Home from Home Care Services Limited

Home from Home Care Services Limited - 168 Burton Road Derby

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Home from Home Care Services Limited - 168 Burton Road Derby is a domiciliary care agency providing personal care. At the time of our inspection, 28 people were being supported by the agency.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not protected from the risk of harm due to inadequate safeguarding procedures and poor assessment and monitoring of risk. People were at risk of infection from poor infection control practice. People did not receive their medicines as prescribed. Staffing levels were inadequate to meet people's needs and staff were not always recruited safely. There was a failure to learn lessons following incidents and investigations.

People's care was not planned and reviewed in line with national guidance. Staff training was not effective and left people at risk of harm. People were not always supported appropriately with their nutrition and hydration. Staff did not work collaboratively with healthcare professionals to promote people's health and wellbeing.

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.

People's dignity was not respected, and they were not always treated with kindness and respect. People's independence not always supported, and they were not consistently involved in their care.

People were not supported to make complaints, and these were not always recorded and reviewed. Care was not planned in a person-centred way and people's interests, relationships, choice and control were not promoted. People's communication and end of life care needs were not understood or respected.

There was a lack of management and oversight by the registered manager and provider. The registered manager was not part of the day to day running of the service. There was a negative blame culture which did not have people at the heart of the service and there was a lack of transparency within the service. Engagement with people, the public and staff was minimal. There was poor cooperation with external stakeholders and healthcare professionals.

Following our inspection, due to the level of risk, the local authority made arrangements for people to received support from alternative care providers.

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 28 March 2019) and there were two multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified 11 breaches of regulations at this inspection. These relate to safeguarding people from abuse, safe care and treatment, safe employment of staff, staffing levels and training, governance and oversight of the service, action with complaints and a failure to provide person-centred care and respecting people's dignity

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 work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 six 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?

Inadequate

The service was not 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.

Home from Home Care Services Limited - 168 Burton Road Derby

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 houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not present during the inspection as they do not live in the area.

Notice of inspection
This inspection was unannounced. Inspection activity started on 25th February 2020 and ended on 26th February 2020. We visited the office location on both days.

What we did before inspection
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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with four members of staff including the office manager, office administrator and care workers.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures and governance documents were reviewed.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection we recommended the provider followed current guidance to ensure staff were kept updated with medication training in line with relevant guidance. The provider had not made improvements.

- People did not receive their medicines safely.
- Care records showed care calls were not completed in line with people's medicines prescriptions and timings. For example, one person was receiving their medicines less than two hours after their previous dose, despite a four-hour gap being required. This was happening because some of the care calls being completed earlier than planned.
- Care records showed one person had not received one of their medicines for a whole month, however this had not been identified and acted upon.
- Another person had not received their morning medicines on one occasion and there was no evidence action had been taken to ensure the person received their medicines at all that day.

The above issues meant people were at risk of potential harm from missed medicines or potential overdose.

Assessing risk, safety monitoring and management

- People were not protected from risks to their health and wellbeing.
- Risk to people's health and wellbeing were not assessed. For example, one person was identified as having swallowing difficulties causing a choking risk. Care records showed no risk assessment had been completed and no referrals had been made to healthcare professionals to mitigate the risk.
- One person had pressure ulcers, there were no skin integrity risk assessments or care plan to monitor and review the pressure ulcers. The person had recently developed more pressure ulcers, which may have been a result of poor management.
- We saw records described one person as having behaviours that may be considered challenging. There was no risk assessment or care plan in place on how to mitigate risks with this type of behaviour. The lack of support strategies had resulted in the person not receiving their medicines on one occasion.
- One person told us of an occasion where they felt "very scared" during a care call where poor manual handling techniques were used. There was also evidence of unsafe moving and handling techniques being used for this person, and this left the person and staff at risk of harm or injury.

Preventing and controlling infection

- People were not protected from the risk of infection due to poor infection control practice by staff.

● People and relatives told us staff had poor infection control practice. One person told us staff would wear gloves to support them with personal care and then wear the same gloves to prepare their meal. By not removing the soiled gloves or washing hands, staff were leaving the person at risk of infection.
● People and relatives told us staff did not always wear uniform or protective personal equipment, such as gloves and aprons. During our visit to the office location, we did not see evidence of provision of aprons for staff.
● We saw the office manager (who also provided care during our inspection), was not wearing a uniform and had long false nails which were dirty underneath.

Learning lessons when things go wrong
● People were not protected from future incidents, as the provider did not learn lessons when things went wrong.
● We saw incidents with medicines, safeguarding concerns and poor moving and handling techniques were not always reported or recorded by staff.
● Management staff were reviewing care records but had not identified concerns documented in them.
● No investigations took place for missed medicines or incidents of aggression. When investigations did take place, management staff told us there were no lessons to be learnt and blamed other factors for the incidents. This lack of investigation and blame culture meant no action was taken to minimise the chance of incidents occurring again.

This demonstrates a failure to provide safe care and treatment in relation to medicines, risk assessments, infection control and lessons learnt. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse.
● Records showed concerns were not always recognised by staff and managers did not respond to any concerns raised appropriately.
● For example, we read in one person's care records that the lock on their door was broken. There was no evidence this had been reported to management or investigated and acted upon to keep the person safe.
● In one person's care record, staff had noted there was bruising on the person's hand. There was no evidence to suggest this had been reported to management or investigated.
● A staff member told us about concerns they had regarding relatives of one person. When questioned, the staff member had not raised these concerns or referred them to the appropriate safeguarding authority for investigation.
● Recent safeguarding investigations and outcomes had not been reviewed to implement any recommendations to prevent the possibility of harm recurring.
● People did not receive a rota of staff who would be attending to them. They also told us how staff did not wear identification. This meant vulnerable people were letting potentially unknown people into their home.

Systems and processes were not in place to identify and investigate evidence of possible abuse, leaving people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we recommended the provider followed current guidance to ensure systems were in place to renew Disclosure and Barring Service (DBS) checks. The provider had not made improvements.
● Staff employed were not always employed in a safe manner.

● Office staff were unable to evidence any up to date DBS checks were in place for two members of staff who provided care to people.
● Conversations and reviews as to whether staff remained fit and proper did not occur. For example, one member of staff had not had a DBS review or conversation about issues which could cause concern since 2007. This meant people were receiving care from people who had not been assessed as continuing to be fit and proper for employment.

There were not sufficient processes in place to ensure all staff were of good character. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended the provider reviewed procedures for late calls and rotas to ensure the risk of missed visits or late calls were minimised. The provider had not made improvements.
● There were not enough staff to meet people's needs.
● We saw care records which identified staff were regularly not turning up on time to care calls and not staying for the required length of time.
● For example, one person's care records detailed how they received their morning call more than an hour early. The person felt this was too early to get out of bed and so care staff left them in bed. The person was at high risk of falls and were therefore at risk of falling if they were to get out of bed alone later in the morning.
● There was no system in place for tracking and monitoring staff to see if any calls were late or missed. Staff were reliant on people ringing the office staff to inform them if care calls were not completed, however some people were unable to use a phone. One person was discharged from hospital but their calls that evening were not completed. The person was found by a healthcare professional the next day to be "very emotionally low, exhausted and thirsty."
● There was no adequate business continuity plan and no emergency process to cover care calls if staff were off. This left people at risk of not receiving the care planned for them.

Sufficient numbers of staff were not deployed, leaving people at risk of not receiving their care in a safe and timely manner. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs and choices were not assessed and reviewed.
- We saw care records were not up to date with people's needs. For example, one person was now nursed in bed, but their care records still advised they be hoisted out of bed.
- We saw care records were not regularly reviewed and people were not included in any reviews.
- The National Institute of Clinical Excellence (NICE) provides guidance on how care should be planned, however this was not being followed as care records had incomplete or missing information regarding people's emotional, social, cultural and religious needs.
- Care records included no information on how people's protected characteristics would be met. Protected characteristics are the nine groups protected under the Equality Act 2010. They include, age, disability, gender reassignment, marriage and civil partnership, religion etc.

There was a failure to ensure planning was person-centred and reviewed regularly. This was a breach of regulation 9 (Person-centred care) 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- People's mental capacity was not adequately assessed or reviewed.
- Care records showed staff did not ensure people's capacity to make decisions was assessed in accordance with the MCA. For example, one person's capacity assessment was not decision-specific and was incomplete. Another person was not offered a choice with their meals by staff as the family chose meals for them.

● Staff did not understand their role in mental capacity. A management staff member told us, "We do not do capacity assessments as we are not qualified." The MCA states, 'the person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made.' This means anyone involved in people's care can assess capacity.
● A management staff member told us, "Most people can give you the basics, bigger decisions we go direct to the family." This meant people's choices and decisions were not known or respected.
● One person had support overnight and a staff member told us they were unable to stay up later than 11pm at night.

There was a failure to ensure care and treatment was provided with people's consent. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not have effective training to meet people's needs safely.
● One person told us, "I don't feel like the staff know what they are doing." A staff member told us, "The training is not good enough. If you were not from a care background, you would not know what to do with the training."
● Staff records showed us staff received paper-based training in a number of areas, however we saw no evidence of competency checks, other than for medicines, to ensure this training was effective.
● Medicines competency of staff was assessed by a member of staff who had not completed the medicines training themselves.
● Despite staff having completed training in behaviours that challenge, care records demonstrated staff had no knowledge of how to manage this.
● Staff had no practical face to face first aid training and there was no competency assessment for the paper-based first aid training, this left people who were identified as at risk of choking supported by staff who would lack the skills to handle an emergency situation.

There was a failure to ensure staff were adequately trained to meet people's needs. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were not respected and met safely.
● People were not involved in decisions about what they ate or drank. One person told us, "The staff do not ask me what I want to eat, they just cook what is in the fridge."
● People's specialist dietary needs, for example a modified diet due to choking risk, were not catered for. For example, one person was supposed to have a soft diet but was made sausage and mashed potato and other high-risk foods regularly.
● People and relatives told us how people were not supported to eat their meals. One relative told us how they found their relative with food in their hair and the food had not been eaten, despite staff being scheduled to stay with them at mealtimes.
● Another relative told us how staff often left food and drink out of reach for their relative. This meant the person was unable to access nutrition and hydration as they were too weak and unable to reach where food was placed.

There was a failure to ensure people's nutritional and hydration needs were met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Staff did not cooperate with other healthcare professionals to provide consistent and effective care.

● Information was not shared with other agencies to ensure people received appropriate care and treatment. For example, referrals were not made to specialist healthcare professionals when risks with choking were identified.

● A healthcare professional told us how staff at the service did not follow recommendations about a person's health needs and this had resulted in a deterioration in their health. They also told us how staff did not work or speak with them when monitoring and reviewing one person's pressure ulcers.

● During the inspection, one person was discharged from hospital, but the office staff did not ask for an update of the person's health needs to see if care needed to be reviewed.

There was a failure to actively work with health professionals to ensure treatment remained safe for people. This is further evidence of a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People's dignity was not respected, and independence not always supported.
- Staff were regularly attending bedtime calls early and this meant some people were being supported to bed as early as 6pm. They would often then not have another call until 8am the next morning, meaning they were left for a lengthy amount of time without support to get out of bed or access drinks.
- One person's care record said they were watched by staff when showering, but there was no reasoning as to why they needed to be observed.
- Opportunities for people to be more independent were not supported by staff. One person told us how they were scheduled to have a call where they would be supported to have a shower, however staff were not using equipment to enable independence and instead doing a strip wash with a flannel. The person told us, "I want a proper wash and have a stool to do so but it is ignored."
- Some relatives we spoke with told us some staff were kind and caring, however people were not always treated with kindness and respect. One person told us, "I pay for the service and don't think it is too much to expect people to be nice to me."
- We overheard staff speaking about people and staff in a derogatory fashion. For example, one staff member said, "Do not send [name], their breath stinks." Another person had been labelled as a "notorious complainer" and the staff member told us how "they are always moaning."
- We saw staff had left people's sensitive information out in the office and had not secured records in a way that met confidentiality standards and good practice.

People were not treated in a caring and compassionate way. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not supported to be involved in their care.
- Care records had no evidence people were involved in their care planning. Their likes and dislikes were not recorded.
- Some people told us they had asked for certain staff not to attend their care calls, but those members of staff were still allocated to support them. One person told us, "There is no consistency with staff that come. I asked for one not to come but they still do."
- There was no evidence to suggest advocacy support had been considered or signposted for people. This left people at risk of not having their choices and preferences respected.

There was a failure to ensure people were involved in their care planning. This was further evidence of a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to record and respond to complaints. This was a breach of regulation 16 (Receiving and acting on complaints) 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 16.

- People's complaints were not always recorded and reviewed.
- One person told us they had an ongoing complaint, but we saw no record of this in the complaints folder. The person's complaint was not acknowledged, and no action taken to resolve the issue. The office staff told us about these complaints and spoke about the person in an undignified way.
- We asked the office staff what action had been taken to meet the regulation for complaints and they told us, "We weren't doing outcomes and lessons learnt for complaints, but you can't always do this as there is not always a lesson to be learnt." This showed a lack of accountability with complaints.
- Complaints records showed some complaints were logged but there was no evidence action was taken to respond to or investigate concerns.

Systems and processes were not in place to investigate and respond to complaints. This was a continued breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care was not planned to promote choice and control.
- We saw care records were basic and not person-centred. There was no evidence people were involved in their care planning and office staff told us this was often done with the family and not the person.
- Care records were out of date and incomplete. Reviews were not done regularly. This meant there was a risk changes to people's care needs were not known or communicated.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were not understood.

● One person's care record stated they had a visual impairment but there was no evidence of how information was given to them in a way they could understand. There was no detail in the care records of how to meet additional needs from their sight loss.

● A member of staff showed us a case study for another person to highlight how they met the AIS. However, there was no reference to enabling the person to access information or communication. This showed a lack of understanding of the AIS.

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 interests and relationships were not supported by the provider.

● People told us staff did very little to engage with them at care calls. When asked if staff sit and chat with them, one person told us, "You are joking, they never sit and just speak with me." Another person told us, "If the staff finish a bit early, they just go, they don't sit and talk to me."

● Care records had no detail about people's hobbies and interests.

End of life care and support

● People's end of life care needs were not assessed and met by staff.

● We saw care records had no end of life care planning and people's wishes were not recorded.

● Staff told us one person had a terminal diagnosis but there was no reference to this in their care plan.

There was a failure to ensure people's care met their needs and reflected their preferences in relation to end of life care, AIS, hobbies and interests, communication and choice and control. This was further evidence of a breach of regulation 9 (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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider failed to have inadequate quality assurance systems in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was a lack of management and oversight by the registered manager who was also the provider.
● There were two members of office staff who were running the service, however they were unable to demonstrate that they had an understanding or knowledge of the fundamental standards of practice that the service is required to meet.
● Systems and processes for monitoring the quality of the service were ineffective and failed to identify risks to people's health and wellbeing. For example, medicine administration records were not all reviewed by the management team and this meant concerns were not identified.
● Despite care records being signed as reviewed, concerns around safeguarding had not been identified or acted on.
● Serious incidents were not investigated. The office manager had been shown video evidence of a staff member using a dangerous moving and handling technique. However, they had failed to investigate this incident and the staff member was continuing to provide care to people without their training being reviewed.
● There was a negative blame culture which did not have people at the heart of the service.
● We heard negative comments from the office staff about people and staff. For example, one person was described as "hard work".
● Management staff were defensive when asked about accidents and incidents and did not investigate or act on accident and incidents or safeguarding concerns.
● The registered manager was not part of the day to day running of the service. Office staff were unable to evidence the registered manager had visited or had input into the service since June 2019.
● There was an inaccurate statement of purpose leaving people at risk of being unaware of who leads the service and what the vision and values are. A statement of purpose explains what a provider does, where

they do it and who they do it for.

Insufficient systems and processes had not been established to ensure compliance with requirements. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● There was a lack of transparency within the service.
● Complaints and concerns raised were not responded to in an adequate manner.
● Staff did not notify CQC of significant events. For example, when people acquired a serious injury. This meant we could not check appropriate action had been taken to maintain people's safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Engagement with people, the public and staff was minimal.
● People and relatives told us they were often not receiving rotas to inform them of when their care calls would be and who would be attending. This had left people we spoke to anxious.
● Despite this being raised by people and relatives, management staff had dismissed these complaints and not rectified the situation.
● The office phone lines had not been working for some time and people, relatives and healthcare professionals told us the on-call number was often unanswered. One person told us, "Every-time I ring the on-call there is no answer." A relative told us, "There was an incident and we could not get hold of any of the staff for days." As this was the emergency phone line people were given in case calls were missed, this left people at risk of harm from missed care provision.
● Some people had been invited to give feedback via surveys, however there was a failure to take action to make improvements following the results.
● Staff were invited to staff meetings and had regular supervisions, however feedback and learning was limited with these.

There was a failure to seek and act on feedback from people, relatives and staff. This is further evidence of a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● There was poor cooperation with external stakeholders and healthcare professionals.
● A healthcare professional we spoke with told us how staff did not work with them to provide care to people and they were often unsuccessful with trying to contact the management team.

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 There was a failure to ensure care planning was person-centred and reviewed regularly.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated in a caring and compassionate way.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure care and treatment was provided with people's consent.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to provide safe care and treatment in relation to medicines, risk assessments, infection control and lessons learnt.

The enforcement action we took:

We took urgent action to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014

	Safeguarding service users from abuse and improper treatment Systems and processes were not in place to identify and investigate evidence of possible abuse, leaving people at risk of harm.

The enforcement action we took:

We took urgent action to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to ensure people's nutritional and hydration needs were met.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems and processes were not in place to investigate and respond to complaints.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Insufficient systems and processes had not been established to ensure compliance with requirements.

The enforcement action we took:

We took urgent action to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There were not sufficient processes in place to ensure all staff were of good character.

The enforcement action we took:

We took urgent action to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of staff were not deployed, leaving people at risk of not receiving their care in a safe and timely manner. There was a failure to ensure staff were adequately trained to meet people's needs.

The enforcement action we took:

We took urgent action to restrict admissions to the service.