Teonfa Limited

Teonfa Care Group (South West)

Inspection report

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10 October 2019
14 October 2019
15 October 2019
17 October 2019
18 October 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Teonfa Care Group (South West), hereafter referred to as Teonfa is a domiciliary care agency that was providing support to 47 people living in their own homes in Plymouth and North Devon at the time of the inspection.

People's experience of using this service and what we found
The service was not safe, and people were placed at risk of avoidable harm. This inspection resulted in the identification of significant and immediate risks. We shared our concerns with the relevant local authorities who acted to provide extensive support and to ensure people were receiving safe care.

There were not enough staff to meet the care needs of people. Visits were being missed, or shortened, or were so late that people weren't getting their continence, nutrition, hydration and personal care needs met. Some people, who had been assessed by a professional as needing two care staff to support them to move safely, were being repeatedly supported by one staff member. This placed the person at risk of a fall or injury and was also unsafe for care staff who were providing care alone.

Medicines were not managed safely; some people were given too much of a medicine and some people had missed doses of medicines. Staff were not confident or competent at administering medicines.

The provider was unable to demonstrate that recruitment of staff was safe. The provider could not find records relating to recruitment. .

Risks to people were not assessed and risks were not mitigated to reduce the potential for harm.

There was insufficient evidence to show staff had training to meet the needs of all the people they supported. Health concerns were not flagged up promptly to health professionals. People did not receive holistic assessments of their needs. There was not a system in place to ensure staff knew what people's needs were, and how to meet them

Staff knew about asking for consent when delivering care. We saw evidence of restrictive practices being used by care staff and endorsed by the leadership in the service. 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.

People told us care staff were kind and caring but unreliable. People said they did not feel listened to by office staff and were not part of deciding how their care was going to be provided.

Over half of people we asked to see care plans for did not have one in place. The service was not person

focussed and let people down in the provision of their care through a lack of consideration for their welfare and preferences. There was a complaints log, but it only contained one complaint, issues that families told us about had not been captured or actioned. The service had not considered the accessible information standard.

There were widespread failures in the leadership of the service. The registered manager had recently left, and the provider and interim manager did not understand the systems and were struggling to run the service. There was no visible leader in the service that knew how the service was run, how to operate effective systems to keep people safe or what people's needs were. On the first day of our inspection we arrived and asked for the provider or interim manager to attend. They told us they were unable to come to the service to meet with us. They were present for the remainder of the inspection.

Care documents were incomplete, out of date or inaccurate and many records requested were missing. The service was unable to keep people safe, support staff appropriately, mitigate risks, or provide a basic level of care when we went to inspect.

We found breaches in regulations relating to safe care and treatment, staffing, consent, duty of candour, recruitment, governance, complaints, making notifications, person centred care, and safeguarding. We also made one recommendation.

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:
This service was registered with us on 18 March 2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about care visits being missed, staffing and medicines.

We have found evidence that the provider needs to make improvements across the whole service. Please see the safe, effective, caring, responsive, and well-led sections of this full report.

Actions taken by the provider at the time of the inspection to mitigate risks were not adequate or effective. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to staffing, complaints, safeguarding, safe care and treatment, good governance, person centred care, making notifications to the CQC, duty of candour, recruitment, and dignity and respect at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Teonfa Care Group (South West)

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 team consisted of three inspectors who visited the Plymouth office over two days and one further inspector who visited the Barnstaple office on one day.

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

At the time of the inspection the service did not have a registered manager in post. The registered manager had left the service in the week before the inspection started. The provider had arranged for another interim manager (hereafter referred to as manager) to oversee the service. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced. We announced the following days of our inspection so there would be a responsible person available to give us access to the service's systems. Inspection activity started on 10 October 2019 and ended on 18 October 2019

What we did before the inspection
We reviewed information of concern we had received about the service and assessed the level of risk. We sought feedback from the local authority on safeguarding concerns. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
On the 10, 14 and 17 October 2019 we visited the office location and met with the provider, manager, office and care staff. On 18 October 2019 we visited the Barnstaple office and met with office staff and the manager. On 15 October 19 we visited three people in their homes with prior consent. During the inspection we spoke with eight people, seven relatives, the registered provider, a coordinator, a quality care supervisor, eight care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed some interactions staff had with people and some people showed us their care records. When we visited the office, we looked at the rostering system, staff files, Medicine administration records (MAR), daily care notes, and other records and policies used in the running of the service.

The local authority took over the rostering of care visits part way through the inspection as risks that people faced were not being managed by the providers. Information of concern was shared with the providers and between CQC and commissioners throughout the inspection to help ensure people were safe.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We liaised with the local authority who continued to provide support to the service to ensure its safe running.

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. We had to intervene several times because we were so concerned about the quality and safety of the care people were receiving.

Systems and processes to safeguard people from the risk of abuse
At manager and provider level there was a lack of understanding of what constituted abuse and what action needed to be taken to keep people safe. This contributed to systemic issues in the service that resulted in the neglect of people.
• For example, systems to safeguard people from abuse were not established or operated effectively. Safeguarding concerns raised in the service were not passed on to the appropriate safeguarding authority or investigated internally. Risks relating to safeguarding were not mitigated.
• There had been recent incidents where a level of unnecessary and disproportionate restraint had been used, resulting in ill effects for one person. The provider had failed to investigate this in a timely manner and had not made a referral to the safeguarding authority as they should. We intervened by reporting it to the safeguarding authority and asked the provider to act.
• Not all staff had training in safeguarding adults and when we asked staff, not all of them knew how and where to report safeguarding concerns.

Safeguarding systems were either not in place or robust enough to demonstrate abuse was prevented, people were subjected to unnecessary restraint and there was a failure to investigate and report abuse. This placed people at risk of harm and some people were harmed as a result of these failings. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• People, relatives, and professionals told us people were not always safe. One person said, "I didn't feel safe, so I sent them away." Another person told us staff were arguing and swearing at each other in front of them and they felt afraid.
• One relative fed back that personal care could be more thorough as their relative became unwell due to hygiene issues that were supposed to be addressed as part of the care package provided by the service.
• Risks that people faced were not always assessed. For example, four out of six people's risk assessments we asked to see were not in place; either in people's homes or in the office.
• People were not always protected from risks associated with their health needs. For example, records showed some people had risks associated with their mental health, epilepsy, mobility or were at risk of developing pressure ulcers. Staff had not been provided with any information to minimise/ mitigate these risks.
• Where risks had been identified by staff, action had not always been taken to minimise the risks or protect people from harm. For example, one person had risks associated with epilepsy. We found record keeping

was poor, did not cover all the risks or give guidance to staff on how to support this person. We brought this to the attention of the provider and informed the local authority of our concerns.
• Safety monitoring was ineffective, there was no system in place to record whether care visits had taken place or if enough staff were available to provide support to people in accordance with their assessed needs. We saw evidence of multiple visits where people had been assessed as needing two staff to support them safely, but instead were supported by one staff member. On the second day of inspection we brought this to the providers attention. On third day of the inspection we found the provider had failed to take any action to address our concerns.

Using medicines safely
• People's medicines were not always managed safely.
• Medicine administration records (MAR's) showed people were not receiving their medicines as prescribed. For example, MAR's showed some people were incorrectly given too much of some medicines and had multiple missed doses of others. One person had experienced multiple seizures after not being administered epilepsy medicines by staff. Another person mental health had deteriorated, and they became unwell as they had not received time sensitive medicines on time. During and following the inspection we shared our concerns with the local safeguarding authority.
• Not all staff administering medicines had been provided with training or were assessed as competent. One staff member said, "No, I haven't had training in medicines, it's ok though, I know what I'm doing." This placed people at an avoidable risk of harm.
• Staff were not always recording when medicines had been given. For example, MAR's for one person who took multiple medicines did not contain any evidence to show this person had taken any medicine between 12 and 17 October 2019. This meant staff were unable to assure themselves this person had taken their medicines as prescribed. We asked the provider to carry out a welfare check, following which urgent medical attention was then sought as the person was feeling unwell.
• Records relating to medicines were unsafe. We found MAR's were poorly filled out; some had people's names missing, were handwritten without a signature from staff or omitted full information on dosage and times medicines needed to be given. There was no evidence that MAR's were checked by the registered manager, manager or provider for accuracy.

Risk were not assessed, managed or mitigated, and medicines were not managed safely. People were harmed as a result of unsafe medicines management. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider and staff told us there were not enough staff with the right availability to meet every person's care needs. There were eight staff vacancies.
• On the service's online system, we generated a report that identified key outcome figures for care visits. According to this system not one person had received care for the full time that they were assessed as needing care for. This report showed a concerning level of missed appointments, with 13 people having over 50% of their visits missed. We discussed this with the provider and they responded that staff were not logging in and out correctly when they visited people's homes. We also fed back that the manager and provider were not always logging in and out of care visits too.
• However, people and relatives told us their visits had not always taken place. The roster showed multiple missed visits. This meant people were not having their assessed risks met and were at risk of harm. One person required urgent care after care visits were being missed and they became unwell. Another person said, "Yes it has affected me, I rely on them for food."
• People, staff and relatives told us their care was being provided by one member of staff when they had been assessed as requiring two. The roster showed repeated instances where people received support from

one staff rather than two. One person told us they felt unsafe as they thought they were going to fall when only one staff member supported them rather than two.
• The rostering of staff was in disarray and unsafe. On our first day of inspection the roster showed some care staff were meant to be visiting three people whose visits started at the same time.
• Travel time was not included in rostering meaning staff had to rush from visit to visit, and could not always stay for the length of time needed to complete all support and care
• Changes in times of care visits due to staffing issues were not communicated and people had to call the office rather than being consulted on changes of visit times. One person said, "I have had to turn them away when they come at the wrong time."

There were not enough staff to meet people's care needs. Staff were not recruited safely. This placed people at direct risk of avoidable harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When CQC and the local authority showed this provider the extent of the issues at the service, they made efforts to address the shortfall in staffing and came down from their home in another county to provide care for people themselves. They also diverted staff from their other branch to support the Plymouth office.
• On the first day of our inspection visit we requested access to staff files and these were not available. On the second day of our visit we again asked for staff files and only two were available for care staff. 17 staff files were missing. We could not evidence that staff were recruited safely or that adequate checks had been completed into the background of staff to ensure they were safe to work with people.
• One staff member told us they were recruited through social media and did not have to fill out an application form. This meant the provider did not have relevant work history that is required in the safe recruitment of staff.

Staff were not recruited safely. This placed people at direct risk of avoidable harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The providers were apologetic about the mistakes and chaos the service was in during our inspection. However, there was a blame culture, with staffing attitudes and the recently departed registered manager being blamed for the unsafe care and support.
• Immediate lessons had not been learned and we saw repeated mistakes being made with staff rosters not being communicated to people, rosters being changed at the last minute and poor communication apparent. This only improved when the local authority stepped in.

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
• Staff files were not in place or missing and the service was unable to evidence staff had undertaken effective induction when they started working for Teonfa. One staff member said, "My induction was ok, but I'm experienced, if I was new it wouldn't have been enough."
• Office staff did not all have inductions that enabled them to do their jobs. For example, one coordinator was unable to show us how to use the rostering system effectively as they had not had an in-depth explanation from the manager or provider on how it worked.
• Staff training records were missing and there was no central training matrix to evidence that staff had been supported to complete training that would enable them to meet people's needs. Staff told us they had received face to face moving and handling training and other basic training but had not completed training specific to people's assessed needs, for example on stoma care or diabetes.
• Relatives raised concerns about the training of staff. One relative said, "Not all the carers understand my husband's needs, that he is so forgetful, I don't think they are well trained. They just ask him does he want any help and he says no. One staff member is good and can get him to have a wash, but most don't seem to know how to work with him."
• There was no evidence of any supervision or support records for staff from April 2019. Staff said they felt supported by the registered manager that had left, but their time was spent covering care visits rather than recording staff supervisions.
Staff were not equipped to meet people's needs through, training, induction or supervision. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 service was not working within the principles of the mental capacity act.
• Staff were not always clear on whether a person had mental capacity to make specific decisions.
• One person was having their choices taken away from them by staff without any assessment in place to determine whether this person had capacity to make this decision or had given consent. This was in regard to staff removing items from within this person's reach and restricting their movement through turning off equipment.
• Consent documents for people were either missing or unsigned by people and staff.

The service was not acting within the principles of the MCA. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We did observe some staff asking some people for consent when we visited them in their homes.

Supporting people to eat and drink enough to maintain a balanced diet
• Some people were happy with how the service supported them to eat and drink. Concerns raised by people regarding the preparation of food and drink were mainly focused on staff being late and people waiting for them to arrive to prepare them a drink. One relative told us how their loved one had to skip meals sometimes because staff were so late. One person told us they sometimes missed meals if the visits were missed or not on time.
• Care staff lacked knowledge about what one person's specialist diets looked like. For example, one person with diabetes was supported by staff to eat and drink. Their care plan explained staff needed to monitor their food intake due to their diabetes. However, their food records showed mainly sweet dishes being prepared and eaten rather than a healthy diet.
• People were not always having their nutritional needs met. Records of food and fluid intake for a person who relied on staff to prepare their meals showed there were sometimes 24-hour periods where they did not choose to eat, we did not see evidence that this was passed on as a concern.

Risk were not assessed, managed or mitigated in relation to people's diabetes and nutritional intake. This was a breach of regulation 12 (Safe care and treatment) 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 service had not always recorded people's assessed people's needs when they had taken place. Records did not include holistic assessments of people's physical, mental and social needs. This meant staff did not know what people's needs were. For example, one person needed specific support with handwashing to avoid infections, but this was not assessed, recorded or communicated to care staff.
• Staff and the provider were unable to tell us when we asked, about any positive outcomes that had been achieved by people with the support of the service.
• We saw care practises that were not in keeping with best practise guidance. For example, unsafe moving and handling practises and staff not following NICE guidance on the safe administration of medicines.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• There was limited evidence to suggest that the service supported people to access healthcare service from documents it had on file. However, staff told us they had contacted health services before for people including the dentist, GP and district nurse.
• The service could not demonstrate it was able to provide consistent, effective timely care. This was evidenced by the lack of documentation and feedback from people, relatives and staff.
• We did not see any evidence the service had supported people to live healthier lives. Nutrition records

showed inappropriate food prepared for people with diabetes, where people had visits missed so could not go out to get exercise or fresh air, and where staff lacked the skills or training to encourage people to engage in personal care and activities that would encourage their wellbeing.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. This is the first inspection for this newly registered service. This key question has been rated inadequate. People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

We saw some caring staff and positive interactions during our inspection. However, the systemic failures resulted in people not receiving a caring service. The way care provision was being managed was not respectful of people and meant staff could attend to people's dignity. This impacted on people's quality of life. This domain has been rated inadequate as a result.

Respecting and promoting people's privacy, dignity and independence

• People's dignity was not respected. One person said it was not dignified for an adult to go to bed at seven in the evening, because that was the time staff would turn up to support them to get ready for and get into bed. Another person said, "It isn't treating me with dignity when I am desperate for the toilet and waiting for them to arrive, so I can relieve myself." Another person was left in soaked and soiled continence pads for up to 15 hours because the service failed to preserve their dignity by providing staff on time to meet their continence needs.

• People were not treated with the respect they deserved and were not valued by the service, people's wishes were not considered, and visits were rushed, late or missed altogether. This was not respectful to people.

• One person explained how a staff member that was in a rush and did not know them, or about their needs, put away all their cups. Due to their sight impairment they could not find the cups and had to drink out of a bowl. This was not dignified for the person and consideration had not been made of their sight impairment.

• When we started the inspection, documents containing confidential personal information were spread around the office and not stored securely.

• Staff told us how they covered people up when providing personal care and ensured curtains were closed and doors shut.

• We asked staff and the manager and the provider to think of any examples of where people had been supported to become more independent. We were not provided with any examples.

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

• People were not treated with dignity and respect by the service. People's wishes were not respected, and their diverse needs not taken into consideration.

• People said care staff were kind and caring and tried their best. However, they were let down by the constant lateness and poor communication. One person said, "I feel sorry for the girls they go above and beyond, they are definitely caring." Another person said, "The carers are good."

• Relatives said when the same staff came, and they knew their family member the care was good. They also said that having to repeat what people's needs were every time a different staff member came meant the support was not consistent. One person said, "It's an impossibility getting the same carers." This showed people were not getting consistent care from familiar staff.

Supporting people to express their views and be involved in making decisions about their care
• People told us they did not feel listened to by the office staff and could not express their views to the service.
• People said care staff listened to them, but they often didn't see any change after they had given feedback.
• People were not involved in the planning of their care and said after an initial assessment they were not contacted again to give their view on their care.

The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

• Care plans were not in place for every person, so their preferences were not captured or communicated to staff. Where care plans were in place they contained very little information. The provider had started to write some care plans, but these were constrained by the limited knowledge they had of people.
• We saw a life history for one person which described what their previous employment had been and what their interests were. No other care plans we looked at contained this information.
• Care provision was not tailored to people's preferences. During our inspection we identified several people who were getting visits at the wrong time and having to go to bed early or wait for food and drink. Two people were not being supported by their preferred gender of carer, which caused them upset.
• One relative explained the impact of the service not meeting the timing preferences of care visits. They said, "Sometimes we have had to miss meals because they messed up the timings, she gets hungry and upset."
• People were not told which staff member would be coming to support them. One person told us it caused them anxiety they did not know who was going to turn up. They had told staff and the office their preference was to know who was coming to provide care, but it had not been considered.
• People told us they did not feel they had choice and control over their care and they never knew which staff would turn up, when they would turn up or if they would have time to provide the full care they required to meet their needs.

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.

• Due to the lack of assessments and care plans the provider failed to fully assess people's communication needs.
• Care staff adapted their approach to meet the communication style of people they supported.

We observed staff taking time to listen to people and giving clear instruction where a person responded best to this.

Care was not person centred, preferences were not recorded or reflected in care provision. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

• There was a complaints policy and procedure.
• The manager showed us a complaints log that had one complaint recorded on it. This did not capture the complaints that had been made in the last six months and there was no record of what recent complaints had been responded to and whether they had been resolved and in what timeframe.
• People told us they did not feel there was any point in complaining because they were not listened to. One person said, "In the past when I have complained the office has been poor."
• Relatives said they had complained in writing and never received a response. One relative said, "When you complain over the phone you just get lip service, nothing changes." However, two relatives said the provider had been in contact with them and they felt more listened to in respect of their complaints in the last few days.

This was a failure to establish and operate a system for recording and investigating complaints, and appropriate action was not taken to resolve them. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
• The service was not supporting any person with end of life care at the time of our inspection.
• We saw end of life wishes captured in one care plan we looked at.
• Staff had not received training in end of life care.

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.

People were not safe, and the governance of the service was poor. We shared our concerns about people and systems with the commissioning local authorities who took immediate action to provide support in the running of the service to help ensure people were safe. The local authorities chose to find alternative providers of care for some people, as a way of managing the significant and ongoing risk to people. This process is ongoing.

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

• People and their needs and preferences were not placed at the centre of the service. People were placed at risk from unsafe care. We saw little evidence of positive outcomes for people and asked three times for examples of this to be provided.
• The culture in the service was not positive and there was a focus on blame rather than accountability.
• Staff morale was low, and staff were leaving the service due to pay issues and the way they felt they were being treated.
• The provider had made efforts to be present and brought staff from other branches when they found out the service was failing. The provider was also involved in care delivery and starting to write care plans. However, this level of involvement was as a reaction to the service being in crisis rather than as part of a supportive culture that could have mitigated some of the risks we found.

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

• The service was in disarray and the leadership team were unsure of what to prioritise. Prior to commissioners stepping in, there was no clear leader in the service. On several occasions we had to ask who was in charge and who was going to be the decision maker and point of contact for staff.
• The provider failed to ensure an audit system was in place to check quality in the service and there was no evidence of provider or registered manager checks for MAR, daily care notes, staff support, care plans or risk assessments.
• We asked the provider to send us evidence of their part in quality assurance. They sent us records to show a report that was sent to them periodically by the ex registered manager. This report focussed on targets rather than the quality of care provision and demonstrated an arms length involvement from the provider.
• Documentation regarding risks, medicines, rostering, supervision, and staff recruitment, was poorly filled out or missing. The providers did not know where records were kept or how to access them. When we arrived, confidential information was spread around in the office and not locked away.
• Systems to ensure risks were effectively managed and mitigated were not in place. We found people being

placed at direct risk of harm through service failings and the actions of staff, the manager and the provider. We requested that a welfare check take place for one person as we were so worried about their health, and another person needed an ambulance calling because of a failure to administer their medicines.
• There was limited support for the registered manager before they left and key office staff were not replaced, meaning people were doing more than one role over a period of time. This placed people receiving care and staff at risk.
• There were widespread failures in the running of the service resulting in breaches of nine regulations, this showed a disregard for the regulatory responsibilities of the provider.

Systems were either not in place or robust enough to demonstrate the quality and safety of services 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 understood the service needed to make improvements and said they were committed to seeing it through. They changed the structure of the service and said they would make sure a provider was always in the office until the service was safer.

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
• There was a lack of understanding from the provider regarding their duty of candour. They failed to inform people and their relatives of the issues in the service in a timely way. At the point of our inspection some people told us they still had not been told what was happening with the service and why visits had been missed or were late.
• People and relatives were not always kept informed when things went wrong such as staff running very late, possible missed visits, and when errors were made with medicines.

The provider failed to understand and act on their duty of candour. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notifications were not made to us when incidents occurred or where people were placed at risk of harm. The provider has a responsibility to report suspected abuse and incidents to us.

The provider had failed to report all notifiable incidents to the CQC this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009; Notification of other incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
• We did not see a focus on an equality agenda because once they were aware of the failures of the service, the providers were prioritising people's safety first.
• People did not feel involved in the running of the service or decisions about their care.
• The providers said they had learned from what had happened and would be more involved in the running of their services.
• The providers welcomed the support from the local authority when they stepped in to oversee the rostering of care and arranged for packages to be moved to other providers because of unsafe care practises.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to report all notifiable incidents to the CQC this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009; Notification of other incidents.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not person centred, preferences were not recorded or reflected in care provision. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting within the principles of the MCA. This was a breach of regulation 11

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was a failure to establish and operate a system for recording and investigating complaints, and appropriate action was not taken to resolve them. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not recruited safely. This placed people at direct risk of avoidable harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to understand and act on their duty of candour. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.