Das Care Limited

Das Care Limited

Inspection report

Room 4, Chiltern House
81 High Street North
Dunstable
LU6 1JJ

Tel: 07460468752

Date of inspection visit:
09 November 2021
02 December 2021

Date of publication:
20 January 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
DAS Care Limited is a domiciliary care service that provides personal care and support to people living in their own homes. The service was supporting 17 people with personal care at the time of our inspection.

People's experience of using this service and what we found
At the beginning of our inspection activity the provider provided us with inconsistent information. This related to the amount of people receiving personal care and the amount of staff who were actively working for the service. This was difficult for the provider to verify.
We had to liaise with the local authority to determine the amount of people that were receiving commissioned care.

People were at risk of poor care and support because there were no governance systems in place to monitor the quality of the service. No audits were being carried out. This meant that the provider had failed to identify and address the issues we found during our inspection of the service.

Although there were enough staff employed to care for people, the provider was unable to demonstrate that staff had been recruited safely. Relatives said their loved ones felt safe with staff and advised that a regular team of staff would visit who knew them well.

No induction for new employees was taking place and not all staff had received essential training. Staff had not received competency assessments or supervisions to ensure they had the required skills to provide safe care and support to people. In most cases staff's previous work experience in other care settings had been relied upon.

People's medicines were not managed safely. Some people did not have medicines records even though staff were prompting their medication and no medication risk assessments were in place. The provider was unaware that this paperwork needed to be completed.

Risk management of people's care required improvement. Not all risks were assessed and those that were did not contain the information staff needed to provide safe care.

Staff were not taking part in the governments COVID-19 testing programme for domiciliary care workers.

A safeguarding concern relating to a person living with dementia had not been reported to the relevant authorities without delay and the provider had limited knowledge of safeguarding processes. A review of this person's care had not taken place to ensure that it was suitable and safe.

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 no mental capacity assessments or best interest decisions in place, and staff and management had limited knowledge of the principles of the Mental Capacity Act 2005 (MCA).

Despite our finding's relatives felt listened to and were involved in decisions about their family members care and support. Relatives confirmed their loved one's dignity was maintained, and staff were able to describe how they promoted people's independence and respected their right to privacy. However, we found that care plans were not person-centred and did not outline individual preferences and wishes on how people would like to be supported or any information about their life history.

Relatives felt able to raise concerns with the management team if they had any and were positive about the care their loved ones received. However, the provider had not set up a system to identify, record and respond to any concerns or complaints.

Staff told us that they enjoyed working for the company and that they felt supported by the manager. The service worked with other professionals to support people with complex health needs to remain living in the community. Feedback received about the provider's professional manner was positive.

The provider responded positively to our findings, welcomed our inspection and planned to make improvements in the future.

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 29/01/2020 and this is the first inspection.

Why we inspected
This was a planned inspection based on the date of registration.

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 recruitment of staff, safeguarding service users from abuse, staff competency and training, safe care and treatment people receive, care that is not person-centred, consent to care, no system in place to identify and manage complaints and the overall management oversight of the service at this inspection.

We took action to impose conditions on the providers registration to prevent them taking on new or increases in care packages until improvements have been made. The provider is also required to give regular updates on progress towards these improvements.

Follow up
We will request an action plan for 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.

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 of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Das Care Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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.

Inspection activity started on 5 November 2021 and ended on 30 November 2021. We visited the office location on 9 November 2021.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the local authority, local Healthwatch and professionals who work with the service. 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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three relatives and one next of kin by telephone about their experience of the care provided. We also spoke with six members of staff including the newly appointed nominated individual, provider, and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed documentation relating to staff recruitment, staff training records, staff rotas, medication records, four people's care records and associated risk assessments. We also reviewed a variety of records relating to the management of the service, including policies and procedures. We contacted one social care professional for feedback on the quality of care provided.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also shared our inspection findings with local authority commissioners.

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.

Staffing and recruitment

- The provider had not ensured there were safe recruitment practices in place. The provider had not requested new staff to complete an employment application form and did not hold a curriculum vitae for staff or have any evidence that an interview had taken place. DBS checks had not been requested. This meant the provider did not have assurance that staff were safe or suitable to care and support people. This put people at risk of harm.
- Staff who had been recruited had not received training in moving and handling and medicines management where they were responsible for this type of care. This meant people were at risk of unsafe care as staff skills were either not current or had not been adequately assessed.

We found no evidence that people had been harmed but there was a risk of this as staff recruitment procedures were not safe and did not meet the standards required. Systems were not in place to demonstrate that staff had been recruited safely. This is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider confirmed shortly after the inspection that the service will improve their recruitment processes and procedures and ensure that necessary checks were completed for all current staff. Staff are also in the process of completing all essential training. Although subsequent actions were planned, until we inspected the service it was likely that recruitment would continue to be unsafe.

Systems and processes to safeguard people from the risk of abuse

- One person's care record showed a potential safeguarding concern. We raised this incident with the provider who was unaware that they needed to notify safeguarding concerns to both ourselves and the local authority, not just to protect people from harm, but to ensure appropriate care and treatment is put in place for people to mitigate the risk of these types of events happening again. This meant that opportunities to prevent further harm may have been missed.
- The providers safeguarding policy had the incorrect local authority contact details for people and staff to raise safeguarding concerns. This meant staff were given out of date or incorrect details to help safeguard people when needed and could put people at risk of harm or further harm.
- Not all staff had completed essential safeguarding adults training. This put people at an increased risk of harm.

The provider had failed to safeguard people from abuse or the risk of this recurring. This is 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.

● Staff we spoke to were knowledgeable about safeguarding and were able to describe different types of abuse and what actions needed to be taken if they had any concerns.

The provider confirmed that she has since spoken to the safeguarding team at the local authority and has submitted the relevant notifications to us. However, until our inspection they had not reported incidents as required.

Assessing risk, safety monitoring and management
● The provider confirmed that there had been no incidents or accidents at the service. However, one relative informed us that their relative had an accident shortly before care staff arrived to provide care and support. This accident had not been recorded by the provider. This meant that opportunities to review people's safety may have been missed, which could put people at risk of harm or further harm.
● People's risks were not fully assessed to reduce the risk of harm. Risk assessment records that were reviewed were unclear, and the information appeared to be embedded within the initial assessment paperwork. This made it particularly difficult to determine what risk they in fact related to.
● Not all risk assessments were in place for people. We found that assessments had not considered people's, choking risks, medication risks, catheter care, continence care or skin integrity needs in order to reduce the potential risk of harm.

We found no evidence that people had been harmed. However, the provider was not thoroughly assessing all risks to people, which put people at risk of potential harm. This is a breach of regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff we spoke with were aware of known risks, but due to a lack of clear risk identification and how these were to be managed, people were put at risk. One staff member said, "I will do [person's] personal care, their balance isn't great, and I will stand there so they can wash their face themselves."

Using medicines safely
● Medicines were not managed safely. Only two members of care staff, out of the nine staff actively providing support to people to either administer or prompt their medication had received the appropriate medicines administration training, and this training was completed the day before our announced inspection. The provider had also completed their training on the same day as care staff.
● Competency checks relating to administering of medication were not taking place. This meant people were at serious risk of harm as staff's skills to safely administer medicines had not been determined.
● Medication records we reviewed were incomplete. For example, it was unclear whether prescribed creams had been applied to a person's body over a period of days. There were no medication records in place for people who were self-medicating but required prompting. This could have resulted in potential harm.
● The provider confirmed that although staff were completing medication records, no medication audits had taken place. There was no assurance therefore that the records were accurate. Where people needed their medicines 'as and when required' there were no protocols in place, which would provide additional guidance to staff. This meant people were at risk of harm due to incorrect administration for 'as and when' required medicines.
● Staff were able to describe what actions needed to be taken if somebody refused to take their medication. One staff member said, "If client's refuse we tell management. Then tell family. On the MAR sheets, we would record, refused or declined." Although people and relatives did not have concerns about medicines there was no assurance that people's medicines were being safely managed.

The failure to manage people's medicines safely was a breach of regulation 12 (Safe care and Treatment) of

the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider confirmed to us during the inspection that they were in the process of implementing a new electronic system into the service, this will be a useful tool to record all information relating to care plans, attendance at calls and medication. However, until we inspected and identified these shortfalls, people were at risk of harm.

Preventing and controlling infection

● The provider shared their infection prevention and control (IPC) policy with us; however, we were not assured that they were following this policy regarding COVID-19 testing for staff. The provider was unable to provide any information to confirm that staff were following government COVID-19 testing programmes.

● Only two members of care staff, out of the nine staff actively providing support to people had completed essential infection prevention control training, and this was completed the day before our announced inspection. Nor had the provider completed any competency checks in this area.

The provider was not checking that staff were following COVID-19 guidelines to prevent the spread of infection. This is a breach of regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Relatives told us that staff followed good infection control practices and would wear gloves and masks when caring for their families. Staff told us they had plentiful supplies of PPE and were able to describe to us the PPE that they wore whilst providing care.

The provider told us during the inspection that staff had been enrolled on IPC training and that revised COVID-19 guidelines had been sent to all staff. However, until our announcement of the inspection this essential training had not taken place, this put people's health at risk.

Learning lessons when things go wrong

● Recording of incidents and accidents was not taking place at the time of our inspection. We asked the provider what the process was for learning from these events and they said, "I will inform care staff of any changes of law, training and anything new that comes through." The provider confirmed that staff team meetings hadn't been set up. Communication with staff took place by telephone through a secure WhatsApp group.

The provider has since confirmed that a staff meeting took place following our inspection which provided an update to staff on the new variant of COVID-19.

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.

Staff support: induction, training, skills and experience
- The provider confirmed to us after our site visit that there was no formal induction for new employees, supervisions, appraisals or competency assessments taking place for staff. However, they told us they would observe staff practice if working alongside them. This meant there was no opportunity for all staff to discuss concerns they had about their role or allow the provider to identify poor practice or training needs.
- Staff had not completed essential training to provide safe and effective care. This exposed people to greater risk of harm. Where staff had, in most cases, completed their training in previous care roles, there had not been assurance that this was effective or up to date.
- Not all relatives were able to comment on the ability of staff, but one relative said, "They have never had a problem with anything that has come up in front of them. They know how to use the turner and commode."

We found no evidence that people had been harmed. However, systems were not robust to ensure that staff had received adequate training to provide safe care. This exposed people to the risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulations) Regulated Activities 2014.

The provider responded after the inspection and told us that they had started completing supervisions and competency assessments with staff. Staff had started to complete essential training, but this was still ongoing. However, until we inspected and identified this matter, people were at risk of harm.

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
- The provider did not work within the principles of the MCA.
- Risk assessments that we viewed indicated that a discussion had taken place around consent to care;

however, this was not clear. We requested a copy of people's written consent to provide care and support and the provider supplied us with a blank copy of the provider's consent to care and support form. Written consent from people had not been requested. Reviews of the provider's policy for consent around the principles of the MCA had been completed but the provider was not following their own policy.

● People who had a cognitive impairment were not assessed to check if they had the mental capacity to consent to care and treatment. Furthermore, best interest decisions were not in place to allow staff to make decisions on people's behalf. The service was only able to provide us with a mental health assessment document.

● The majority of staff hadn't completed training on MCA or DoLS at the time of our inspection. Both the provider and staff's knowledge were very limited. The lack of clear guidance, accurate assessments of people's mental capacity and staff's understanding of the five key principles of the MCA put people at risk of having decisions made not in their best interests.

The provider had failed to ensure the principles of the MCA were followed. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider advised that they would assess people's needs and ask what their care preferences were on the first care call. This meant that the provider could not be sure they could meet people's care needs prior to care commencing.

● Records we reviewed contained limited information and did not accurately reflect the full range of people's needs. For example, assessments had not considered people's communication preferences.

● Another care plan we looked at indicated that a person had an impairment of the brain, when this wasn't the case. Care staff described how they supported this individual, which was in line with care provided to someone with a diagnosis of dementia. This meant there was a risk that people's care would not achieve good outcomes.

● Relatives confirmed that they were involved in the initial care planning process.

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

● Care records we looked at described health professional guidance relating to eating and drinking difficulties, which included the consistency to which food and drink should be prepared for some people. However, the provider and staff were not aware of anyone being supported by the speech and language therapy team (SALT). Daily notes confirmed that staff had prepared a drink for someone who had eating and drinking difficulties. Although there was no harm, and on this occasion, the drink was prepared as per professional guidance, staff needed to be aware of professional guidance when providing support in preparation of food and drinks, as guidance can change. If the incorrect consistency of food and drink was prepared for people, this could result in potential harm.

● Care records indicated the general support required for the preparation of people's meals. One relative said, "As a family we provide the meals and the [staff] will heat it up in the microwave." Staff confirmed they would sit with people and have a chat during their breakfast and lunchtime care visit.

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

● The provider told us that they work alongside the district nursing team in relation to catheter and pressure care. If care staff felt there were any concerns relating to these specific areas of care, they would notify health professionals immediately in order to request additional support.

● A social care professional provided positive feedback on care being provided. They said, "I am quite impressed with DAS Care Ltd as they have been involved in a quite complex case. The [registered manager]

and their team had worked well with [name of person] they have listened to their wishes about timings and what they will accept help with, and the service has been creative and shown initiative."

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 ensure all staff had the completed relevant training to make certain they had the right skills to provide safe, effective and compassionate care. This meant the provider could not be assured people would be treated well and provided with support when needed.
- Relatives felt staff were kind and caring. People felt listened to and respected. One relative said, "Staff really do care for [family member]. I would struggle to care for [family member] the way they do it, that is quite lovely." Another relative said, "As a family we feel listened to. The staff know my [family member] well and can pick up on when she is unwell."
- Staff spoke in a caring way when describing people and knew them well. Staff were able to explain people's preferences and how they wanted to be cared for. For example, respecting people's cultural diversity and providing personal care in a way that would respect a person's beliefs.
- Compliments shared by the provider were also positive. These included, 'The service has been fantastic in taking care of [family member] needs. The staff are compassionate and empathetic.'
- We received positive feedback about people's care, however, there were no formal systems or processes in place to demonstrate the effectiveness of the care being provided which meant that there was the potential for people to receive poorer care because of this.

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

- Relatives in the main said although they were involved in the care planning process, their family members care plan had been transferred from a previous care provider or reablement team. One relative said, "Adjustments had been made to the initial plan, and the [registered] manager has said if we start to struggle in the evening, they can get someone over." Another relative told us, "We made a point of sitting down with the [registered manager] and reviewed what is going on, and times when things are happening."
- Staff were compassionate and aware that they were often the only person people would see and would always have a chat during the lunchtime visit to support people's wellbeing.
- The provider confirmed that they would involve people and their relatives in care planning and people's preferences would always be respected. However, the information recorded on both initial assessment paperwork and care plans was very limited, which could potentially have an impact on the effectiveness and safety of care people were receiving.

Respecting and promoting people's privacy, dignity and independence

- Relatives told us staff respected their family members privacy and dignity. One relative told us, "They absolutely do. We live in a bungalow and the carers always make sure the blinds are closed. Carers will also

encourage my [family member] to put her jumper on, for the exercise, but of course if [family member] struggles they will help her."

● Staff told us how they promoted people's privacy, dignity and independence. For example, supporting people to be independent with certain aspects of their personal care, standing nearby for safety purposes and preparing the environment in advance.

● Relatives confirmed that their family members were given choice in relation to night-time routines and drink choices.

● Care plans evidenced people's preferences in relation to support from male or female care workers, however details on how to support people to remain independent, for example when supporting someone with personal care, was not described.

The provider told us that they would continue to update care plans for all people.

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

- The provider told us that a quick assessment takes place when visiting people at their first care call. An assessment of care should take place prior to agreeing a service. This could potentially lead to person-centred care not taking place.
- The provider confirmed information provided by people including likes and dislikes and their life experiences would be included within all care records. However, people's care records lacked detail and we were not assured that people were receiving person-centred care. People's life history had not been recorded. Information relating to individual preferences, interests, and hobbies was also limited.
- Care plans did not reflect how people's long-term health conditions impacted on their daily life; the information recorded was more task specific. This would make it particularly difficult for staff to know how to support people effectively and provide individualised care.
- Some care records lacked the detail staff needed to provide personalised care. For example, records did not inform staff how to support a person with their personal care. Staff did not understand the term 'person-centred' and care plans were not personalised. This meant that there was a risk that people would not be supported in a way they preferred.

The provider had failed to produce care records that were individualised. This put people at risk of receiving care that was not appropriate to their needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Following our inspection visit the provider confirmed some immediate action had been taken to update care plans in order to drive improvement in this area.

- One relative told us they felt that staff knew their family members likes and dislikes. They said, "When they come and sit with [family member] they will natter and chat. They have got to know [family member] ways."

Improving care quality in response to complaints or concerns

- The provider spoke to people and their relatives on a regular basis to give them the opportunity to express their views on the care being provided. However, there were no systems or processes in place to record any concerns or complaints. This meant that any learning opportunities to improve the quality of care to people could potentially be missed.

The provider had failed to establish an accessible system to identify, record and respond to complaints. This is a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● People knew who to speak to if they had any concerns or needed to raise a formal complaint, but no formal complaints had been made. One relative said, "We spoke with the [registered manager]. The early care visit is a bit earlier and the [registered manager] explained why they made changes and that it suited my [family member] as she is going to bed a bit earlier. There were no concerns, it's something we were able to discuss and understand and I think they are taking the right action."
● Staff told us, "If there is anything wrong to do with people's care, we make the manager aware." Another staff member said, "The [registered manager] is on point, clients are priority, but the manager also takes good care of her carers, which is good."

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 information contained within the provider information return did not reflect a full understanding of the AIS. The provider confirmed they did not have any alternative formats for communication in place at the time of our inspection, however, would be able to provide these upon request. AIS should be in place for prospective service users for who standard printed information is not suitable.
● Not all people's communication needs had been considered or assessed. For example, one care plan described difficulties relating to communication due to a long-term health condition. However, there were no further details providing guidance on how to best support the individual's communication needs.
● One relative complimented the service, "My [family member] speech is not so good, so it's quite difficult to understand [family member], but the [staff] are so patient enough to listen to [family member] needs." The provider confirmed there were staff who were multilingual, and this allowed for effective communication with people using the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Where people were supported to access the community, staff supported them according to their preferences. Staff told us that following their suggestion a person's care had recently increased to support requested activities both at home and within the community to reduce the risk of isolation and loneliness.

End of life care and support
● The service was not supporting anyone with end of life (EOL) care at the time of the inspection.
● The provider told us that they had spoken to people and their relatives about EOL care, but these conversations specifically related to do not attempt cardiopulmonary resuscitation orders (DNACPR) rather than EOL care planning. Care records that we reviewed did not reference any information relating to DNACPR orders.
● Staff confirmed they had not completed any end of life training with the service. This meant that EOL care may not be as dignified as it could be should the need ever arise.

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

- There was a significant lack of provider oversight at this service. The provider had failed to develop effective systems and processes to organise, monitor and manage the quality and safety of care being provided since the service was first registered. For example, there were no systems in place to monitor care visits, including late or missed care visits or the quality of care being provided to people.
- The provider had not consistently followed required standards, guidance and their own policies. The generic policies had not been reviewed with up to date information. For example, the safeguarding policy and procedure described the wrong local authority, rather than the ones people were referred from.
- The provider was not following the guidance contained within the services policies. For instance, during our inspection we became aware of an incident that neither ourselves nor the local authority had been made aware of. When this was raised with the provider, they were not aware of their responsibility to report to other partner agencies, even though this guidance was contained within their policy. By failing to notify the relevant organisations of incidents and accidents there was a risk of missed opportunities for additional support to mitigate further risk of harm or injury to people.
- No audits were being completed at the service. This meant there were no systems for identifying, capturing and managing organisational risks and issues, which would make it difficult to improve the service. For example, no medication audits were taking place. These audits are essential in identifying potential and actual medication errors, making sure that staff are following correct procedures, and that people are receiving medicines safely.
- Staff had not been recruited safely, there was no formal staff induction and the provider had failed to provide adequate training prior to care staff actively working, this exposed people who were in receipt of care to a greater risk of harm.
- The provider had failed to establish a system to identify, record and respond to concerns and complaints. This meant that any learning opportunities to improve the quality of care to people could potentially be missed. At the time of our inspection there had not been any formal complaints.
- A copy of the provider's statement of purpose was requested on the day of the onsite inspection, as we do not currently hold a copy within our system. This has not been forwarded to us. This meant we could not be assured exactly what service was being provided.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider responded to some of our concerns immediately following the inspection. This included completing an action plan to keep up to date progress on all aspects of safe recruitment of staff, including pre-employment checks, training attendance, and staff competency checks, which is still ongoing. The plan also records any actions taken to implement governance systems and audits to monitor the quality of the service. The provider reported the notifiable incident as described above to CQC in line with current legislation. The provider has confirmed that a new electronic rostering system which will record care plans, care notes, medication information will be fully implemented by the end of the year.

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

● Care plans did not show evidence of person-centred care. Although some preferences and hobbies had been recorded, but these were minimal. The care records lacked detailed information. There was no information relating to people's likes, dislikes, choices, or any life history. This created a risk of negatively impacting people's wellbeing.

● Staff did not know what 'person-centred care' was. However, staff were able to speak confidently about people's preferences and how they cared for people. Staff said, "The best way to find out how people prefer their daily care is to speak to them or their families."

● Risk assessment records that we reviewed lacked detail. Risk assessment data had been combined with the initial assessment documentation. We also found there were missing records relating to other areas of risk. For instance, what measures needed to be taken to prevent skin damage, or how to support people with their continence care. This could result in a serious incident taking place, which could harm a person.

The provider has confirmed that risk assessments and care plans are currently being updated.

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 provider had failed to effectively monitor the performance of the service. This meant that any shortfalls in care would not be identified. This could have a detrimental effect on the care people received. Incident and accidents had not been formally recorded or notified to the appropriate organisations. Therefore, accurate analysis to identify patterns and trends could not take place. Opportunities to prevent reoccurrence and learn lessons could have also been missed.

● The provider and staff confirmed that no formal staff meetings had taken place. All communication with staff takes place via telephone, mobile messaging or through virtual means. There was a risk that important information or advice regarding all aspects of delivering care would be missed.

The provider has confirmed that they are working with the local authority to improve the quality monitoring systems, records and care provision at the service. The provider has also confirmed that a staff meeting had now taken place.

● The provider was open during the inspection visit and acknowledged and welcomed inspection feedback.

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

● Relatives, all staff and external professionals told us that they found the provider to be approachable and supportive.

● The provider told us they would regularly speak with people and their relatives about the quality of care

received. Relatives confirmed to us the provider contacted them in order to gather feedback on the care provided. However, there was no evidence to demonstrate that feedback had ever been collected from people, or on behalf of people who were receiving care. Also, whether there were any actions required to improve care.

The provider requested written feedback on care provided from relatives during our inspection activity and confirmed they will continue to make the necessary changes to improve current processes.

Working in partnership with others

- The provider told us that guidance shared by health professionals is discussed with staff and information put into people's folders. However, we have not been able to verify this from records we looked at or records that were not available or provided. One relative told us, "The service act very responsibly. [Family member] recently had a fall at home. [Staff] took action straight away and contacted the emergency services to get [family member] into hospital." Unfortunately, the provider had not recorded this incident within their governance systems. This meant that opportunities to prevent reoccurrence could have potentially been missed.
- The provider was a member of other care related organisations which provided them with knowledge and insight into best practice.

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 Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to produce care records that were individualised. Regulation 9 (1)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the MCA were being followed. This meant people who lacked capacity were not being supported to make informed choices and decisions. Regulation 11 (1)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and Treatment The provider had failed to ensure that there were

sufficient number of suitably qualified staff to support people to stay safe and meet their needs.

The provider had failed to carry out robust care assessments in order to protect people from the risk of potential harm.

The provider had failed to put systems in place to monitor late or missed care calls.

The provider had failed to set up robust medicines management systems. This put people at risk of potential harm.

The provider had failed to check that care staff were following COVID-19 guidelines to prevent the spread of infection.

Regulation 12 (1)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was unaware of what constitutes a safeguarding concern and had failed to notify us or the local safeguarding team of allegations of potential abuse. Regulation 13 (2) (3)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

The provider had failed to establish an accessible system to identify, record and respond to complaints.

Regulation 16 (2)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective systems and processes were in place to organise, monitor and manage the quality of the service and ensure that people received safe and appropriate care. Regulation 17 (1) (3)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to establish safe recruitment practices when employing new staff. Regulation 19 (1) (2) (3)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff had the skills, knowledge and experience to deliver

effective care and support.

Regulation 18 (1) (2)

The enforcement action we took:

As a result of our serious concerns about people's safety we decided to impose conditions on the providers registration