TOB Care Services Ltd

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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
TOB Care Services Ltd is a domiciliary care service, supporting adults in the community who require assistance with personal care. This included people living with dementia, physical disabilities, mental health needs and sensory impairments. 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. At the time of our inspection there were seven people using the service.

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

There were inadequate risk management processes in place to ensure people received safe care and support. Initial assessments and ongoing assessments of need were inadequate to clearly detail how to support people who had risks identified. For example, risk of falls, malnutrition and dehydration, catheter care, skin damage and accessing people's properties.

The provider was accepting new packages of care without having done any assessments to check the service could meet people's care and support needs. This had led to the provider having to hand back a package of care which did not provide consistent support to people.

There weren't always written care plans or risk assessments for staff to follow in line with best practice. There was a lack of appropriate recording of incidents for example when someone developed blisters (which became infected) from their catheter. The involvement of medical professionals wasn't recorded.

The provider had failed to record falls, incidents and accidents or to notify other health and social care professionals to ensure people were receiving safe care and support. This did not demonstrate that the service had oversight of issues affecting people's care and support needs to ensure they received a safe service.

People were not protected from abuse and improper treatment as systems and processes were not established and operated effectively. The provider did not demonstrate an understanding of their safeguarding role and responsibilities or the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. Policies did not give staff clear instructions to ensure they provided safe care. It was not clear whether staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

Recruitment practices were not safe. There was limited or no recruitment documentation in place, and what

was available was incomplete. The provider was not able to be clear with us about who they had employed and when they had started or ceased working for the service.

Staffing arrangements did not match the support commissioned by the local authority. People's preferences with regard to visits were not decided by them, nor in line with hours commissioned by the local authority. This did not demonstrate a service providing care and support in line with both people's preferences and commissioned hours.

Medicines management was not robust. There was little evidence that staff had received medicine training and competency assessments to ensure they were competent to carry out this task. Neither was there any written evidence that the provider had checked medicine practice whilst working with staff in the community and via records.

Infection control practices were not safe. Not all staff had received training in infection control, which meant we could not be assured that staff were following good hygiene practices during care and support.

People's legal rights were not protected because staff did not know how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support were not assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005).

The providers systems to assess people's needs and develop care plans were ineffective. The information in care plans was inconsistent and did not reflect the information in assessments. The provider did not have the relevant knowledge and skills to ensure care was delivered in line with standards, guidance and law. There was a lack of relevant training and seeking involvement from health and social care professionals. This did not enable the provider to support people and provide them with evidence-based care and support according to their individual needs. We were not assured of the provider's competence at meeting people's health care needs with appropriate/timely liaison with health professionals.

Not all staff had the right skills to make sure people received compassionate support and have enough time to get to know them as individuals, including having enough time to enable them to understand people's care and support needs, wishes, choices and any associated risks.

People were not always supported in a way that made them feel like they mattered. People were not treated with dignity and respect and staff did not see people's privacy and dignity as a priority.

People did not receive care and support which was person-centred and took account of their needs and wishes. Staff did not always adopt a positive approach in the way they involved people and did not respect their independence. The provider was unable to give any information to us about how the service respected people's diversity and any arising needs.

The service was unsafe, ineffective, uncaring, unresponsive and was not well-led. A whole service safeguarding enquiry was in progress with the local authority. A suspension of local authority placements was in place, and the provider agreed a voluntary suspension of new private placements.

The provider had not recognised the quality of the service placed people at risk of unsafe care. The provider did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs. This demonstrated a failure to understand their responsibilities of their registration and in line with regulations.

Following our inspection we made safeguarding alerts to the local authority and action was taken to move packages of care to alternative providers.

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

Rating at last inspection
This service was registered with us on 8 June 2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

The inspection was prompted in part due to concerns received from the local authority about a complex package of care being handed back to them, poor care planning, a lack of robust recruitment, a lack of relevant policies and procedures, a lack of understanding of the Mental Capacity Act and the provider's poor understanding of regulations and legislation. A decision was made for us to inspect and examine those risks.

Enforcement

We will continue to monitor the service and will take further action if needed.

We have identified six breaches in relation to safe care and treatment; person-centred care; need for consent; good governance; staffing and fit and proper persons employed.

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

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

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.

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.

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.

TOB Care services 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 Care Act 2014.

Inspection team
The inspection was carried out 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 provider is also the registered manager and is registered with the Care Quality Commission. This means they 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 would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four members of staff, which included the provider.

We reviewed a variety of records relating to the care and support provided, records for three members of staff. We requested a variety of records were sent to us relating to staff training and regarding the management of the service, but these were unavailable.

After the inspection
After our visit we sought feedback from people using the service, relatives, staff and health and social care professionals to obtain their views of the service provided to people. We received feedback from one person using the service, two relatives, four staff and four health and social care professionals. We continued to seek clarification from the provider to validate evidence found and to request evidence which still wasn't forthcoming.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- There were inadequate risk management processes in place to ensure people received safe care and support.
- Initial assessments and ongoing assessments of need did not clearly detail how to support people who had risks identified. For example, risk of falls, malnutrition and dehydration and skin damage.
- The provider was accepting new packages of care without having done any assessments to check the service could meet people's care and support needs. This had led to the provider having to hand back a package of care which did not provide consistent support to people.
- Risk assessments about accessing people's properties and how to manage situations if entry was refused were not detailed enough to ensure staff provided safe care. For one person, there were no records of times when the provider was unable to access their property to provide care and these refusals had not be shared with the local authority.
- People's moving and handling assessments and falls risk assessments were inadequate to support people to move appropriately and as independent as possible.
- There was little evidence of the provider appropriately recording incidents in the service or of them alerting medical professionals.
- For example, for one person who required leg bandages, the daily note stated the staff member had removed a person's wound dressing in response to the person saying it was painful. The record stated the staff looked at the wound but it didn't record any subsequent related action taken by the staff in response, for example referring to a health professional. The person's relative confirmed that the provider does not contact them about concerns such as this.
- Catheter care was poorly managed. There were no written care plans or risk assessments for staff to follow in line with best practice when people required support with catheter care. There was a lack of appropriate recording of incidents for example when someone developed blisters (which became infected) from their catheter. There were no incident forms completed nor was there a record of involvement of medical professionals.
- Staff told us there were no body maps in place to guide staff where creams should be applied to protect skin integrity. This placed people at risk of skin breakdown or damage.
- One person's care plan stated they needed two carers for home visits due to their mental health. Despite this, the provider attended a visit alone. During the visit the person became verbally aggressive and locked the provider in their house. There was no contemporaneous incident form completed. Staff continued to make lone visits. There was no assessment of the risk posed to staff or the risks this posed to the person if staff were unable to deliver care.
- For two people, their falls risk assessment tools were incorrectly added up. This therefore suggested

incorrectly they were at a lower risk of falling than was actually the case. This meant they were at risk of not being supported in the safest way possible to try and prevent them falling.
• The provider had failed to record falls, incidents and accidents or to notify other health and social care professionals to ensure people were receiving safe care and support. This meant there was no learning when things went wrong to make sure that incidents didn't happen again in the future.
• We asked the provider about lessons learnt when things go wrong. They told us that the local authority had stated that people's care plans were not detailed enough. They went on to say that they were changing the system used in response to the local authority. We did not see sufficient improvement in the quality of the documents as a result of the change in format.

People were at risk of unsafe care and support due to inadequate risk management processes. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Recruitment practices were not safe. There was limited or no recruitment documentation in place. Those documents that were in place were incomplete. The provider had not always completed their own Disclosure and Barring Service (DBS) checks, instead using certificates from staff members' previous employers. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions to ensure staff are appropriate to work in this type of service. The provider had not explored gaps in staff members' employment history and there were also no clear records of interviews taking place or references being sought prior to new employees starting work with the service.
• The provider was not able to be clear with us about who they had employed and when they had started or ceased working for the service.

Recruitment practices were not safe. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staffing arrangements did not always match support commissioned by the local authority. People's preferences about the timing of visits were not always taken into account. A person told us, "The organisation decided the time that they would come." They also told us, "I never know when they are coming" and that they did not call to tell her they would be late. The same person told us "When they are an hour late, they say things like, I had to wash someone's hair." This did not demonstrate a service providing care and support in line with both people's preferences and commissioned hours.

Using medicines safely
• Medicines management was not robust.
• One person's care plan stated they managed their own medicines and the provider told us they had capacity to do so. However, the provider went on to say they needed a locked cabinet in their house to store medicines, which contradicted them stating the person had capacity and was able to administer their own medication. There was no risk assessment to check the person was safe to do this and no considerations of their capacity to manage their own medicines.
• We received conflicting information about medicine administration records. A staff member told us there was not a medication administration record (MAR) in a person's house. The provider told us the MAR chart was in the person's home, but then said they took the MAR chart with them when they visited. If a person didn't let them in to administer medication, the provider would ask through the door whether the person had taken their medicines. If they said 'yes', the provider marked it on the MAR chart as the person having taken them. One MAR chart had 15 entries in 16 days indicating that the provider had got verbal confirmation from the person to state that they had taken their medicines.

• There was written evidence that two staff had received training in administering medication, but no evidence that any other staff had received it. There was no written evidence of staff undergoing assessments to ensure they were competent to carry out this task before administering people's medication. Neither was there any written evidence that the provider had carried out spot checks of staff's medicine practice whilst they were working in the community. This did not ensure staff were administering medicines correctly.
• There were no audits undertaken to ensure people were receiving their medicines as prescribed.

Medicines management was not robust. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Not all staff had received training in infection control, which meant we could not be assured that staff were following good hygiene practices during care and support.

Infection control practices were not safe. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider supplied staff with masks, gloves and aprons to use when supporting people with their personal care. This helped to minimise the risk of infections spreading. They stated, "There is personal protective equipment (PPE) in people's houses. Aprons, gloves and masks. I check that there are supplies."

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from abuse and improper treatment as systems and processes were not established and operated effectively.
• The provider did not demonstrate an understanding of their safeguarding role and responsibilities or the importance of working closely with commissioners, the local authority, and relevant health and social care professionals, on an on-going basis. Policies did not give staff clear instructions to ensure they provided safe care.
• Information was not available for people on adult safeguarding and how to raise concerns.
• Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, how to report concerns within the organisation and externally such as the local authority, police and the Care Quality Commission (CQC).
• It was not clear whether staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
• People's legal rights were not protected because staff did not know how to support people if they did not have the mental capacity to make decisions for themselves.
• People's capacity to make decisions about their care and support were not assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). There were no mental capacity assessments in people's care files and the provider lacked understanding of the MCA.
• People's capacity to consent to care had not been assessed and best interest discussions and meetings had not taken place. Care records did not demonstrate consideration of the MCA and how the service worked alongside family and health and social care professionals when there were changes in a person's capacity to consent to care.
• A person's care plan stated they could make choices and understand simple and complex information on good days but suggested on bad days they might not be able to communicate well. Communication is a key factor in having capacity for a decision. However, no mental capacity assessments had been carried out.

People's capacity to make decisions about their care and support were not assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). 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; Staff

working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The providers systems to assess people's needs and develop care plans were ineffective. The information in care plans was inconsistent and did not reflect the information in assessments. For example, with regards to eating and drinking, moving and handling to support people to mobilise safely, and pressure area care.
• The provider did not have the relevant knowledge and skills to ensure care was delivered in line with standards, guidance and law. There was a lack of appropriate guidance and relevant training for staff. This did not enable the provider to support people and provide them with evidence-based care and support according to their individual needs.
• People were not supported to see appropriate health and social care professionals when they needed to meet their healthcare needs. We saw limited evidence of health and social care professionals' involvement in people's individual care on an on-going and timely basis. For example, GP and community nurses. Records did not demonstrate how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. For example, with regards to catheter care and nutrition and hydration.
• We were not assured of the provider's competence at meeting people's health care needs with appropriate/timely liaison with health professionals.

People's needs and choices were not delivered in line with standards, guidance and the law. People were not supported to access appropriate healthcare services. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• The provider told us that there was an induction process for new staff. However, there was little written evidence of this and what existed was incomplete. We were therefore not assured that new staff had the necessary skills to support people appropriately.
• The provider told us that new staff carried out shadow shifts before being able to work alone. However, they had no written evidence to demonstrate when shadow shifts might have taken place or how they had assessed the competency of staff as a result of these shadow shifts.
• The provider told us that they carried out spot checks and supervisions to ensure staff were supported to carry out their roles safely and to ensure they were providing people with care and support in line with their individual needs. However, they were unable to provide us with written evidence of these checks or support taking place.
• Moving and handling training had been provided online. There was no face to face session arranged for staff to learn how to use moving and handling equipment appropriately which is important to ensure people are being moved safely.

Staff did not receive relevant training and support to enable them to carry out their roles. This was a breach of regulation 18 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 commissioned needs were not being met. For example, a person was funded for staff to prepare all food and drink. The person had lost a lot of weight whilst being responsible for preparing their own food and drinks. The provider stated, "I know him better than them" and told us the person could make their own food and drinks and staff do not monitor the person's weight. This person has since ceased being supported by TOB and is receiving care and support from another service.
• Where risk assessments identified people were at nutritional or hydration risks, there was no information on how to manage these. The care plan for one person with stage three kidney disease stated they needed support with making sure they had sufficient fluids. However, there was no guidance on how much fluids

were needed or how much support they required. This placed the person at risk of a deterioration in their physical health.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

• Not all staff had the right skills to make sure people received compassionate support and had enough time to get to know them as individuals, and enable them to understand people's care and support needs, wishes, and choices. One person told us the provider was quite rough when washing them, adding that "everything is average."

• People were not always supported in a way that made them feel like they mattered. One person commented, "The one this morning (the provider) said that she had to be quick because she had an important meeting to go to. I thought, that's not my problem. (Provider) says things like, I am going now. I say yes, let me know anytime you want to go if you're running late or something." This did not demonstrate meaningful care and support or take into account people's individual needs and wishes and promote people's overall wellbeing.

• People were not treated with dignity and respect and staff did not see people's privacy and dignity as a priority. One person commented they felt ordered around. "They don't ask, they just do things. They suddenly say, stand up and now and again I feel that I'm being a bit ordered."

• Staff did not always adopt a positive approach in the way they involved people and did not respect their independence. The provider was unable to give any information to us about how the service respected people's diversity and any arising needs.

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

• People were not listened to and they were not supported to express their views. People and their relatives did not feel involved in make decisions about their care.

• People were not involved in developing their care plan. People and relatives commented, "The organisation decided the time that they would come" (they would have preferred staff to have discussed it with them and come to an arrangement that suited them) and "I was not involved in deciding (relative's) care plan."

People did not receive person-centred care and support. This was a breach of regulation 9 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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People did not always receive care and support which was person centred and took into account their needs and wishes.
• One person told us visits from the service didn't always meet her preferences, saying "I don't think I'd recommend them based on I never know what time they're coming, and sometimes they stay for ages and sometimes not for very long at all."
• A family member told us they were not involved in deciding their relative's care plan, nor had they or their relative seen the documents or been asked to sign them.
• Relevant assessments were not always complete or not up to date, from initial planning to on-ongoing reviews of care. This meant staff didn't always have the information they needed to provide support in line with a person's likes, needs and preferences.

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.
• We looked at how the provider complied with the Accessible Information Standard. The provider had taken limited steps to comply with the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss. For example, care plans recorded whether people wore glasses. However, they did not contain clear communication plans explaining how people's needs could be met. For example, whether or not large print or braille documents were needed or provided.

People were not always given information in a format they could understand. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
• People were not being supported at the end of their life at the time of our inspection.
• The service did not engage people in planning their end of life care.

Improving care quality in response to complaints or concerns
• People were not invited to express their views about their care and support. There were not regular

opportunities for people and people that mattered to them to raise issues, concerns and compliments.
• People were not made aware of the complaints system when they started using the service. This meant people were not given enough information if they felt they needed to raise a concern or complaint.
• There was no system in place to record complaints, which would enable the provider to respond in line with their duty of candour responsibilities.

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.

This is the first inspection for this newly registered service. This key question has been rated 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. 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 service was unsafe, ineffective, uncaring, unresponsive and was not well-led. A whole service safeguarding enquiry was in progress with the local authority. A suspension of local authority placements was in place, and a voluntary suspension of new private placements.
- The provider had not recognised the quality of the service placed people at risk of unsafe care.
- The provider did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs. The provider told us, "I have a look at things." They were unable to provide any evidence, verbal or written, about undertaking audits to check the quality of the service. They proceeded to state, "No, I don't have to write it down." The provider believed they did not need to do audits for the first three months. This demonstrated a failure to understand the responsibilities of their registration in line with regulations.
- There were no formal processes to check the quality and accuracy of risk assessments and care plans. This meant people were at risk because staff did not have the guidance, they needed to support people safely.
- There was no system in place for the provider to review safeguarding concerns, accidents and incidents. This meant they were unable to determine what worked well, lessons learnt, and improvements needed to minimise the risk of recurrence.
- The provider had not identified that recruitment practices were not safe. They did not have clear records about who they had employed and when they had started or ceased working for the service. They had not identified that staffing arrangements did not match the support commissioned by the local authority.
- The provider had not identified that policies and procedures were not adapted and relevant to the service and did not tell staff what they needed to know. For example, how to manage medicine errors or escalate concerns.
- The service did not work consistently in line with regulations, legal frameworks and current evidence-based practice guidelines to ensure a safe service. For example, they did not demonstrate an understanding of and compliance with the Mental Capacity Act.
- There was no system in place to check the competency of staff in administering medicines and the completion of medicines administration records. This meant people were at risk from unsafe medicine administration.
- The provider had not identified people did not receive care and support which was person centred and considered their needs and wishes.

• The provider was not clear about their regulatory responsibilities. They were unable to provide evidence of safe training and ongoing monitoring of staff competence.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider did not understand the importance of adopting an equality, diversity and human rights approach in the way care and support was delivered.
• Reporting of incidents, risks, issues and concerns was unreliable. There was a lack of evidence to demonstrate how people, their relatives and health and social care professionals were told about incidents or how these had been responded to.
• Engagement with people was minimal. The provider did not invite feedback from people to assess the quality and safety of the service and ensure positive outcomes for people's individual care and support needs.
• People confirmed that they had not been asked for feedback about the service. The provider told us on the day of our site visit they didn't need to do this for the first six months of their registration.
• Registered providers and registered managers have a legal responsibility to inform the Care Quality Commission about any significant events that occur including any serious injuries or safeguarding events. The provider had failed to ensure this had happened.

The provider had not established and did not operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and choices were not delivered in line with standards, guidance and the law. People were not supported to access appropriate healthcare services. People did not receive person-centred care and support. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions about their care and support were not assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of unsafe care and support due to inadequate risk management processes. Medicines management was not robust.

	Infection control practices were not safe. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established and did not operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not safe. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements did not match the support commissioned by the local authority. Staff did not receive relevant training and support to enable them to carry out their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.