Lean on Me Community Care Services Ltd

Northolt

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Northolt, also known as Lean On Me, is a domiciliary care agency. It provides personal care to mostly older people living in their own homes in the London Borough of Ealing. It also supports some adults who are living with dementia and adults who have physical disabilities. At the time of our inspection the service was providing care and support to 72 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People told us they felt safe. However, the provider had not always appropriately completed risk management plans regarding the risks of the COVID-19 virus to people's health and well-being so as to identify all t reasonably practicable measures to reduce those risks.

The provider's systems in place to monitor the quality of the service and make improvements when required had not always been effective. Despite the provider's checks and audits some people's care plans had not been updated to set out the care they received, reflect people's preferences or clearly identify how to meet some people's communication or sensory impairment needs.

We found the provider's systems for coordinating care visits only provided limited assurance staff were always deployed effectively to meet people's care needs. The provider was in the process of launching an online monitoring staff monitoring system to reduce the risk of late or missed care visits.

People and relatives felt staff were caring and treated them with dignity and respect. Staff promoted people's privacy.

There were arrangements in place to support people to take their medicines safely.

Staff felt supported in their roles and were confident they would be listened if they raised concerns. They were provided with induction, a blend of online and room-based training and supervision. Staff helped people to access healthcare services.

The provider regularly sought people's and their relatives' views about the quality of the care people received. The provider conducted regular checks on staff to assess the performance and how they were working with people.

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 mostly supported this practice.

We have made a recommendations about and the safe handling of people's money.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 28 August 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made sustained and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. It was also prompted in part due to concerns received about how the provider deployed staff to meet people's needs effectively and a decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. The rating for the service remains requires improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

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

We have identified breaches in relation to risk management, person-centred care, and having effective systems in place to monitor and improve the quality of the service at this inspection.

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

Follow up
We will request an action plan 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 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 always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

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 always well-led.

Details are in our well-Led findings below.

Requires Improvement

Northolt

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
This inspection was undertaken by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. Some staff also provided care to some people living in care or nursing homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 4 January 2021 and ended on 14 January. We visited the office location on 6 and 7 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 six people who used the service and six relatives about their experience of the care provided. We spoke with the registered manager and a number of staff, including a care coordinator, a supervisor, office support staff and quality consultants working for the provider. We looked at the care records of seven people using the service, the staff files for six care workers and a variety of records relating to the management of the service.

After the inspection
We requested further evidence and continued to seek clarification from the provider to validate the evidence we found. We spoke with five care workers and three adult social care professionals who have worked with the service to get their views about the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- At the last inspection we found the provider gave staff little or no guidance on how to recognise a person was becoming unwell due to their identified health conditions and what staff should do in that event. At this inspection we found improvements had been made but we still found issues with how the provider assessed and managed risks to individuals' health and well-being.
- The provider assessed the risks COVID-19 presented to people and identified higher risk factors of this for some people, such as their age and conditions like diabetes or high blood pressure. However, all the assessments we viewed still concluded the risks to these people were low. Additionally, assessments did not record any measures for staff or the provider to take to lessen these risks. This meant the provider had not always sufficiently assessed the risks to individuals' health or identified reasonable actions they could take to reduce them. We discussed this with the provider so staff could update people's risk assessments appropriately.
- The service did not always follow current national guidance in relation to infection control. The provider had completed a workplace assessment on maintaining the office environment during the COVID-19 pandemic, but this did not demonstrate robust and reliable measures to always keep staff safe in line with national guidance. For example, we observed staff on site were not always able to socially distance and there was no evidence of frequent surface and equipment cleaning. We also observed staff in the office not practicing social distancing consistently, as set out in the workplace assessment, and some staff wearing masks did not always do so in a safe manner. We brought this to the registered manager's attention so they could review their office risk management practices in line with guidance on promoting a COVID-19 safe working in domiciliary care services.

We found no evidence people had been harmed however, this indicated risks to people's safety and wellbeing were not always assessed, monitored and managed so they were supported to stay safe. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had completed specific risk assessments to consider health conditions that some people

lived with, such as epilepsy, diabetes or depression. These set out for staff information about a condition, how it might affect the person, and clear guidance on actions to take if the person became unwell.
● People's risk management plans considered hazards to staff and people at their homes and surroundings. For example, if there were cramped conditions, animals on site, the use of electrical appliances, access issues and the local neighbourhood.
● Service records indicated supervisors continued to visit people's homes periodically to check if they were safe. These also showed when supervisors checked if people's equipment was safe to use or needed servicing, such as their stair lift.
● Staff records showed staff had completed basic first aid and fire safety training help them support people in case of an emergency.
● There were arrangements for preventing and controlling infection when staff were working with people using the service.
● The provider gave staff information and training on infection prevention and control, including about COVID-19. Staff were provided with suitable personal protective equipment (PPE) to keep themselves and people safe. This included gloves, aprons, face masks, hand sanitisers and shoe covers. Staff told us they always adequate had sufficient supplies of these.
● People told us staff who visited them always wore their PPE and took other precautions such as washing their hands. People said they felt they were being as protected as possible from COVID-19 and commented, "I feel safe from the virus."
●Records showed the provider contacted people and their relatives regularly to check if they were feeling safe during the pandemic and that staff were wearing their PPE. Staff were accessing regular COVID-19 tests.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our last inspection we recommended the provider seek and follow best practice guidance on sharing safeguarding adults information and make sure all staff are aware of this. The provider had not made improvements.
● Staff completed safeguarding adults awareness training and those we spoke with knew how to recognise and respond to safeguarding concerns. However, two care workers did not know they can also report safeguarding concerns to statutory services and not just the provider. This meant people were not always supported by staff who were aware they can report concerns in this way to help people and organisations work together to prevent the risks and experience of abuse. We raised this with the registered manager, and they took prompt action to make all staff aware.
● At the last inspection we found the provider did not always promote safe working with people when staff handled their money, such as when shopping for a person. At this inspection we saw the provider had instigated periodic checking of people's money-handling records. However, we found an anomaly with one person's money-handling records. We brought this to the registered manager's attention, and they sought assurance that the person was happy with the care they received.

We recommend that the provider research and implement guidance on the safe handling of people's money when providing shopping support so as to safeguard people from the risk of financial abuse.

● People and their relatives told us they felt safe with staff and the care they received, including with their shopping support and the handling of their money.
● They provider responded to these and investigated these where required. For example, in response to concerns reported to the local commissioning authority.
● The provider took disciplinary or performance management action to address concerns about individual staff performance to reduce the likelihood of these re-occurring.
● The provider had safeguarding policies and processes in place to protect people from the risk of abuse.

People and their relatives told us they thought their family member was safe.
● Staff were confident if they did report concerns to their seniors then they would be listened and responded to. There was information in people's care plans on types of abuse and how to report this.
● The provider reported safeguarding concerns to the local authority and engaged with local safeguarding processes. This included attending meetings with other agencies and taking action to investigate and address safeguarding concerns.

Using medicines safely
At our last inspection we found medicines were not always managed in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

While we found some improvement was still required at this inspection, enough improvement had been made and the provider was no longer in breach of regulation 12.
● The provider had processes in place to support people to take their prescribed medicines.
● Staff had received training in medicines support and the provider assessed staff to ensure they were competent to give the medicines support being asked of them. However, we noted some recent competency assessments had not been fully completed. We discussed this with the registered manager so they could complete this process with staff.
● People's care plans stated when staff were to support people with their medicines. People's plans also recorded when a person's relatives were responsible for arranging their medicines and helped them to take these.
● Medicines administrations records (MARs) set out the necessary information for the safe administration of people's medicines. We saw staff had completed MARs appropriately to record if people had taken their medicines or not. The provider periodically audited MARs to make sure they were being completed appropriately.

Staffing and recruitment
● Almost everyone we spoke with said the right staff usually arrived at the right time for their care visits. An adult social care professional stated this had not always been the case since the last inspection as sometimes two staff had not attended a person who had been assessed as needing this level of support. The local commissioning authority was in the process of investigating a concern about a person not receiving planned care visits as required when we inspected.
● The provider was reliant on care staff or people contacting the office to say if staff were running late or had not attended to someone. There was evidence of this taking place in a timely manner, but office staff did not always record the actions taken in response to make sure people did not miss visits. The provider did not record, monitor and review late visits to identify how to reduce the frequency of these. This gave the provider only limited assurance staff were always deployed effectively to meet people's care needs. The provider was in the process of re-launching an online system to monitor 'real-time' staff attendance and reduce the risk of late or missed care visits.
● People said the provider would let them know if staff were running late. People commented, "The carer is always on time but if there was any problem the office would let me know" and "They are always on time although on the odd occasion they have informed us they are delayed."
● The provider arranged for staff to attend people who lived in the same or nearby postcode areas so staff did not have to travel far between visits. Staff confirmed this and told us they had enough time to travel between their care visits. One person said they felt staff rushed them during their visit, but others did not. One relative said, "They are very patient with [the person], they don't rush."
● Staff rotas and daily records of care showed that most of the time the same care staff visited people. This

meant people had an opportunity to develop a trusting relationship with the staff supporting them. One relative told us, "We are very pleased with the two carers assigned to [the person] and we very much appreciate the continuity as [the person] gets upset with change."

● There was a 'no entry/response' protocol in place. Staff we spoke with knew what actions to take if there was no response from a person when they visited.

● Staff recruitment records showed the provider completed necessary pre-employment checks so they only offered positions to appropriate applicants. These included information about applicants' previous work histories, gathering references from their previous employers and obtaining criminal records checks with the Disclosure and Barring Service.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

● We found staff supported people in line with the MCA, but people's care plans did not always promote this. The provider completed assessments of some people's mental capacity but did not specify what decision they considered a person may lack the capacity to make and why. We discussed this with the registered manager so they make improvements to address this.
● People had signed their care plans to indicate they agreed to their planned care arrangements. The provider recorded when they had safely obtained people's consent via a telephone call during the COVID-19 pandemic.
● Staff had completed awareness training on working in line with the MCA and described promoting people's choices about their day-to-day care.
● Staff included relatives in discussions about their family members care where appropriate to help people be involved in decisions about their care. One relative added, "We have a good relationship, but the carers also respect boundaries and don't offer opinions unless we ask for them."
● People's care plan files included clear reference to whether or not a person had recorded an instruction to not attempt emergency healthcare treatment.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people with their meals, where this was part of their planned care. Daily records of the care indicated people were being provided with meals and drinks regularly. However, sometimes staff did not always record what a person ate or the choices they may have been offered. Staff had completed nutrition awareness training so they could support people safely to have enough to eat and drink. A person told us, "They will help by heating up a meal for me if I ask them." A relative commented, "[Care staff] will see

to lunch… it all depends on what [the person] fancies."

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

● The provider assessed people's care and support needs before beginning to provide a service. Assessments and care plans set out people's ethnicity, religious beliefs and marital status. They included basic information about people's medical history, known allergies, mobility issues, and medicines support needs.

● People's care planning documentation included information for staff on promoting equality for people who identify as LGBT+, although the registered manager told us the service did not currently support anyone who identified as such. 'LGBT' describes the lesbian, gay, bisexual, and transgender community. The '+' stands for other marginalised and minority sexuality or gender identities.

● An adult social care professional told us the provider was quick to respond to requests for information and complete re-assessments of people needs. For example, when a person was being discharged from hospital back to the community.

Staff support: induction, training, skills and experience

● The provider gave staff training and support so to support people safely.

● Staff told us they felt supported by the provider and their line managers, who they could contact when they needed help. One staff member told us, "They're always on call, you can call them at any time." Records showed staff supervisions were held periodically throughout the year. Often these were conducted by phone to keep people safe during the pandemic.

● Records indicated staff completed a range of mandatory and supplementary training so they were competent to support people. Mandatory training included person-centred care, professional boundaries, health & safety, incontinence awareness, moving and handling, and dementia awareness. Supplementary training included awareness of epilepsy, diabetes and high blood pressure to help staff understand how to work with people who lived with those health conditions.

● New staff received an induction to the service which included training and then shadowing more experienced staff. A new member of staff told us they found this process helpful. Most people and relatives told us they thought people had the skills to support them, although some people felt new staff could be supported more by their managers.

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

● The service supported people to maintain their health and access healthcare services.

● We saw records that showed staff worked with other agencies to help meet people's health needs. For example, contacting people's GPs to arrange people's prescribed medicines or reporting a change in a person's needs to the local commissioning authority.

● Staff described how they had responded to signs of a person being unwell and contacted healthcare professionals for them. People and relatives told us staff helped people to manage their health needs, such as highlighting skin integrity problems. Relatives said, "They will notice any changes and alert us so we can contact the GP if needed" and "They were the ones who noticed [the person] was off a few weeks back and sure enough [the person] was diagnosed with a chest infection."

● People's care plans identified if they needed support to brush their teeth and manage their oral care.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

- Whilst staff were individually caring, we found the service was still not always caring to people. The provider had not been sufficiently caring to make sure people were always safeguarded from avoidable risks of harm. We also saw an ongoing lack of person-centred care planning that put people at risk of not receiving care individualised to their needs.
- People told us the staff who visited them treated them in a kind and caring manner. Their comments included, "They never make you feel like they don't have time for you. They make you feel important. I like them very much." A relative described their family member's relationship with a care worker, "They really get on well together and it is lovely to see." An adult social care professional also said staff had been very caring and attentive when providing one-to-one support to an individual.
- Staff had completed training in promoting equality and diversity in their work. People's care plans recorded information about their characteristics, such as their marital status, disabilities, sexual orientation and religious beliefs. For example, one person's care plan detailed their religion while acknowledging they chose not to practice this.

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

- Records of people's care indicated they and their relatives were involved in making decisions about their care. This included reviews of people's care plans, which the provider had sometimes conducted by telephone to minimise risks of COVID-19 exposure to some people. People we spoke with also told us this happened.
- The provider called people regularly to check on their care experiences and to ask for feedback about how staff treated them. This gave people opportunities to express their views about the service.
- Care workers explained to us how they involved people in their day-to-day care, such as asking how a person would like to be supported to wash or what they would like help with first. A person told us, "They ask me what I want that day. They are very kind and caring and we know each other well."

Respecting and promoting people's privacy, dignity and independence

- Most people told us staff treated them with dignity and respect. One person stated, "[The care worker] has great skills, very compassionate and professional."
- Care staff described how they promoted people's privacy and dignity while providing personal care. This included giving people space when needed, covering the person's body appropriately, and checking the room was private and a comfortable temperature. A person commented, "They treat me with dignity and always cover me up when washing. I never feel left exposed or anything." Records showed staff had

completed awareness training on promoting 'dignity in care.'

● Staff gave examples of helping people to be independent, such as encouraging a person to use their walking frame so they can mobilise safely.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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
At our last inspection we found people did not always receive care and support that recognised and reflected their individual needs and personal preferences. This was a breach of Regulation 9 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.
● The provider did not make sure people always received care and support in a planned way that recognised and reflected their individual needs and personal preferences.
● Some people's care plans appeared to be written in standardised terms with little personalised information about the person on how they preferred to be supported. For example, where people required support to wash there was no information about their bathing or personal grooming preferences. Another person preferred to take their medicines in a particular manner. While this was known to staff and the person's relative it was not clearly set out in their care plan. The registered manager updated the plan after we raised this with them.
● Some people's plans stated they required support with personal care but there was no information about what staff were meant to help the person with. Some plans set out a list of care tasks for staff to complete in a visit, some plans did not.
● Some care plans had not been reviewed or updated since our last inspection visit in June 2019. For example, one person's plan was dated 2017. This meant it was not clear that the person's care plan reflected the person's needs and the care they were currently receiving.

We found no evidence that people had been harmed however, these issues indicated people did not always receive care and support that recognised and reflected their individual needs and personal preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans recorded some basic information about people's care preferences, like people's preferred names and the gender of care staff people preferred.
● At the time of the inspection the registered manager was in the process of transferring people's care plans to a new format which recorded more information about people's care needs and their preferences. This included information about the outcomes people wanted their care to help them to achieve.

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 recorded and planned how to meet people's communication needs, but this was not always done in a consistent manner. We discussed this with the registered manager so they could make improvements.
● One person's care plan stated, "I have a learning disability which makes it difficult for me to communicate effectively," and that staff should speak clearly. There was no other information on what the person's specific communication need was and how staff should support them.
● Another person was deaf and used a hearing aid and British Sign Language (BSL) to communicate. The care plan included a page of BSL alphabet letters and some 'sing-along' signs, but there was no guidance on if and when staff should use these with the person to help effective communication.

We found no evidence that people had been harmed however, these issues indicated people were at risk of not always receiving support that recognised and met their individual communication needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people's care plans stated when the person's first language not English or provided information to staff about how sensory impairment, glaucoma for example, may affect their communications with others.

Improving care quality in response to complaints or concerns
At our last inspection we found the provider did not always operate effectively a system for handling and responding to complaints. This was a breach of regulation 16 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.7

While we found some improvement was still required at this inspection, enough improvement had been made and the provider was no longer in breach of regulation 16.

● The registered manager reported that they had not received any complaints from people or relatives. People had reported complaints or concerns to the local commissioning authority, instead. Records showed there were far fewer instances of these than at our last inspection. Adult social care professionals told us the provider responded to the concerns as required.
● People told us they knew how to raise a complaint or concern and felt they would be listened to. One person said, "There is no problem getting through to the office if you need them. I think they would deal with any problem if I had one." Most people said the provider had responded satisfactorily when they had raised an issue. There was information on how to raise a complaint in people's care plans. The provider also used a regular survey to check if people knew how to raise a complaint.

End of life care and support
At our last inspection we recommended the provider seek and follow good practice guidance on promoting good end of life experiences in domiciliary care. At this inspection we found the provider had made improvements.

● The provider recorded in people's care plans if a person had preferences regarding their end of life care should their needs change. Plans also recorded if a person did not want to discuss this with the provider when this was offered.

- The registered manager informed us no one was receiving end of life care at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems were always either in place or robust enough to demonstrate safety and quality and was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider conducted checks and audits to monitor safety, quality and make improvements when needed. However, these systems had not consistently operated effectively as the provider had not fully addressed the issues we found.
- The assurance systems had not identified and addressed that risks to individuals' health and wellbeing from COVID-19 were not always appropriately assessed or that reasonably practicable actions were taken to reduce these risks. Similarly, the provider's systems had not identified and addressed issues with maintaining a COVID--safe office environment.
- The provider's assurance systems had not identified and addressed in a timely manner that some people's care and risk management plans needed to be updated. The systems had not identified that some people's plans did not always provide sufficient information about their personal care needs. Similarly, systems had not identified that some plans did not always set out person-centred information about people and their preferences for how they liked to be supported.
- The provider's auditing system of a person's money-handling records had not identified the anomaly we found. As a result, the provider's system had not identified and addressed that for a number of years staff were not supporting the person in line with procedures to keep people safe from the risk of financial abuse. This also indicated that the provider's systems for monitoring people's care arrangements were not always effective. We also referred this concern to the local commissioning authority for investigation.
- The provider did not always operate a robust system to monitor and check that people's care visits were completed as planned.

● We found some of the daily logs completed by staff were not always complete and accurate records of people's care. For example, some logs did not document staff providing personal care to a person when this was a need set out in their care plan. This meant the provider did not always keep detailed, accurate and contemporaneous records about the care people received to meet their needs.
● Since the last inspection the provider had notified the CQC of important events that affected the service as it is legally required to do. However, regularly the provider had not supplied sufficient information about the events reported. For example, the circumstances of a person passing away and the service's involvement with the person at that time. We raised with registered manager on a number of occasions, including for a notification submitted during this inspection process. This indicated that arrangements to improve the service were not consistently applied.

We found no evidence people had been harmed however, these issues indicated systems were not robust enough to demonstrate quality was effectively and consistently managed. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider conducted regular quality assurance checks with people. These included monthly telephone calls and periodic visits to people at their homes. The checks were well documented and indicated a range of issues were discussed with people, such as staying safe during the pandemic, if staff were wearing PPE, if they were happy with the care staff. Supervisors also conducted unannounced checks on staff to monitor their performance. Both people and staff also told us these took place.
● The provider had audited staff recruitment files to make sure these were up to date and assured the registered manager of safe recruitment processes.
● The provider displayed the ratings for the last inspection at the service's office and on their website.
● The provider usually sent surveys to people twice yearly, although this arrangement had been disrupted slightly by the pandemic. These enabled people to be involved in the service by providing feedback about their care. A large majority of respondents rated their care as 'good' or 'very good'. The provider, though, could not demonstrate improvement actions taken in response to some people's negative observations. Also, the provider had not conducted since our last inspection any analysis of their findings to identify learning and improvement opportunities. The registered manager told us this was because they had focused on other service priorities during the pandemic and they planned to complete an analysis in the near future.
● One person remarked that they felt their service had improved: "If you had asked when we started using them, I don't think I could've said yes but there has been an improvement and I would say 'yes' I would recommend them now."
● The registered manager held and documented monthly team meetings to discuss the service and improvements required or being made. Topics covered included improving communication between office and care staff and ensuring care staff reported any changes in people's care needs swiftly.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives mostly spoke positively about the service.
● Almost everyone we spoke with said they would or had recommended the service to others, although one person said they would not as they had felt rushed in care visits. One person said, "I would absolutely recommend and have already passed their details onto a friend".
● Staff gave positive feedback about working for the provider and felt supported in their roles. One care worker said, "The manager, the administration, they are quite understanding. They are always on call, you can call them any time." Another commented, "They are comforting people in the office, they are always

asking about how the clients are, how you are doing. I appreciate these things."

Working in partnership with others

● The service worked in partnership with other agencies, such as social workers, nurses and GPs and hospital staff, to help those agencies provide coordinated care to people. However, adult social care professionals gave us mixed feedback about how the provider worked with them. Their comments indicated the provider did respond to requests for information in a timely manner most of the time, but this was not always consistent. The provider was working with relevant professionals to address this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not have robust arrangements to make sure service users received care and treatment which was appropriate, met their needs or reflected their preferences and received support that recognised and met their individual communication needs Regulation 9(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users because they did not always assess the risks to the health and safety of service users receiving care and/or do all that was reasonably practicable to mitigate such risks Regulation 12(1)

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 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality of the service and to assess, monitor and mitigate risk Regulation 17(1)

The enforcement action we took:

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