to support them to complete daily routines safely.
● People reported concerns about the timeliness of calls. A relative described that a person's calls were regularly over an hour late. This resulted in the person attempting to manage their personal care unsafely. Another person said, "Sometimes they haven't shown up. If you don't come. How do you know I'm not behind a door and fallen over? It is worrying."

Systems and processes to safeguard people from the risk of abuse
● There had been ineffective action to resolve the theme of late calls. This had put people at prolonged risk of harm. Records showed a relative had supported someone when staff were running late, the person then fell and required paramedic attendance. There was no evidence of investigation to prevent this re-occurring.

● There was a lack of auditing and oversight at the service. Staff were required to document what had occurred during care visits. However, there was limited auditing of these notes. This meant themes like missed medicines were not highlighted and potential neglect was not highlighted.
● The service had received an allegation of abuse, staff had responded appropriately by contacting the local authority and police.
● People told us that staff made them feel safe. They did not feel at risk of abuse while using the service.

Preventing and controlling infection
● People told us that staff followed infection control procedures when visiting (like washing their hands and wearing gloves).
● We observed safe infection control procedures when we visited people. Staff told us that they were provided with enough personal protective equipment.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

At our last inspection the provider had failed to gather consent from people in line with the Mental Capacity act. This was a breach of regulation 11 (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.

- People's ability to make decisions had not always been assessed, this risks staff not supporting them in their best interests. For example, records described a person's home as 'cluttered' and explained that the person did not like others to clean their home. However, records guided staff to 'clean discreetly'. This guidance was against the person's wishes and their ability to make decisions about cleaning their home had not been assessed.
- When speaking with staff, it was clear that decisions were often made with family members, without assessing the person's ability to make their own decision. Records showed that family had signed consent for care and treatment on behalf of people. Therefore, people were not always involved with decision making.
- Two people regularly declined support. Staff had continued to encourage them to accept support. There was no assessment of the people's ability to consent to care. Staff described how they would continue to prepare for care tasks, in order to encourage compliance (for example running a bath after the person had said "no", in order to encourage compliance). This decision to continue to provide care was not supported by best interest documentation.
- Staff did not have access to Mental Capacity Act documentation or company policies. We were not

provided with evidence that all staff had been trained in the mental capacity act. One staff member explained that they supported a person with confusion but did not understand the requirements of the MCA. The failure to ensure staff had access to guidance and skills, meant people's rights were not being respected.

People's ability to make decisions were not always assessed in line with the Mental Capacity Act. This is a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Care records were not kept up to date with people's needs. This put people at risk of receiving unsafe care. For example, a person's care plan guided staff to use a hoist. However, family and staff advised that the person was no longer safe to use a hoist and the person must remain in bed. The professional advice was not recorded for staff, which put the person at risk of being supported unsafely.

● The National Institute of Clinical Excellence (NICE) provides guidance on how care agencies should support people. This guidance had not always been followed to meet national expected standards. For example, NICE guidance states that a record of people's care should be kept in people's homes. This was not happening, as all records were electronic. This is an ongoing concern from the previous inspection, and we have continued to receive concerns from the ambulance service that this lack of paper documentation has impacted on the provision of emergency care.

● NICE guidance also guides staff to follow the care agencies policies. We identified that office staff did not have access to policies, despite these staff answering care staff's telephone queries. This can impact on the safety of advice given by office staff and result in staff not following expected standards.

Staff support: induction, training, skills and experience

● We were not assured that staff had the required knowledge to complete their roles effectively. One staff member was unsure who they could report concerns about abuse too. Another staff member was responsible for updating care plans, but lacked knowledge on what level of information was required.

● Staff told us that they were provided with an induction, in order to learn about expectations of their role. Staff reported that this was helpful.

● Training records were not kept up to date, so we could not be assured that staff had received training as required.

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

● Professional therapist advice was not always documented for staff to follow. For example, a person was recommended to sit up to eat and drink, two people were prescribed thickener to reduce the risk of choking. These needs were not documented for staff to follow. This risks people not being given effective support to eat and drink.

● People told us that staff offered to prepare food/drink of their choosing. We observed people being given a choice by staff.

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

● Professionals were not always contacted when people's needs changed. For example, staff reported that a person experienced self-harm and suicidal ideation. However, no referrals had been made to mental health professionals when this person made these comments. This puts the person at risk of harm from untreated mental ill health.

● Where professionals had been contacted, their advice was not always documented on care plans. This

risked staff not being aware of and following professional guidance. For example, two people's equipment had changed in order to mobilise safely. This professional advice had not been documented for staff to follow. This meant the person may be supported to move with unsafe equipment.

● We were made aware that one person had recently been discharged from hospital with deteriorating health. There had been no re-assessment of their need before arriving home, and their care plan was not up to date. They had a deteriorating health condition, but staff were not provided with guidance on how to manage this. We were also not assured that all staff had been trained to support this health condition. This poorly managed hospital discharge put this person at risk of not receiving effective care.

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 had 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

- Staff did not always arrive on time. People told us that this poor punctuality caused anxiety. One person said, "When they come, they are quite caring. But leaving me to worry about them coming is not very caring."
- People told us that when staff visited, they were kind to them. Our observations were generally positive, but we observed one poor interaction. A staff member asked, "Would you like to go to work?" Then laughed and said "[Person] wants to go to work." This person was confused and unable to leave their bed. These comments were uncaring as they could cause further confusion.
- We heard uncaring comments about people while we were in the office. For example, staff laughed about a person's poor mental health and described a suicide attempt as a 'tantrum.'

Staff confirmed there was no mental health care plan, to guide them on how to respond when this person was distressed. We did not see evidence that staff had received mental health training. This increased the risk of staff not responding in a compassionate way.

Respecting and promoting people's privacy, dignity and independence

- During the office visit, we observed one person being given a nickname according to their surname. For example, "Mr Bloggs" would be referred to as "Bloggy." The new manager agreed that this was undignified and was observed to correct staff while we were present.
- Records showed us that a person's personal information was documented in their partner's care records. This is a poor management of data protection and privacy.
- We observed people being treated with dignity during care calls. This included asking permission to start care tasks, and shutting doors to ensure personal care was supported in a private way.

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

- People and relatives told us that they felt involved with planning their care, and that care staff knew how they liked to be cared for. However, people's involvement with care planning was not always documented. This risks their decisions not been recorded and followed by new staff.
- We observed staff offer people choice during care visits. For example, whether they would like a fresh drink making or to if the person would prefer to continue drinking their current drink.

Inadequate

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 deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care staff did not arrive at the expected time to meet people's needs and preferences. One person explained that care had been arranged to support them while they had an injury. However, carers arrived late so they completed care tasks alone. This meant their needs were not met.
- Care was not always delivered to meet people's individual needs. Time sensitive medicine were often given late, staff had not ensured medicines were always in stock, professional advice was not always sought when needed.
- People's personal needs were not always recorded in their care plan and therefore care may not be delivered in line with their preferences. For example, daily records showed a person became agitated if spoken to when eating. The information was not in the person's care plan. This meant staff were not guided to prevent agitation and upset occurring again. The new manager agreed that this level of information should have been in the care plan to prevent this occurring in the first place.
- People were not always provided with a preferred gender carer. One relative said, "We would prefer a male carer, but [person] hasn't been asked." A relative had requested male carers, but staff confirmed that the person themselves had not been asked. This puts the person at risk of receiving care from a staff member that is not of their preferred gender.
- We identified that care records did not always explain people's communication needs. For example, one person had impaired eyesight. However, there was no detail of how written information should be provided to them. Two people experienced confusion, but information had not been gathered on how best to communicate information to them.
- People's end of life care needs were not always assessed. We reviewed two care files of people who had passed away. These people had complex needs including a pressure wound and anticipatory medicine. However, staff were not provided with guidance on how to support these needs.
- During the inspection, a person left hospital with an end of life prognosis due to a deteriorating health condition. The provider had not re-assessed the person's needs before they arrived home. This meant the person arrived home with substantially different care needs, to the guidance staff were provided with. This put the person at risk of ineffective care.

We found care was not always delivered appropriately to meet people's 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.

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.

● Records were not currently up to date with people's communication needs. This risks their needs not being met
● The new manager was aware of the AIS and the requirement. They advised that if people required information in a way they could understand (for example, larger font). Then this would be provided. They intended to improve the personalisation of care records, so staff would be better guided on how to communicate with people.

Improving care quality in response to complaints or concerns
● Complaints were not always documented to improve care. We heard a phone call complaint about the quality of staff cooking. The office staff responded "What do you want me to do? Teach them to cook too?" The staff member told us that they would not record the complaint because the person "calls every day anyway." The staff member's response to this complaint was not respectful and dismissed the person's concerns. The failure to log this complaint meant that a theme of poor staff cooking skills would not be highlighted.
● Staff gathered people's feedback on the phone. Records showed multiple complaints about staff punctuality. This was an ongoing concern from the last inspection. The provider has not responded to people's complaints to ensure this was resolved.
● There was no formal review of complaint themes. This meant potential themes would not be recognised.
● People told us that other than poor timeliness, they had not had reason to complain about the service.

We found complaints were not responded to appropriately. This was a breach of regulation 16 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection, shortfalls in the quality of leader ship had resulted in unsafe care. 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.

● There was a lack of auditing and oversight to improve the service. The registered manager had left the service a month before our inspection. A staff member advised "Nothing has been audited since [registered manager] left and we aren't sure what they audited." The provider had not overseen the registered manager's improvement plan and had not restarted audits after the registered manager left. We found improvements had not been made from the last inspection.
● While staff were now recording punctuality, there had been ineffective action to make improvements. The timeliness of care calls had worsened on a monthly basis. People reported this causing them anxiety and resulted in them completing tasks themselves unsafely. One person said "I wish I didn't have to have them. They make me worry when I have to wait."
● We had ongoing concerns about the quality of care plans. These records documented incorrect timing of medicines, incorrect equipment and missing guidance from health professionals. Staff were not guided on how to safely care for people. There was no formal auditing of care plans to ensure they were up to date. A staff member responsible for updating care plans was unaware of the information required to improve them.
● Incidents and medicines were not formally audited to ensure that improvements were made. Records showed us that incidents were not responded to safely and medicines were not always given as prescribed. A lack of oversight meant these concerns had not been highlighted and resolved. People had continued to receive poor quality care due to ineffective oversight.
● We were not provided with policies related to the running of the service. Care staff also did not have access to policies. The new manager told us that they were attempting to make policies more accessible. Not having access to policy guidance, risks staff not following safe processes.
●The provider did not keep an up to date record of what training staff had completed. This meant they could not assure themselves that staff were well trained. We requested an updated summary of staff training was sent to us, we identified that this document was still not up to date as it did not include training certificates that we had observed during inspection.

● There was no registered manager in place. It is a legal requirement for a service to have a registered manager, as they and the provider are legally responsible for the safety of the service. The provider had failed to create improvements in the absence of a registered manager.

There was a lack of governance at the service. This meant people had continued to receive poor quality care and expected improvements had not occurred. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and staff reported that since the new manager had arrived (two weeks previously), they had noted some improvement in the quality of the service. This manager advised that they intended to become the registered manager for the service.
● The new manager had created their own action plan. This highlighted similar concerns to those identified during the inspection. We will assess the effectiveness of this at our next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We heard negative conversations in the office, including the new manager referring to a relative as "horrible" and a suicide attempt being described by staff as a "tantrum". This poor-quality culture is not open and inclusive.
● Complaints were not always recorded, where people had repeatedly complained about punctuality, no change had occurred. This was not empowering, and themes of complaints and incidents had not been analysed. This meant that poor quality care had not been resolved.

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
● Since our previous inspection, the management team had sent reassurances that the service has improved. We expect services to be open and transparent about whether improvements are being made. However, we found the service remains to be of the same poor quality and these assurances were not correct.
● Records showed poor quality practice. This included poor response to medicine errors and a late call resulting in a person falling and calling an ambulance. Due to records not being formally reviewed, the provider was unable to be open when things went wrong. This is because incidents were not always recognised.
● The provider had submitted statutory notifications as required. This is information about events occurring at the service, which the service is legally required to notify CQC about.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's feedback had been gathered and an annual survey had been gathered from the last inspection. There was no evidence that these themes had been analysed and addressed.
● The new manager advised that that they intended to meet all people using the service and gather face to face feedback. They had begun this process. There was currently a lack of documentation evidencing that people were involved with reviews.

Working in partnership with others
● The service had not worked with other professionals to improve care. At the last inspection, the ambulance service had expressed concern that there was limited documentation in people's properties to support emergency health care responses. We found this risk remained.

● Professional advice was not always documented for staff to follow. For example, staff were unaware of the level of a person's pressure damage or what setting a specialised mattress should be set at. This lack of documentation put the person at risk of not receiving suitable pressure care and a worsening skin condition.

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 11 HSCA RA Regulations 2014 Need for consent People's ability to make decisions were not always assessed in line with the Mental Capacity Act. This risked people's human rights not being respected

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not respond to complaints in order to improve the service

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 9 HSCA RA Regulations 2014 Person-centred care Care was not always delivered appropriately to meet people's needs and preferences.

The enforcement action we took:

We made a proposal to cancel this provider's registration. No appeals were made. The provider has since stopped supporting people

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service has been rated inadequate for a second time. The provider has failed to resolve concerns at the service. Ineffective governance has continued to place people at risk of harm

The enforcement action we took:

We made a proposal to cancel this provider's registration. No appeals were made. The provider has since stopped supporting people

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not complete safe recruitment checks to ensure staff were safe to support people.

The enforcement action we took:

We made a proposal to cancel this provider's registration. No appeals were made. The provider has since stopped supporting people