

Teonfa Limited

Teonfa Ltd

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?	Requires Improvement ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Teonfa Ltd is a domiciliary care agency providing care to 99 people in their own homes. The service supports people with various physical and mental health needs as well as autistic people and people with a learning disability. At the time of the inspection the service was supporting 97 people with personal care.

People's experience of using this service and what we found

Right Support:

People experienced risk of harm because risks were not assessed and staff did not recognise abuse or when people's rights were not being upheld. Staff did not always ensure that people's environments were safe and clean.

Risks in relation to moving and handling, medicines, fire, infection prevention and control (IPC), catheter care and self-harm had not been explored. Risk assessments were often missing altogether offering no guidance for staff about how to support people safely in these areas.

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 supported this practice.

Staff did not recognise situations where people needed support to assess if they had the mental capacity to make their own decisions and how they could be supported with those decisions in ways that were in their best interest. This led to cases of self-neglect, fire hazard and unlawful medicine administration going unreported.

People's wishes for the support they would like in the event of becoming ill or at the end of their life had not always been discussed or recorded. This meant there was a risk people's wishes and rights in relation to care and treatment would not be known or upheld in the event of a medical emergency.

People chose to live in their own homes and could choose who they lived with. Where people consented, their relatives and friends were involved in planning and agreeing their care but were not supported to review the care. Staff did not always support people to access local health services where required

Right Care:

The service did not have enough suitably trained and skilled staff to meet people's needs and keep people safe. Staff did not understand how to protect people from poor care or abuse. Safeguarding concerns were not always escalated to the registered manager or reported to the relevant authorities. Staff received training on safeguarding and abuse awareness but not all staff understood this training and did not apply any learning to their practice.

People were not all provided with culturally appropriate care in consideration with their wishes. Some people felt their preferences and needs were not always understood by staff where English was not their first language. Other people requested female only staff and were unable to have this resulting in some personal care not being given as per their care plan due to embarrassment.

Care was not always person centred and co-ordinated. Information in people's care plans did not reflect their full range of needs or promote their well-being and enjoyment of life. . Guidance for staff was sometimes contradictory or missing and did not therefore enable personalised and accurate support.

People's experiences of the care provided varied. Some people felt staff treated them well and with care and kindness. Most people told us staff did not talk to them or promote their independence.

Care was not always being delivered at the right times although most people told us this was improving.

Right Culture:

People were supported by staff who did not understand best practice in relation to the wide range of strengths, impairments or sensitivities people may have. This meant people did not always receive compassionate and empowering care that was tailored to their needs.

Staff did not evaluate the quality of support of support provided to people, involving the person, their relatives and other professionals. Systems in place to monitor the quality of care such as audits and competency assessments of staff, were carried out by staff who were not qualified to do so. The registered manager did not conduct any audits and analysis of quality themselves. This meant the quality of care people received was not sufficiently monitored and areas of concern not always identified.

People did not feel that staff were always competent and well trained. Staff training provided was not sufficient to ensure staff fully understood the needs of the people they were supporting, especially in relation to specific conditions such as dementia or autism. This meant staff were not able to provide the right support to people to meet their needs.

Most people felt able to complain to the staff or managers but some people did not feel comfortable and would complain externally or not at all.

The service promoted people's rights and person centred care in their policies. However, this was not always practiced. People's quality of life was not enhanced by the service's culture because the behaviours of the management and staff did not respect or recognise people's rights to choose. Staff did not ensure risks of a closed culture were minimised. People did not receive support based on transparency, respect and inclusivity.

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 12 January 2021). The provider

completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about the quality of care provided, care visit times and staffing. A decision was made for us to inspect and examine those risks.

This inspection was also carried out to follow up on action we told the provider to take at the last inspection. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We have identified breaches in relation to medicines, managing risks, safe care, staffing, staff training, quality assurance processes, consent to care and inaccurate records at this inspection.

We have served a warning notice against both the registered manager and the provider for each of the 7 breaches of regulation found at this inspection. We expect the provider to make the required improvements to ensure they are fully compliant with the regulations.

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

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

Special Measures:

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not 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 ●

Teonfa Ltd

Detailed findings

Background to this inspection

The inspection

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

Inspection team

This inspection was carried out by six inspectors, one inspection manager and an Expert by Experience. 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.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 7 December 2022 and ended on 28 December 2022. We visited the location's office/service on 7 and 13 December 2022. We visited people in their homes on 7, 8, 12 and 19 December 2022. We held meetings with the registered manager via remote technology on 12, 19 and 28 December 2022.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection

We spoke with 11 people and 17 of their relatives. This included speaking to 7 people in their own homes. In addition to this we observed staff practice in their own homes for 2 people who were unable to easily communicate with us.

We spoke with 17 members of staff including 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 spoke with 3 professionals.

We reviewed 16 people's care records including medicines records. We reviewed 4 staff recruitment and induction records and a variety of other admin documents, audits and policies.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to safely manage risk to people. Systems to keep people safe such as staff guidance about people's care and medicines were not robust enough. This placed people at risk of harm. 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

Assessing risk, safety monitoring and management; Using medicines safely

- The provider had failed to improve in the area of risk management and safe administration of medicines since the last inspection. Concerns previously identified in this area over the previous two inspections had not been addressed by the provider and continues to place people at risk of harm.
- People had not had risks assessed or regularly reviewed in areas such as medicines, pressure care, moving and handling, choking, falls, fire safety, self-harm and infection prevention and control. For example, one person who liked to store combustible material in piles throughout their home and who smoked cigarettes had not been supported to review the fire hazards and access support to understand the risks to their wellbeing. This put the person at risk of harm.
- Risk assessments we were told by staff had been completed, had not been. During the inspection staff presented one person's falls risk assessment as another person's. Staff later confirmed the person who was at risk of falls, did not have any risk assessments in place. Subsequently, the person's risk of falls was not being monitored and staff were not aware of how keep the person safe in relation to falls.
- A second person's care plan stated they were a high risk for death by suicide but these risks had not been explored and there was no further information in their file.
- Another person who was at risk of choking had no risk assessment about how to keep them safe when supporting them to eat and drink. This person had also not been referred to the relevant health professionals for swallowing assessments and advice. Staff had not recognised this as a risk and had failed to escalate the concerns to the registered manager or senior staff.
- People told us staff training could be better in relation to moving and handling. People told us not all staff knew what to do and had to be told by other staff how to use equipment. Staff had no clear guidance in relation to manual handling in people's care files except for one person. When inspectors asked, staff were unable to locate a risk assessment either in paper files or electronically for one person who required support using a hoist. This meant people were at risk of being harmed while supported by staff who were not suitably skilled and knowledgeable to safely meet their needs,
- Medicines were not managed safely. Staff told us they were crushing and administering medicines

covertly without professional's agreement to determine if this was safe to do. The modification of medicines without consultation and agreement could have resulted in harm to the person.

- People did not have protocols in place for medicines given as and when needed (PRN). Provider checks of staff practice in relation for medicines were conducted remotely by admin staff based only on electronic records rather than observing practice and checking medicine stocks and storage in person. The reviews did not therefore identify the concerns found by inspectors.
- Staff had received training in medicines administration. However, staff did not have a good understanding of the medicine they were administering or what protocols needed to be in place. They did not know what controlled drugs were or what it meant to administer medicines covertly. This placed people at risk of harm because they were given medicines by staff members who did not understand the risks.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Medicines were not managed or monitored safely and required assessments and protocols not in place. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The provider had given staff training in infection prevention and control, however failed to ensure staff responded effectively to risks and signs of infection. One person's home presented a high risk for the spread of infection. The person told us that staff did not clean as per their care plan. They said, "[Staff] should clean weekly, but there is dust everywhere." Staff told us they were prevented from cleaning but they had not sought support.
- The registered manager failed to ensure Personal Protective Equipment (PPE), such as gloves and face masks were used effectively and safely. The registered manager and staff were not aware of the current government guidance in relation to the use of PPE and the prevention of spreading infections such as COVID-19. Inspectors observed that some staff wore face masks and other staff did not or wore them incorrectly. This put people at risk of harm.
- The provider had an infection prevention and control policy. This did not have up to date guidance. In addition, the registered manager failed to ensure staff adhered to this policy. For example, the guidance in the policy stated risk assessments should be carried out for infection prevention and control and staff report concerns. We found this was not being done.

Systems had not been established to assess, monitor and mitigate risks to infection prevention and control. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse,

- The provider did not have effective safeguarding systems in place. Staff had failed on two occasions to recognise safeguarding concerns related to fire risks, depriving a person of their rights and medicines. They failed to submit the required notifications to CQC or the local authority safeguarding team.
- Staff failed to demonstrate an understanding of most forms of abuse or how to report concerns external to the provider such as to CQC or the local authority safeguarding teams.
- The provider had not identified any of the above safeguarding concerns or the staff team's lack of understanding of their responsibilities and therefore had not taken action to ensure people were protected.

The provider had not ensured systems were effective in preventing and protecting people from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings during this inspection, most people and relatives told us that they felt safe.

Staffing and recruitment

- The provider failed to ensure they were employing staff who had the right skills to do the role. Pre-employment checks such as disclosure and barring checks were inconsistent, and records showed numerous discrepancies in all staff files reviewed. For example, one person started their employment without a Disclosure and Barring Service (DBS) check. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Staff references had not all been verified or explored where there were discrepancies. Gaps in staff employment had not been explored and recorded.
- Recruitment procedures were not effective in assuring the provider of the staff members good character and conduct necessary for them to safely perform their role.
- The registered manager told us the staff member who had been delegated the responsibility for recruitment had left the organisation and therefore as a result, there was currently no-one monitoring recruitment procedures.

The provider had not ensured recruitment systems were operated effectively to ensure staff were fit and proper to carry out their role. This placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our last inspection care visit times were inconsistent resulting in late and missed care visits. At this inspection not enough improvement had been made in this area. One person told us, "The arrangement was for [Staff] to come in at 9am. They don't come till 10 or 10.30am. In the evening they were supposed to put me to bed at 9pm, but yesterday it was 8pm. We have complained about this, but they take no notice."
- Analysis of Teonfa's data for care visit times showed 37% of care visits were over 15 minutes late, 19% of which were over 45 minutes late, with one care visit being over one hour and 20 minutes late. Staff told us the person preferred the later time, but this had not been updated in the schedule or care plan. A relative told us, "I've had to raise this issue with the Council and asked them to monitor the timings. It has improved."
- The registered manager had not identified these concerns when reviewing care visit outcomes. Therefore, there was still further improvements to be made in this area to ensure there were sufficient numbers of staff who were deployed in ways that ensured care visit times were consistent and people's needs met.

The provider had not ensured staff were deployed in ways that ensured care visits occurred as scheduled. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- The registered manager failed to share lessons learnt effectively in meaningful ways when incidents occurred. For example, lessons learnt focused more on telling staff what they should or should not do but not enabling reflection on what went wrong and how to improve this in similar situations.
- Staff confirmed to us they were not supported to reflect or discuss when things went wrong. Staff did not understand how to reflect on their experiences at work to improve their practice.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People did not feel that all staff were trained well or competent in their roles. One person said, "Some of the [staff] are not well trained and need to be told a lot by the other [staff] what to do."
- Staff training and induction was ineffective. The training programme set out meant staff had to cover 11 subjects within one day. This did not give sufficient time to support staff, some of whom were new to care, to learn and understand how to perform their role safely and effectively. This was evident when speaking with staff as they did not have knowledge of recognising abuse, the Mental Capacity Act 2005, people's conditions and end of life training. Some staff told us they could not remember if they had training or not in some subjects.
- Staff did not have a good understanding of the conditions people were diagnosed with and how best to support them. Staff did not understand what it meant to be autistic. Another staff member who supported a person with catheter care did not know to look out for early signs of infection and what this might look like. Other staff were unaware of how dementia might impact a person's daily living.
- In July 2022, The Health and Care Act 2022 introduced a requirement that where providers support people with learning disability and autism their staff must receive training on learning disabilities and autism that is appropriate to their role. Although Teonfa support autistic people and people with a learning disability, they had not provided training about autism to their staff. Staff had received e-learning training on learning disabilities but were unable to demonstrate an understanding of this.
- Staff had also not heard of the CQC policy on Right support, right care, right culture or the principles within it. This policy is statutory guidance about how CQC regulate providers supporting people with a learning disability and autistic people. This is guidance the provider must ensure the staff team are aware of and implementing. This meant staff were supporting people without training or an understanding about people's needs. One person told us "Staff do not understand what to do and this makes me irritated." The registered manager told us they planned on providing this training in January 2023 but did not yet have a date booked.
- Staff who required it, had not been supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. The registered manager and the nominated individual told us this was now being rolled out to all staff.
- Most staff told us they felt supported by the registered manager but we found supervisions were not always effective. For example, supervision notes and other staff records did not demonstrate how staff had been supported to develop in their roles. There was no evidence of competency assessments. Supervision

notes contained identical wording across different staff and different supervisors. This demonstrated a standardised approach that failed to support staff as individuals in a meaningful way.

The provider had not ensured staff were supported to have the right skills, knowledge and understanding to perform their roles. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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.

- Staff did not understand the principles of the MCA or recognise restrictive practices. Staff had consequently failed to escalate concerns about restrictive practices. For example, when people's medicines were locked away so the person could not access them or when medicines were administered to people that were hidden in food without their knowledge or consent.
- Administering medicines in this way without the person's knowledge took away their right to refuse medicines. There was no evidence of assessment of the person's mental capacity to understand this had been completed. The provider had not consulted with relevant professional to make the appropriate referrals to the Court of Protection to approve a DoLS for this practice.
- Some people had signed documents to show they did understand their care plan and consented to it. However, other people had no evidence that consent to provide care had been sought and one person's consent form had been signed by a staff member.

The provider failed to have effective systems in place to ensure staff practice followed the principles of the MCA. People had experienced unlawful restrictions. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager had not ensured that people's needs were always assessed and recorded prior to providing care. In some people's care records there was only evidence of the local authority or hospital care needs assessment. The information from the local authority had been used to develop their care plan.
- People told us they had a chat with the provider about their care at the start but there was no evidence of what had been discussed, if risks to the person had been explored or what their current care needs were. There was no evidence of the provider identifying what changes might be needed from the local authority assessment when supporting people in their own home.
- Some people's care records showed inaccurate and contradictory information. This meant people might not have their needs effectively met in a way of their choosing.

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

- People gave mixed views about the level of support they got when accessing healthcare. Where people were able to request health care involvement staff supported this, however where people were unable to, staff did not have the knowledge or skills to identify peoples deteriorating health which resulted in people being put at risk.

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

- We had received concerns in relation to staff not understanding how to prepare meals for people. However, we did not find evidence of this.

- Not all people being supported by staff required support with eating and drinking. Where they did, people told us they had no concerns in this area. However, we identified risks of choking for one person that had not been identified by the provider or made safe.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Feedback from people about how well they were treated was mixed. Some people felt most staff were friendly and caring but they were not supported by staff who understood their individual needs. For example, a person told us, "[Staff] are kind and caring. Very good staff." A relative said, "Some of [the staff] want to come in, do the minimum, and get out. They have no compassion."
- Other people said they felt rushed. Most people said staff did not talk to them while providing care. One person told us, "[Staff] take a long time coming in and shutting the door. They never say hello." A relative said, "[Staff] are not very warm or talkative. Task oriented I would say."
- Some people felt their preferences and needs were not always understood by staff where English was not their first language.

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

- People told us they had discussions about their care when Teonfa Ltd first began to provide support but did not recall ever having been involved in reviewing their care since then. One person said, "We did have a discussion when [staff] first started, but I don't know about the care plan." A relative told us, "We met at the beginning, but there hasn't been a review as yet."
- There was some evidence of care reviews in people's files. However, these records did not show evidence of people having been involved in reviews of their care. They did not always record the names of people or any comments they might have made when sharing their views.

Respecting and promoting people's privacy, dignity and independence

- People told us they mostly felt respected by staff. However, some people said that staff spoke over them and did not give them the time or opportunity to do things for themselves.
- People told us they had requested a specific gender of staff as they were embarrassed receiving personal care. They told us they were not able to have this so have "had to get used to" other genders of staff coming in to support them.
- Some people told us staff walked around on their telephones speaking to other people rather than to them. One person said the staff they hadn't met before just walked straight into their room which upset them seeing two strangers suddenly in their home.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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

- People's care was not always personalised. Care plans were found to contain contradictory information about the level of care people required and were often very brief. This meant guidance for staff was not always clear about how to support people's preferences.
- During the inspection staff presented one person's care plan which contained information from another person's care plan. This information was incorrect and where likes and dislikes had been identified information could not be relied upon as accurate. This could have resulted in the wrong care and treatment being offered to that person.
- People's choices in relation to care visit times, gender of staff and life choices were not always respected nor concerns recognised. One person told us, "I don't think [staff] know my likes and dislikes that well." A relative told us, "[Teonfa Ltd] send different [staff members]. [My family member] doesn't like change." Another relative told us, "I don't think enough of [the staff] have an understanding of dementia to handle situations fully."
- One person's care plan said they had macular degeneration and the file contained general information on the condition. However, there was no guidance for staff about how this impacted the person and at what stage of degeneration they were currently.
- There were no people being supported with end of life care currently. The service had previously supported people at the end of their life and staff had received training on palliative care. Care records did not always evidence people wishes for illness and end of life.
- Staff could not all remember having training on palliative care and were unclear on differences in care to be aware of when supporting a person at the end of their life.

The provider failed to ensure sufficient guidance for staff to ensure people's care needs could be met in away that reflected their preferences and respected choice. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- There was a complaints policy and procedure in place. Most people knew how to complain and would do so if required. However, some people felt they could not go to the provider to complain due to concerns about the response and would instead speak to a social worker. One person said, "It is difficult to contact the office to make a complaint."
- There was some evidence of identifying lessons learnt from the complaints, but they focused more on identifying what to tell staff in relation to what went wrong rather than how they would improve systems, training and staff development. There was no evidence of how the provider had analysed the information in

the complaints to improve practices and procedures.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People did not currently have specific communication needs. Each person was asked to complete an assessment of their communication needs to let the staff know what their preferred language and format of communication was. Staff understood that some people might need information in different languages or formats.

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's current care needs did not include the provider supporting them with social interests.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

At our last inspection we found systems were either not in place or not robust enough to demonstrate quality and staff competence was effectively monitored and managed. This placed people at risk of harm. 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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The registered manager and care staff were not aware of the current requirements, best practice and mandatory guidance in relation to their roles. This meant they were not implementing these standards and not meeting the requirements. The registered manager did not have the skills and knowledge to perform their role and have a clear oversight of the service.
- The provider had not succeeded in achieving a rating of good in the key question of well-led since they were registered with CQC. Across seven inspections, the provider had only been able to achieve an overall rating of good once and had consistently been non-compliant with the requirements of the regulations. This demonstrated the provider had not been able to implement lessons learnt and maintain improvements to the quality of care and systems at the service.
- Governance processes were ineffective and did not help to hold staff to account, keep people safe, protect people's rights or provide good quality care and support. There was no quality assurance framework in place that would enable the provider to measure the quality of care accurately. The registered manager and nominated individual did not conduct any audits or assessment. Subsequently they were not aware of many of the concerns identified in the inspection. Those concerns included significant shortfalls in staff knowledge and practice, unsafe medicines management and lack of appropriate responses to safeguarding concerns.
- During the inspection the registered manager was unable to locate, and access requested records in the providers computer systems without support from office staff. This suggested they were not familiar with the systems and where records were stored making it difficult for them to check quality themselves.
- Staff were delegated the task of conducting audits and competency checks without being supported to develop the necessary skills to do so. Information collated in audits conducted by office staff did not

support the improvement of the service as the information was not able to be analysed in a way that provided meaningful feedback.

- Records had shown staff being asked about their knowledge in relation to medicine administration and safeguarding. There was no record of following up with the staff member to offer guidance when their answer had not been correct. There were no action plans for staff as to how they would improve their knowledge or skills.
- Data supplied to CQC by the provider in relation to care visit times showed incomplete data, continued issues with late care visits and staff logging in at more than one person's home at a time. We shared this with the provider who told us this was due to an admin error in the system creating false 'actual in and out' times. However, this meant data used to show if staff had arrived for a care visit and at what time, could be falsely created by the software system and could not be relied upon as accurate.
- The provider was currently using three different systems for records while transitioning from a paper based system to electronic records only. Some people still had paper records but there was also a combination of two other software systems used (one live and one dormant).
- We spoke to the registered manager about our concerns in relation to multiple systems and asked to see how they had assessed the risks in relation to the transition to electronic records. The provider confirmed they had not assessed the risk and had no transition plan in place.
- The provider did not ensure staff had the skills to access the electronic care system. We found staff were unable to demonstrate how to access risk assessments electronically. We also found differences in the detail and quality of people's records both in the office paper and computer files and in people's homes. Some people had full records, but most people had missing care plans, missing risk assessments, inaccurate records and missing medicine records. Some people had no care plans or records at all in their homes. This meant that guidance for staff was inconsistent and confusing.
- The provider did not keep up with national policy to inform improvements to the service. There was no evidence of staff receiving meaningful support to encourage continual learning and self-reflection. Staff were not being supported to develop their skills and take time to reflect on their practice and understanding when things have not gone well.

Systems were either not in place or not robust enough to demonstrate quality was being monitored and assessed. Staff competence was not being effectively monitored and managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager did not promote a positive and personalised culture. They did not ensure that staff understood how to meet people's needs in ways they preferred. They did not ensure times of care visits were consistent or that people's wishes were respected.
- Not all people felt safe to speak up and report concerns to the provider. One person said, "I think I would go directly to the social worker."
- The provider did not ensure risks to people had been explored with them and people were not given the opportunity to access specialist external professional support where required.
- Staff did not understand the importance of personalised care and promoting the principles of the Right support, right care, right culture policy or valuing people. One person told us, "I feel safe but [staff] do not understand me." Another person said, "There is no chit chat, [staff] only want to know what they need to know."

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

- There was evidence of people's views about the service being gathered. For example, the provider completed telephone surveys. However, the feedback from people and relatives was mixed and some people and relatives told us they were not regularly consulted about their views of the service. One person told us, "I was not involved in the care plan process. I cannot recall being sent any surveys or being involved in reviews."
- Most people and relatives told us they thought communication from office staff and management needed to be improved. People and relatives told us they were not communicated with on a regular basis. One person said, "Some of the [staff] are okay, but it's hard to explain things to some others in the office." A relative said, "Whenever I am speaking to someone at the office, someone [else] will butt in. You can hear someone in the office say, 'let me handle this.' I have called and asked for someone and been told they are not in and will call back, but don't."
- Most staff told us they felt supported by the registered manager but not engaged by them to help identify improvements to systems and practices.

Working in partnership with others

- There was evidence of working with the local authorities. However, feedback received from professionals was mixed in relation to the effectiveness of the provider to make improvements in areas such as care time visits, staff competency in relation to moving and handling techniques, effective record keeping, good governance and communication.

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 The provider failed to provide sufficient guidance for staff to ensure people's care needs could be met in a way that reflected their preferences and respected choice.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to have effective systems in place to ensure staff practice followed the principles of the MCA. People had experienced unlawful restrictions.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Medicines were not managed or monitored safely and required assessments and protocols not in place. Systems had not been established to assess, monitor and mitigate risks to infection prevention and control and safeguard people from abuse.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required

improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity

Personal care

Regulation

Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider had not ensured systems were effective in preventing and protecting people from abuse and improper treatment.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity

Personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

Systems were either not in place or not robust enough to demonstrate quality was being monitored and assessed. Staff competence was not being effectively monitored and managed.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity

Personal care

Regulation

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had not ensured recruitment systems were operated effectively to ensure staff were fit and proper to carry out their role.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.

Regulated activity

Personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured staff were supported to have the right skills, knowledge and understanding to perform their roles.

The provider had not ensured staff were deployed in ways that ensured care visits occurred as scheduled.

The enforcement action we took:

We have served a warning notice on the provider and registered manager to ask them to make the required improvements by 31 March 2023 and ensure compliance with the regulations.