Forever Homecare Limited

Forever Homecare

Inspection report

46-48 High Street
Burnham
Slough
Berkshire
SL1 7JP

Tel: 08002983301
Website: www.foreverhomecare.co.uk

Date of inspection visit:
25 January 2021

Date of publication:
02 March 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Forever Homecare is a service providing care and support to people in their own home. At the time of the inspection the service was supporting 47 people, and we were told everyone received support with personal care. The service provided both regular daily visits to people receiving personal care and at times provided some live-in staff members providing a 24-hour support service. The service supported people in Buckinghamshire and Berkshire.

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
Most people we spoke with provided negative feedback regarding their care, although there were some examples of mixed feedback and a smaller number of positive comments. One family member told us, "They are kind and respectful and treat her with dignity, they are lovely."

Many people raised concerns regarding the timing of visits. People did not receive a copy of their weekly care rota, meaning they were unsure who was coming or when they were due to arrive. One person commented, "There isn't a rota; it's a rush sometimes. The timings are not easy." Another family member added, "There is little consistency; the carers are always changing."

Some people complained staff arrived late and left early or missed visits. One family member told us, "Occasionally a carer wouldn't show up at all. Once they didn't turn up for three days." Another person told us, "They don't stay the right amount of time, they do go early."

Some people described examples of receiving poor care, such as items being left out of reach or their front door being left open. Feedback showed people were not receiving high quality person-centred care. One family member told us, "They don't give her any dignity. They tried to change her in the lounge until I told them not to." One person using the service told us, "They talk to each other in their own language. I ask them to speak English but they don't. When they do speak English I can understand them."

We found safe care and treatment was not provided. People were not safeguarded from abuse and risks to them, including infection control risks in relation to COVID-19. Safe medicine practices were not followed. Accident and incidents were not effectively managed and there was no evidence of learning from these incidents to prevent reoccurrence.

Safe recruitment practices were not followed. We found staff were not always supervised and trained in line with the provider's policy. Staff we spoke with reported they were able to contact the office, or an on-call person, to seek advice and support when needed.

The records and systems in the service did not support best practice on the application of the Mental Capacity Act 2005 to ensure people were supported to have maximum choice and control of their lives in the least restrictive way possible and in their best interests.

The service was not well managed or monitored. The service did not have a registered manager in place. The provider had failed to undertake effective oversight and supervision of the service manager who was responsible for key aspects of the service including safeguarding adults. At the time of our site visit, the service manager was in the process of handover with a recently appointed care manager.

Some people expressed concerns regarding the management of the service particularly in relation to communication. One person told us, "I have to chase everything. They are very helpful, but I have to chase." Other comments from families included, "I don't know who the managers are" and "I would raise queries and questions; no one would come back to me." One person summarised their concerns by telling us, "I wouldn't recommend the company because of lack of communication, poor timekeeping and lack of management."

The service failed to make the required notifications to us and did not understand their responsibility under the duty of candour regulation. There was no duty of candour policy in place and we made a recommendation the provider refers to current guidance to develop and implement an appropriate policy.

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

Rating at last inspection
The last rating for this service was good (published 17 August 2017).

Why we inspected
We received concerns in relation to the safe management of medicines and management arrangements for the service. The service did not have a registered manager in place. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

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

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

We have identified breaches in relation to safe care and treatment, safeguarding from abuse, recruitment practices, good governance, duty of candour and in informing the Commission of incidents and information they are required to.

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 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 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Is the service well-led?

Inadequate

The service was not well-led.

Forever Homecare

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector, one inspection manager and one 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. The Expert by Experience made telephone calls to people and relatives receiving the service about the support and service they received.

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 did not have a manager registered with the Care Quality Commission. When a manager is registered with the Care Quality Commission, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 25 January 2021 and ended on 29 January 2021. We visited the office location on 25 January 2021 where we spoke with staff and viewed a range of records. We continued to review documents shared electronically. We contacted staff and people using the service by telephone and email on 27 January 2021 and 28 January 2021. We conducted a virtual meeting with the provider on 29 January 2021 where we provided feedback and requested additional information and supporting evidence.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from local authority 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 also requested feedback from Healthwatch in Buckinghamshire and Berkshire. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with two people using the service and 14 family members. One additional family member provided their feedback by email. We also spoke with nine members of staff, including six care and support workers, an administrator, care manager, service manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also sought feedback from five further care and support workers by email but received no replies.

We reviewed a range of records. This included eight people's care and support plans, and four medication records. We looked at six staff files in relation to recruitment, training and supervision. We reviewed a variety of records relating to management of the service including policies and procedures, staff risk assessments, two staff handbooks, training matrix and quality assurance surveys.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from professionals and received written feedback from seven professionals during the inspection process.

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 good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems were not effective in responding to safeguarding concerns. Some safeguarding referrals were kept in a folder. Only one referral included follow up information, meaning it was unclear if concerns had been investigated and how risks were mitigated.
- Where safeguarding concerns had been brought to the service's attention, insufficient action was taken to protect people from abuse. Concerns had been raised about the incorrect use of a hoist and slide sheets by staff, which caused wounds when a person was pulled along a sheet. A safeguarding meeting was held with the local authority, and a service manager offered assurances improvements had been made, including the purchase of a hoist for in-house training. At the time of our inspection no hoist was in place and training records showed moving and handling training was either incomplete or out of date for all staff.
- Staff we spoke with demonstrated varying levels of awareness about safeguarding adults. Some staff told us they had received training and knew to escalate concerns. Other staff showed limited understanding. One staff member was unaware theft of money would be considered a safeguarding concern of financial abuse. A care manager could only identify two forms of abuse but advised they had information to refer to and was aware concerns should be reported to the local authority.
- Training records indicated most staff had received safeguarding training within the last two years. However, one staff member had not received training after joining the company and supplied a certificate from a previous employer. We found another person's training had not been renewed in line with company policy.
- We received two versions of the staff handbook. The handbook contained concerning information, stating staff should consider the 'appropriateness of intervention' by weighing factors such as the length of time abuse had been occurring, the extent of the abuse and the impact on the individual. The list of guidance questions included "Did the victim subject to abuse consent willingly?". A staff member reading the document could become confused about if or when a concern should be escalated, which could pose a risk to people using the service. We were later asked by the service to discard this document and received a second handbook dated May 2020 containing limited information about safeguarding.

The service had failed to implement effective systems to investigate and appropriately respond to allegations of abuse. 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.

The provider agreed to develop an action plan in response to our findings and told us they planned to purchase a hoist and bed to improve staff manual handling training.

Assessing risk, safety monitoring and management

● People were not always protected from the risks associated with their care. Information within care and support plans about risks lacked detail and was sometimes inconsistent, out of date or contradictory.

● Some people presented with behaviours that challenged. One person using the service reportedly had a history of violence and was described as becoming verbally aggressive towards staff. The care plan instructed staff to inform the office and gave general advice to be vigilant and very patient. There was no specific guidance for staff such as strategies for de-escalation. Another person using the service had been physically aggressive towards staff on two occasions. This person's care records stated there was a risk of verbal aggression but did not mention physical aggression or provide guidance for staff on how to manage this.

● Some people who used the service had diabetes. We reviewed the care plan for someone prescribed insulin. There was no risk assessment in relation to diabetes to inform staff of the risks associated with this condition. Some staff we spoke with were not aware of symptoms someone with diabetes may develop when becoming unwell.

● Some care plans contained contradictory or out of date information. One person's care plan stated the person refused to use a hoist and asked staff to assist with transfers using a walking frame. We were told the person has since been encouraged to use the hoist, however the care plan had not been updated. This could lead to staff confusion around safe transfers, which could have placed the person at risk.

● One person using the service was at risk of self-neglect, tending to miss, refuse or overdose on medication. Part of their care plan instructed staff to hide their medication, and another section stated medication was kept by the person in their living room. The person could have been at risk as it was unclear where medication should be securely located and what staff should do if the person refuses support.

● Another person using the service was prescribed an anticoagulant blood thinning medication. This was not identified in their records as an anticoagulant, and no risk assessment was in place to inform staff of the risks associated with this medication. We spoke with a manager at the service involved in completing risk assessments, who was not aware of the increased risks associated with blood thinners when someone has a fall.

● Some people were at risk of skin damage or pressure wounds. One person's care plan informed staff a person's skin was prone to easy damage and to use prescribed cream. There was no guidance on where or how often to apply the cream. The person expressed concerns about their care, advising, "I told the girls to handle my skin gently. They are very rough even though they've been told." Another relative also expressed concern about skin care, telling us, "They moan about their feet being dry but don't do anything about it. There's plenty of cream for them to use."

Learning lessons when things go wrong

● People were not protected from risks of avoidable harm as incidents and accidents were not always appropriately recorded, reported or followed up. We looked at the incident and accident records for the service. The last incident was recorded on 13 July 2020, however we were aware of a recent incident when a person using the service was found stuck on the floor after slipping from their chair. The service manager spent "a good part of two hours with three staff members" to try to hoist them off the floor. This had not been recorded as an incident and was logged on daily records. This method of recording made it difficult for the service to identify where action was needed in response to reoccurring incidents.

● There were five incidents recorded between June 2019 and July 2020. In all of these it was not clear what action had been taken to prevent a reoccurrence and no indication that people's care plans or risk assessments had been reviewed and updated following these incidents.

● The provider confirmed there were no systems in place to learn from incidents and implement improvements to prevent a reoccurrence.

Risks to people were not clearly identified and managed, and systems were not established to promote learning from incidents to mitigate risks to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings. The provider planned to seek professional advice regarding the format and content of care plans and risk assessments, with the aim of improving documentation.

● Staff we spoke with were aware to call for medical assistance and inform the office when incidents such as falls occurred. One staff member described calling the ambulance and remained with the person whilst awaiting assistance.
● Some staff were able to demonstrate a better awareness of risks. One member of staff shared their understanding about the risks of pressure sores, and the risks of bleeding associated with anticoagulant medications. Another staff member, due to their own personal experiences, was able to demonstrate a knowledge of risks associated with diabetes. We found knowledge and awareness was inconsistent across the staff team.

Staffing and recruitment
● People were not protected from the risks associated with the employment of unsuitable staff. This was because the provider had not completed all the required pre-employment checks. One staff member's file did not include proof of identification and two files did not include a record of interview. We found application forms were not fully completed with information such as reasons for leaving a previous role.
● The service had failed to obtain references in line with their own policy, which stated two references should be taken. One staff member had one reference on file and another staff member had no references. This person was lone working in the community.
● The service had failed to apply for DBS checks when required. During the inspection four staff were identified who needed a new DBS check. We found evidence of unsafe practice, such as accepting a photograph sent by email of a previous DBS certificate. The service had not seen the original document or applied for a new DBS check.
● The service failed to explore gaps in people's employment history or query discrepancies within application forms. One staff member's application identified three gaps in employment; there was no evidence this had been explored as part of recruitment.
● The service had not considered how health issues disclosed during recruitment could impact an individual's ability to work safely, meaning reasonable adjustments had not been considered. We identified two members of staff with health issues including a spinal problem, but there was no evidence this had been explored to consider risks to staff themselves or people receiving support.

Systems were not in place for the safe recruitment of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not ensure staff had the qualifications, competence, skills and experience needed to deliver safe care. One staff member described the company offered no training after a discussion about their previous experience and training in past care roles. The staff member reported giving medication for approximately two weeks before a manager observed their competency. Other staff described receiving an induction which involved e-learning and a period of shadowing.
● The service supported some individuals with more complex needs, such as people living with dementia, experiencing alcohol misuse needs, people with behaviours that challenge and people at end of life. Most staff we spoke with either had not, or couldn't recall, receiving any specific training to enhance their

knowledge and understanding of complex needs. Some staff told us they had received training about dementia however, could not demonstrate a good level of awareness. When asked about their experience of dementia training, one staff member advised, "I have to talk to them nicely, they forget things."

The service had failed to ensure staff had the training, competence, skills and experience to deliver safe care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider immediately reviewed staff DBS checks in response to our feedback and requested DBS checks for four members of staff. The provider also planned to review arrangements in place for the recruitment, induction and training of staff.

Preventing and controlling infection

● The service's infection control policy had not been updated in response to COVID-19, and therefore information in key areas such as personal protective equipment (PPE) was not in line with national best practice guidance. The policy did not refer to the use of face masks or eye protection.

● Staff received training and leaflets in relation to donning and doffing PPE, but not all staff had their competency assessed. This meant the provider could not evidence staff were following safe practice.

● The service did not test staff regularly for COVID-19 infection. We received inconsistent feedback regarding how test kits had been obtained, whether these were purchased privately or ordered from the government national testing programme. We did not receive evidence regarding the legitimacy of the test kits in use. Most staff we spoke with confirmed they had not received regular tests, although one office-based worker did state they received a weekly test.

● Some staff were at increased risk of COVID-19 due to factors such as ethnicity or underlying health conditions. We reviewed staff risk assessments and found some were incomplete, and it was unclear how the information had been used to mitigate the risks for staff at greater risk.

● Some people using the service expressed concern about staff compliance with infection control measures. One person commented, "Sometimes they don't wear masks." Another person told us, "Their hygiene is awful. They change my pads then use their phone without washing their hands." A third person commented, "They have improved but not all of them are wearing aprons. I think they are all wearing masks but there was a problem last week with gloves."

The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to sign up online to the government national testing programme for domiciliary care staff. We have also signposted the provider to resources to develop their approach.

● Staff we spoke with confirmed they had received adequate supplies of PPE, including eye protection. Staff also confirmed they had received training materials in relation to infection control.

Using medicines safely

At our last inspection we recommended the provider review their medicines policy to include the latest national best practice guidance. The provider had not made enough progress and we identified additional concerns.

● Records indicated that medicines were not given as prescribed. We reviewed four people's medicines records and found several discrepancies. One person was prescribed a pain relief patch which required changing every 72 hours. The patch had not been signed for over a period of 28 days, and subsequently signed for twice daily for 12 of the next 14 days. Another person was prescribed a medication used to prevent breathing difficulties. The medicine record instructed staff to administer one tablet each morning. Over a period of nine days, staff had signed for the medication three times per day. At the time of our inspection the service had not identified the issues we found, and therefore had not determined whether these were recording issues or administration errors.
● Feedback from people and relatives highlighted concerns of poor practice. One family member commented, "It's recorded but I don't know where. In the past there's been meds which have been left and not given." Another family member informed us, "Sometimes one carer tries to push medication on him when he says he already had it."
● Medication administration records did not include essential information to promote safe administration. One person was prescribed paracetamol and we observed staff signing for the medication twice daily. The written administration record did not include the dosage, times prescribed or route. This meant it was unclear whether medicine had been given safely in accordance with the person's prescription.
● Allergies were not accurately documented on people's records. One person's care plan identified an allergy to painkillers codeine and tramadol. This information was not included within their medicine record which could have posed a risk to their safety.
● The provider did not have safe systems in place to effectively respond when people ran out of medicines. One person's medicine ran out on 2 December 2020 and no contact was made with their next of kin to chase up the prescription. The relative learnt of the issue on 8 December 2020 after checking daily records and took immediate action. The provider acknowledged there had been a breakdown in communication, and this placed the person at risk.
● We learnt a computer system issue meant electronic medicines administration records did not populate when information was entered by care staff. Staff made a note on daily records to confirm they had administered medication, but this was not an accurate record of the specific medication given. This was a known issue and a period of more than two months passed before paper records were reintroduced in November 2020.
● The medication administration protocol given to staff was not in line with national guidance. When outlining the five key factors to consider when administering medication, it did not ask staff to check they were giving medication by the correct route. There was no reference to seeking the person's informed consent before administering medication.

We found evidence safe medicine practices were not promoted and record keeping was inconsistent and at times incomplete. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to investigate the concerns we had identified with medicines records. The provider visited one person at home to check their immediate safety and ensure medicines were given correctly.

● Some people and relatives we spoke with told us medicines were given safely. One person told us, "They give me my medication and watch me take it. The pharmacy organises my medication." Another person commented, "They give me the tablets with a glass of water. Then tell me what they are or what they are for."

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 good. 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.

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

- The provider had identified concerns regarding the culture of the service. We were told feedback was given to staff that uniforms and ID badges should be worn, and staff were told they should not wear flipflops. We were advised some staff contracts had been terminated due to concerns about attitude or performance. We heard recruitment difficulties had impacted progress, with a manager at the service commenting it was, "hard to replace carers miserably failing us."
- Support was not always person-centred or inclusive. One relative told us, "Staff aren't polite and don't explain anything…They don't ask her what she wants to eat; they ask me! She can speak for herself." Another person told us, "I don't think they take me seriously. Two staff came the other day and they didn't even say anything. Not 'hello', nothing."
- Staff were deployed based on availability due to staff shortages. This meant people's preferences for male or female care staff were not always met. One family member told us they reduced the level of care and relied more on family support because female staff were not provided in line with the person's preference. The provider informed us this person would accept some males, but daily records indicated a high percentage of male staff, which was not in line with their wishes.
- People told us the service did not support them to achieve good outcomes and raised concern about the management of the service. One person told us, "I'm fed up with ringing the office saying those things to be done. Sometimes there is no one in the office and they never called back."
- Staff rotas were not well managed, meaning people did not receive support in a timely manner. We also heard concerns staff did not stay the required amount of time. Most staff we spoke with advised they were given limited or no travel time. A relative told us, "They don't stay the right amount of time; 10 minutes if you're lucky." Another family member told us, "They have half an hour leeway, but they go way beyond this and they don't stay the right amount of time."
- Information in people's care records and in particular risk assessments were generic and task focused. This meant we could not be assured care records contained enough detail relating to people's individual needs to ensure these were met. One person's care plan stated staff should keep their skin moistened and hydrated. The care plan contained no further instructions to staff on how to achieve this, such as which cream should be used, and where this should be applied.
- We found examples of disempowering language used. Five people's care plans used the same wording, informing staff, "I can follow the verbal command of the staff and can assist intermittently during personal

care." The care plans did not encourage staff to seek consent or engage with people before initiating personal care. There was a risk people's dignity and independence could be compromised. One person told us, "They try and do things their way, not what I want."

● Gaps in care records meant staff were not fully equipped to meet people's individual needs. Seven of the eight care plans we reviewed listed the person's religion as not to be mentioned. This appeared to be a standard approach as there was no indication religious or cultural needs had been explored. Some care plans briefly identified the person's hobbies but with insufficient detail to help staff engage with the person. Hobbies were listed such as going out, drinking alcohol or watching TV. One family member told us, "If they get access, they don't talk to them…they haven't established any kind of relationship."

● There was no structured process in place to review people's care needs. A copy of care plans held electronically was used as an indicator as to when an annual review was due. One relative told us, "When needs change, they don't change the care plan. They never review." Another person told us, "I have a care plan and have asked for it to be reviewed after two years; so far it's not been done."

● Information in people's care records demonstrated the provider lacked an understanding of the requirements of the Mental Capacity Act 2005. Mental capacity assessments that had been completed stated that people had been asked to complete memory tests as part of their assessments and these did not relate to their capacity to make specific decisions related to their care.

Management systems were not in place to promote high quality, person centred care. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff provided positive feedback regarding staff culture. Some staff used a secure messaging application service to regularly communicate with one another. A staff member told us colleagues are supportive if they need assistance with covering extra visits and felt staff helped one another.

● We received a small number of positive comments from people using the service. One person told us, "Staff treat me with kindness and respect." A family member commented, "They treat us all with dignity and respect and are kind and caring."

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

● The service did not have a registered manager in post, and at the time of our inspection there was no application to CQC in process. The previous registered manager left 3 October 2018. The service had a part-time service manager who was in the process of handing over tasks to a care manager during January 2021. The management team did not demonstrate a good awareness of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's action plan consisted of 12 actions, some of which were routine tasks such as updating the training matrix and three actions were supervision dates for staff. The service was already aware of significant concerns such as staff shortages and ineffective administrative systems. The action plan did not set out a vision or strategy for improvement, and all actions were pending.

● Systems to monitor the quality of the service were absent or ineffective and had not identified the issues we found. We found no evidence the service had learnt from complaints, safeguarding concerns or accidents and incidents. A service manager advised us they completed weekly and monthly audits of the service, including monthly audits of medicines records. This information was not accessible to the care manager or nominated individual, and we received no evidence audits had taken place.

● Electronic systems could monitor the timeliness of visits and identify missed visits however, we found no evidence this information was being used to improve the service. An automated report indicated a total of 11,439 missed visits however, it was unclear what period this covered and therefore the information had

little usefulness. We were advised systems were in place, including a screen, to monitor visits in real time, and contact staff who were running late. We did not see this screen in use during our site visit.
● The service had policies relating to monitoring and clinical governance. The policies did not clearly identify which aspects of the service should be subject to auditing or quality monitoring and did not specify a frequency or schedule for audits.
● The service had been unable to locate key policies when asked, such as the accident and incident policy. Administrative and IT systems appeared disorganised and ineffective. A staff member informed us they could not access information on a laptop because a team member who left some weeks ago had not provided their password. Some information was more accessible via online document storage.
● The service did not have effective systems to promote learning and development within the staff team. Staff files and feedback from staff confirmed staff did not receive regular supervision. Some staff had no supervision record on file. Other staff described receiving supervision at varying intervals, such as every two months, three months ago, less than once a year or never. The training matrix also indicated many outstanding training courses across the staff team.

People did not receive care from a service which was effectively monitored and managed. Systems were not in place to identify learning or required improvements in the quality of care people received. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings and planned to recruit a registered manager for the service.

● Some staff provided positive feedback in relation to the management of the organisation. Some staff identified the nominated individual as approachable and accessible when support was needed. One staff member commented, "every time I call, she answers my call."

● Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. CQC had not received any safeguarding notifications from the service throughout its history. We observed a safeguarding folder which contained a number of safeguarding referrals. Key individuals within the management of the service were not aware of the requirement to report safeguarding concerns to CQC.
● The service had failed to notify CQC when a person using the service sustained a serious injury in 2019.

Systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The provider confirmed they would develop an action plan in response to our findings and agreed to inform themselves about reporting requirements.

● The provider confirmed the organisation's statement of purpose had been updated when new directors took over the organisation in 2020. This had not been shared with CQC and the provider was not aware of the requirement to do so.

Systems were not in place to make the required notification to CQC in accordance with requirements. This was a breach of Regulation 12 (Care Quality Commission Registration Regulations 2009).

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

characteristics
● The provider had not formally engaged with all staff for the purpose of gathering feedback or to identify ideas to improve the service. The provider told us they planned to introduce initiatives to build staff engagement, such as an employee of the month scheme.
● We were advised three staff meetings had been held since August 2020. Meeting notes were not taken, meaning staff did not receive written confirmation of verbal guidance and people who could not attend were not updated. Some staff informed us meetings had become less frequent since the start of the pandemic.
● Following the arrival of new company owners in August 2020, a questionnaire was sent to people using the service in September 2020. We viewed the four returned responses. There was no written analysis of the results to demonstrate how this would be used to improve the service, or to consider reasons for the low survey uptake. We were informed the results had been followed up with staff in supervision and training.
● The service had not considered alternative ways to seek quality assurance feedback. The service supported people living with dementia and people with English as a second language, who may have struggled to read and respond to a multi-page questionnaire.

The service had failed to effectively seek and act on feedback from relevant persons, including staff and people using the service. This was a 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
● Key individuals at management level within the organisation were not aware or lacked understanding of the duty of candour regulation and how this should be implemented.
● The service did not have a duty of candour policy. When asked to supply a copy of the policy, we received a policy from a different organisation based in the same building, who do not hold an approved registration with CQC.
● This meant effective systems were not in place to identify or respond to incidents under duty of candour procedures. We found there were no duty of candour records relating to an incident where a person using the service had been found by staff with a fractured hip.

We have made a recommendation the provider refers to current guidance to develop and implement a policy in relation to the duty of candour.

The provider confirmed they would develop an action plan in response to our findings, and advised they were committed to improving their knowledge and understanding of the regulation.

Working in partnership with others
● The service had limited links with external organisations. Management at the service informed us their ability to establish new links had been impacted by the COVID-19 pandemic.
● The service worked in partnership with a local authority who commissioned care and support for people. The service was described as not very responsive regarding referrals. Another professional expressed concern regarding a lack of communication from the service when a person's toilet became blocked for some time and was completely full of waste. The service explained they supported the person to make private arrangements with a plumber and didn't feel it necessary to update the social worker.
● We identified concerns regarding the cooperation and transparency of the service in relation to safeguarding people from abuse. A service manager attended a safeguarding meeting where concerns of neglect had been substantiated and it was agreed an apology letter should be written to a family member.

This information was not accurately shared with the service's nominated individual, and the service had failed to send the agreed apology. We asked for action to be taken by the service and they agreed to compose the apology letter.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose Systems were not in place to make the required notification to CQC in accordance with requirements.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Systems were not in place to identify or report incidents to CQC in accordance with requirements.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not in place for the safe recruitment of staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed, and systems were not established to promote learning from incidents to mitigate risks to people.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse and neglect.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not effectively managed and good governance was not established.

The enforcement action we took:

We served a warning notice.