Green Leaf 24Hr 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Green Leaf 24Hr Care Services is a domiciliary care service providing personal care to people living in their own homes. 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. The service provided care and support to older people. The service was providing personal care to one person at the time of the inspection.

People's experience of using this service and what we found
The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Staff did not have confidence in the provider to appropriately deal with concerns if they reported them. However, staff knew where they could go outside of the organisation to raise concerns if necessary.

The provider had not always assessed and managed risks to people's safety. Staff reported that there were no risk assessments within the person's home and they had not received any guidance and support from the provider to meet people's needs safely. The provider did not have a system in place to monitor accidents and incidents. There was no learning from accidents and incidents to reduce the risks of issues occurring again. Accidents and incidents had occurred which the provider was unaware of.

Staff were not recruited safely. The provider had not carried out any employment checks for one staff member who was working for the service. Recruitment records for other staff had been falsified. Staff had not received any training, induction or support. Staff had not received supervision to gain feedback on their performance, identify training needs and discuss any concerns.

Medicines are not well managed. Staff have not had medicines training. The provider had not assessed staff competency to check they were giving medicines safely. Medicines administration records did not list all prescribed medicines the person was taking. Medicines records had gaps.

The provider had not ensured people were protected by the prevention and control of infection. Staff had run out of personal protective equipment (PPE) to help them carry out their role safely to help prevent the spread of healthcare-related infections.

Prior to people receiving a service their needs were assessed. The person receiving care had been assessed the day before they started to receive a service in September 2018. The assessment for the person had not been reviewed and updated since September 2018. Although the provider had put a care plan in place following the assessment of the person's needs, the care plan had not been placed in the person's home. This meant that staff working with the person did not have all the information they needed to provide the person the care that they needed.

Quality monitoring processes were poor and did not provide the information the provider would need to be

assured of the quality and safety of the service provided. The provider did not have sufficient oversight of service. The provider had not completed audits or checks to make sure the service being delivered was safe and effective.

The provider had no oversight about people's health needs and how staff were meeting these. People's health and medical conditions were included in their care plans which were kept in the office. The staff did not have access to the information. They were not aware of people's health conditions and what signs to look for if their health was becoming unstable and when to seek medical support. .

The provider had not effectively logged or handled complaints according to their policy. The complaints policy did not have all the information people needed to escalate concerns if they were not happy with the response from the provider. We made a recommendation about this.

People told us they were well treated, and staff were kind and caring towards them. People were treated with dignity and respect by staff. However, the provider had not treated people with dignity and respect and had not treated people in a caring manner through the failure to provide safe, effective, responsive and well-led care.

People received support to prepare and cook meals and drinks to meet their nutritional and hydration needs. People directed their own care. Staff encouraged and supported people to maintain their independence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People told us they had control of their lives and made choices and decisions. People's communication needs were met.

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 17 October 2017 and this is the first inspection. The service was not providing any personal care until September 2018.

Why we inspected
This was a planned inspection based on our current inspection programme.

Enforcement
We have identified breaches in relation to medicines management, risk management, infection control, safe recruitment, keeping people safe from abuse, training and support for staff, failure to assess and plan care to meet people's needs and failure to put in place systems to monitor and improve the service.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always 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.

Green Leaf 24Hr Care Services

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.

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. The registered manager was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was announced. 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.

Inspection activity started on 04 December 2019 and ended on 12 December 2019. We visited the office location on 04 December 2019.

What we did before the inspection
The provider had completed a provider information return prior to this inspection. This is information we

require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed the information we held about the service.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not been to the service and had not received any information about the service. We received feedback from a local authority quality assurance worker, who told us they did not have any involvement with the service at the current time. We used all of this information to plan our inspection.

During the inspection
We spoke with one people who used the service, one friend and one relative about their experience of the care provided. We spoke with three staff including the provider.

We reviewed a range of records. This included one person's care records and medicines records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, further recruitment records and policies and procedures.

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 for this newly registered service. This key question has been rated 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

- The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. The provider's policy did not give staff the information they needed. Staff had not been given access to policies and information about keeping people safe from abuse.
- Staff knew how to spot signs of abuse and mistreatment as they had previous experience of working in care. Staff had not received safeguarding training.
- Staff did not have confidence in the provider to appropriately deal with concerns if they reported them. However, staff knew where they could go outside of the organisation to raise concerns if necessary. The staff member we spoke with had not had any safeguarding concerns to report.

The failure to establish and operate effective systems to protect people from abuse 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.

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

- The provider had not always assessed and managed risks to people's safety.
- When the person's needs had changed and deteriorated risk assessments such as falls risk assessments had not been reviewed and updated. The person had fallen on a number of occasions and had injured themselves. There was no moving and handling risk assessment in place to detail how staff should support the person after they had fallen.
- Staff reported that there were no risk assessments within the person's home and they had not received any guidance and support from the provider to meet people's needs safely. Staff followed their own intuition and liaised with relatives to gain safety advice.
- Staff reported that they had to work things out for themselves and they liaised with relatives for guidance and support to help them meet the person's needs.
- The provider did not have a system in place to monitor accidents and incidents. There was no learning from accidents and incidents to reduce the risks of issues occurring again.
- Accidents and incidents had occurred which the provider was unaware of. Staff had completed accident records and recorded in the person's daily notes that falls had occurred. The provider had not checked the daily records and had not collected the accident forms from the person's home.
- Actions had not been taken by the provider to report and refer the person to health care specialists as a result of falls, such as the community falls team or occupational therapists. The person had not been assessed to see if they needed specialist equipment to meet their needs and reduce the risk of falls and injury.

● Staff had taken action when the person had injured themselves. The records showed that staff liaised with the district nursing service to ensure wounds were appropriately managed.

The failure to manage care and treatment in a safe way through assessment and mitigation of risks was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

● Despite the lack of systems and processes in place to ensure people were safe, people and relatives told us they felt safe. One person said, "Oh yes I feel safe with [staff member], the whole thing makes me feel safe there isn't just one thing." A relative said, "They keep mum safe."

Staffing and recruitment

● Staff were not recruited safely. The provider had not carried out any employment checks for one staff member who was working for the service. This staff member worked as a live-in carer. The staff member had not completed an application form, had not been interviewed, had not been Disclosure and Barring Service (DBS) checked and had not been asked to provide identification and references. DBS checks help prevent unsuitable staff from working with people who could be vulnerable.

● Recruitment records for other staff had been falsified. We spoke with the provider about this and they admitted this. We also discussed with the provider safe recruitment practice to ensure people are safe.

The provider had failed to operate effective recruitment procedures. 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 person receiving care and support had a live-in staff member who worked six weeks on and two weeks off. They received consistent 24 hour care and support from the staff member. They told us, "I love having [staff member] here." The person's friend told us, "[Person] is very comfortable with [staff member] and she is visibly relaxed and happy, when different carers come [person] becomes quite down."

● A relative told us, "Mum does go downhill when the staffing changes and the cover is in. She becomes more confused and anxious partly because she doesn't know them and partly because they don't know her so well."

● A relative said, "Sometimes they have not been able to find cover which means the staff member ends up staying longer than planned. There are always issues with changeover day happening and dates and times change. Mum has lots of different staff all the time. The normal staff are good but each time they have their planned break for a few weeks it's a different person."

● There had been an occasion in September 2019 when the normal care staff was unable to get back to provide care at the agreed time and the staff member providing the two-week break had to leave. This left the person without any care and support for six hours. The relative told us, "I rang [provider] she couldn't cover and didn't have anyone. My husband had to pop in and see mum to check she was ok. He shouldn't have to do that."

The provider had failed to effectively deploy staff to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not well managed. Staff did not have medicines training. The provider had not assessed staff competency to check they were giving medicines safely.

● Medicines administration records (MAR) did not list all prescribed medicines the person was taking.

● The person was in receipt of 'as and when' required (PRN) medicines. PRN protocols were not in place to detail how they communicated pain, why they needed the medicine and what the maximum dosages were. Staff administering these medicines did not have all the information they need to make sure the person was receiving their medicines safely.
● Medicines audits failed to pick up that MAR's had missing and incomplete information. The audit had failed to identify that the MAR for June 2019 was missing, and the MAR for July had not been signed between the 1 and 12 July 2019. There was a risk the person may not have received the medicines they needed when they needed them during this period.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection
● The provider had not ensured people were protected by the prevention and control of infection.
● Staff had not received the appropriate training to learn how to minimise the risk of infection spreading.
● Staff told us they had run out of personal protective equipment (PPE) to help them carry out their role safely to help prevent the spread of healthcare-related infections where necessary. One staff member said, "I was without gloves for one month, [provider] kept saying she was bringing these and never came so I had to ask for some from [relative]." The staff member told us that the provider eventually delivered three boxes of gloves on 03 December 2019.

The failure to take appropriate actions to ensure risks of infection were managed in a safe way is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires Improvement

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 Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received any training, induction or support. One staff member had been employed since August 2019 and had not carried out training to give them knowledge and skills to meet people's needs. They said, "I have not had any training at all. I have done mandatory training with my old company."
- Staff had not received an induction to the service and had no information or knowledge about the service they were working for. One staff member said, "I don't have a contract, I have not seen any policies and I don't know anything at all about the company."
- Staff had not received supervision to gain feedback on their performance, identify training needs and discuss any concerns to enable them to carry out their roles safely. A staff member said, "I don't see [provider] I have not had any supervision, I get feedback and support from [relative], they are only a phone call away."

The provider had failed provide support, supervision and training to enable staff to carry on their roles to meet people's assessed needs. This was a breach of Regulation 18 (Staffing) 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

- Prior to people receiving a service their needs were assessed. The person receiving care had been assessed the day before they started to receive a service in September 2018. The assessment was used to develop the person's care plan.
- The assessment included oral healthcare and included people's protected characteristics under the Equality Act (2010). For example, their religion, culture, health needs and their abilities.
- The assessment for the person had not been reviewed and updated since September 2018, despite the person's needs changing within that time. The assessment recorded that they did not require any help and assistance at night, however daily records and discussions with staff showed that the person did require this level of support when they were unwell.

We recommend the provider considers National Institute for Health and Care Excellence (NICE) guidance on assessment and care planning.

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

- The provider had no oversight about people's health needs and how staff were meeting these. The

provider had not been liaising with relatives and health and social care professionals when required.
● People's health and medical conditions were included in their care plans which were kept in the office. Staff did not have sight of these so some staff would not be aware of peoples medical and health conditions. The person receiving care had a live-in staff, their main member of staff knew them well. When people needed medical assistance, staff firstly contacted the relative, then health care professionals and then the provider if they had concerns.
● The person was at risk of not having their health needs met when staff who did not know them well were allocated to work with them. These risks were reduced by the person having a relative living nearby who had regular contact with them.

The failure to assess and plan care to meet people's needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A person told us that staff helped them with their medicines and had called the doctor or ambulance when they had needed it.
● A relative told us, "They (staff) support her with her breathing which gets bad when she panics. They pick up when she is not well, and they call me." The relative gave examples of when staff had rung them to report that their loved one had a cough. They gave the staff member advice and the staff member contacted 111. They explained, "If mum is not well, they (staff) suggest that she stays at home and not go to [day service]."
● A staff member gave examples of when they called the community nurses, GP and other health professionals when required. Staff worked together with other organisations to deliver effective care, support and treatment.
● Discussions evidenced that a person's dental and optical health needs were met. A relative said, "Our friend supported [loved one] to the dentist last year. Her eyes were tested last year, they came out to the house to do it. Carer supported mum up to the hospital." A staff member confirmed they spent time with the person at the hospital until the person was settled on a ward.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to prepare and cook meals and drinks to meet their nutritional and hydration needs. A relative said, "They do make meals to meet her needs. She has a small appetite; they tempt her with fruit and yoghurts and lots of drinks."
● People chose what food they wanted from their own store of food. People's care records clearly listed foods they had eaten and drunk.
● People were happy with the support they received at mealtimes. One person told us, "I am more than happy with the food." A friend said, "[Staff member] is planning to make Christmas special she is cooking a roast dinner and has been baking apple pies and other things that [person] likes."
● The staff member knew the person's likes and dislikes for food and drink and enabled them to carry on with eating a takeaway each week as they had done this for many years. The staff member said, "She likes her fish and chips on a Saturday, I walk to the chip shop to collect them."

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.

- Staff gave examples of how they supported people to make their own decisions. A staff member explained how a person was not keen to shower and preferred a wash, they gently encouraged the person but respected their wishes.
- People told us they had control of their lives and made choices and decisions. A relative told us, "Staff give choices of clothes and they listen to mum." The person receiving care and support had capacity to make their own day to day decisions and choices. Relatives supported them with making financial decisions.
- The person's care records evidenced that the relative had signed a consent form in relation to safe keeping of keys prior to the service starting.
- People were not restricted in their own home and had freedom to move around their home.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- The provider had failed to treat people with dignity and respect by not providing people with safe, effective, responsive and well led care. The provider had failed to engage with people and their relatives.
- Despite the provider's failure to treat people with dignity and respect. The person receiving care told us they were well treated, and staff were kind and caring towards them. They said, "[staff member] calls me by my preferred name and always respects my privacy and dignity. If they are all like [staff member] they are doing alright. Other staff have been lovely too, but they are not like [staff member].
- Relatives told us they were happy with the care their loved one received. A relative said, "Mum is fortunate the carers that have been found are good. Staff are kind and caring and they call her [name] which is her preferred name. She doesn't always remember their names. [Staff member] is mum's favourite."
- A staff member told us they knew the person well and enjoyed their company. They said, "We have a good relationship, she is a very pleasant lady. At home she likes her TV and naps. She likes to watch things on [video sharing platform] which we do together and following stories, she likes animal programs."

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

- People were involved in developing their care plans. Where people had difficulty expressing how they liked things done, people's relatives were involved in speaking up for them.
- On a day to day basis people directed their care. People told us they were asked how they liked things to be done.
- Staff worked closely with people's relatives and friends, as appropriate, to make sure people got the support they needed. One relative said, "[Staff member] always lets me know if something has happened."

Respecting and promoting people's privacy, dignity and independence

- Staff supported the person to maintain their privacy and dignity. They gave the person space to ensure they could spend time with their friends and family and ensured that they provided personal care when the person wanted it and in the way they wanted it.
- People's confidential records relating to their care were kept by the provider in a locked cabinet in the office to maintain people's privacy. Any records stored on a computer were protected by password which meant they could only be accessed by authorised persons.

Requires Improvement

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 Requires improvement: This meant people's needs were not always met.

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

- Although the provider had put a care plan in place following the assessment of the person's needs, the care plan had not been placed in the person's home. This meant that staff working with the person did not have all the information they needed to provide the person the care they needed. .
- This had impacted on the person when their usual member of care staff took their two-week break. Staff working with them during this period did not know them well and the person was reported by people that knew them well to be anxious and unsettled. .
- The care plan has not been reviewed or amended since it was put in place in Sept 2018. There had been no formal review of care completed with the person and their relative, despite their needs changing in the 15-month period. This put the person at risk of receiving care that did not fully meet their needs.
- A relative told us, "The care plan has not been reviewed or changed since the package started in September 2018. The only thing that has changed which needs adding to it is that when mum is ill carers need to help her at night. They will need cover as they can't be expected to work night and day."

The failure to assess and plan care to meet people's needs and preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- A relative told us they knew who to complain to about the service. They explained they had complained to the provider verbally on a number of occasions; most recently about staff change over times/days and the lack of gloves for staff.
- The provider had not effectively logged or handled complaints according to their policy. No complaints records were found. The provider told us about one complaint only which was received in November 2018 and resolved through a meeting.
- The provider sent us their complaints policy. This did not detail the external agencies that people could go to if they were not satisfied with the response they had received. For example, the local authority or the Local Government Ombudsman. This meant people did not have all the information they needed to escalate concerns if they were not happy with the response from the provider.

We recommend that the provider reviews their complaints systems and processes to ensure that complaints management is robust.

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.

● The provider told us that the person's communication needs were met as they were fully supported by a relative. The person was able to communicate verbally with staff. The provider told us they would produce larger print and alternative formats if required in future.

End of life care and support

● The service was not providing support to anyone at the end of their lives.

● A person had a do not attempt resuscitation' (DNAR) in place which had been agreed with their GP or consultant and relative. A relative did not wish for the service to discuss the subject with their loved one, and this was respected.

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.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Quality monitoring processes were poor and did not provide the information the provider would need to be assured of the quality and safety of the service provided.
- People's daily records were not checked by the provider to ensure care had been delivered according to the person's needs and preferences. The provider did not have oversight of the person's care and any changes in health.
- The provider did not have sufficient oversight of service. The provider did not have suitable systems in place to check the quality of the service. The provider's quality assurance systems had not identified the concerns we raised in relation to medicines practice, risk management, staff recruitment, infection control, training, support and supervision and care planning.
- The medicines audits that had taken place did not pick up areas of practice that were not safe.
- The provider had not continuously improved the service to ensure it was meeting people's needs. Robust systems had not been put in place to ensure regulations were met.
- The provider's policies and procedures were not always fully complete. They had been purchased 'off the shelf' from a company and had not always been made individual to the service and the location of the service. Staff did not have access to policies and procedures to assist them to carry out their roles safely.
- People's records were not always accurate or complete.
- People and their relatives had not been asked to complete feedback surveys about the care and support they received from the service. A relative said, "I have not had surveys. I would not recommend the company. The carers are really nice. It [service] does not seem professional."
- Staff received no information about the company they worked for. A staff member told us there had been frequent problems with being paid on time. They said, "I don't get payslips. I have no fixed pay date. It is very frustrating and messes up my direct debits. [The provider] doesn't seem to value me as an employee."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; 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

- The provider's website detailed; 'As a care provider, we closely monitor our staff and provide our service users with continuity of care to meet their changing needs. Our personnel are trained, experienced and fully compliant with the CQC's care regulations. We recruit ethically and our compliance is tight and detailed - ensuring quality and safety.' The provider had failed to monitor staff, train staff and ensure that care was

safe, effective, responsive and well led.

● The provider's mission on their website was to 'Conduct our business with honesty and integrity and to fulfil our obligations and commitments all the time.' We found that the provider had not met their mission and promise. They lied during the inspection and fabricated records after the inspection.

● The provider had not worked with people, relatives and health professionals such as nurses to ensure people received joined up care.

● The provider did not communicate effectively with staff.

● When things had gone wrong or there were incidents, the provider had not been open and transparent about these and informed relatives and commissioners as appropriate.

Systems to operate and monitor the quality and safety of the service were not robust. Systems to seek and act on feedback from relevant people were not in place. Records were not accurate or complete. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider had little or no understanding of the regulations and how to meet these, despite having a copy of them to refer to.

● The provider knew they needed to inform the Care Quality Commission (CQC) of significant events that happen within the service. There had not been any incidents reported to CQC since the service was registered.

● The provider had not submitted financial records to Companies House within agreed timescales which led to a proposed strike off of the company. We discussed this with the provider during the inspection and they took action to address this. They submitted their required accounts to Companies House on 18 December 2019 and the compulsory strike-off action was discontinued on 21 December 2019.

● The information regarding the proposed strike off was available in the public domain. A relative had found this information, which led to anxiety and distress and fear over the care package for their loved one being removed with little or no notice. The provider had not alerted them to this.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider has failed to assess and plan care to meet people's needs and preferences. Regulation 9 (1)(2)(3)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to take appropriate actions to ensure risks of infection were managed in a safe way. The provider has failed to take appropriate actions to ensure medicines are managed in a safe way. The provider has failed to manage care and treatment in a safe way through assessment and mitigation of risks Regulation 12 (1)(2)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to establish and operate effective systems to protect people from abuse. Regulation 13 (1)(2)(3)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19

pandemic.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure systems to operate and monitor the quality and safety of the service were robust. The provider has also failed to put in place systems to seek and act on feedback from relevant people and failed to ensure records were accurate or complete. Regulation 17 (1)(2)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures. Regulation 19 (1)(2)(3)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed provide support, supervision and training to enable staff to carry on their roles to meet people's assessed needs. The provider had failed to effectively deploy staff to enable them to carry out their duties. Regulation 18 (1)(2)

The enforcement action we took:

We cancelled the provider and registered manager's registration. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.