Hands of Compassion Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hands of Compassion is a domiciliary care agency. It provides personal care to adults living in their own homes, some of whom are living with age related frailty and dementia. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection, staff supported 10 people with personal care.

People's experience of using this service and what we found
People's associated health risks were not always appropriately assessed. People's care records did not reflect their needs, staff told us they relied on people to tell them what support they required. Risk assessments for people who required support with pressure area care were not in place and their care records were vague. One person had sustained a pressure injury, healthcare professional guidance had not been included in the care plan to inform staff on how to support them with position changes to relieve the pressure and promote healing of their wound. Risk assessments had not been completed for people who had catheters in place or for people who required support with moving and positioning.

People were always not protected from the risk of being supported by unsuitable and untrained staff. The provider's recruitment policy was not followed; staff were deployed before recruitment checks had been carried out and appropriate training had been given. Staff did not receive ongoing supervision and training to ensure they were following best practice.

People were not always protected from risk of abuse; The registered manager had failed to ensure staff had received safeguarding training and had access to the relevant policy. The registered manager had failed to recognise an incident as a safeguarding concern and had not reported the concern to the local authority.

People's care records did not include health care professional's advice or contact information for staff to raise concerns in the event of complications. For example, there was no information on who staff could escalate concerns to for one person who had a catheter.

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. Mental capacity assessments were not always carried out, the provider failed to check the legal status of people's representatives when making decisions on their behalf.

People were not always asked for their views and their feedback was not always acted on. The provider's governance systems were inconsistently carried out and did not highlight shortfalls identified at our inspection. The provider had failed to sustain and make improvements to the service following previous inspections.

People told us staff were kind and considerate. Comments included, "They have been very kind and supportive, they have done what I want, and what I need." And, "The carers are excellent, very friendly, kind and useful."

People spoke highly of the registered manager and told us they were confident complaints would be handled efficiently. One person told us, "I know I could complain to [registered manager]. I speak to all the staff who come in, they are very friendly, anything small I can speak with them, but I wouldn't call it a complaint."

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 24 December 2020). There were continued breaches of regulation 12 (Safe care and treatment) and regulation 17 (Good governance). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations 12 and 17 for the third consecutive time and further breaches of regulations have been identified.

As a result of our inspection of 22 January 2020, we placed conditions on the providers registration for the breach of regulation 17 (Good governance). These conditions included the registered provider must a send monthly report to the Care Quality Commission. The report must include the results of audits and actions taken undertaken for the management of medicines, care plans, risk assessments, missed calls and accidents and incidents. The provider had not always complied with this condition since the last inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We undertook this focussed inspection to check the progress of the action plan. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hands of Compassion Limited 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people from risk of abuse, assessing risks to people, medicines management, implementation of the Mental Capacity Act 2005, staff recruitment, staff training

and supervision, and good governance at this inspection.

We issued two Warning Notices. The provider failed to ensure the safe care and treatment of people. The provider failed to ensure fit and proper persons were employed to support people with a regulated activity. The provider is required to be compliant by 25 September 2022.

We served a Notice of Decision on the registered provider. They are required to supply monthly submissions to CQC in relation to compliance with governance of the implementation of mental capacity assessments, staff recruitment, staff training and the competency of staff.

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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Hands of Compassion Care Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a short period of notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 20 July 2022 and ended on 29 July 2022. We visited the location's office on 20 July 2022.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of a monitoring activity that took place on 28 June 2022 to help plan the inspection and inform our judgements. We sought feedback from Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided and gained feedback from two people's relatives. We spoke with eight members of staff including the registered manager, a director, team leaders and care workers.

We reviewed a range of records. This included five people's care records and medication records. We looked at 14 staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including audits and logs were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. The provider had failed to ensure the proper and safe management of medicines. This was a continued 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 our last inspection, risks to people were not always identified and managed. For example, where people were at risk of pressure damage to their skin, information was not available to staff on the signs of deterioration they should look out for and what action should be taken. At this inspection, risks to people's health were still not assessed to mitigate the risk of harm.
- Some people were at risk of developing or worsening pressure damage to their skin. Appropriate care plans and risk assessments continued to not be in place. Care plans lacked important detail such as, the location of the wound or vulnerable area. Where staff supported a person to change their position to relieve pressure, there was no guidance, such as, position changes from left to right. There was no evidence staff were supporting the person with position changes. Care plans did not reflect what staff told us, for example, a person declined to go to bed and preferred to stay in their chair. The person's care plan did not reflect this increased risk and the person had sustained pressure damage to their sacrum.
- Where staff were required to support people with catheter care, there was no guidance available on how to support them. There were no care plans or risk assessments in place; one person's care plan advised staff to empty their commode and did not reference they had a catheter. One staff member told us they were unaware of the person having a catheter in situ until they arrived for the care visit. The staff member said they were not confident to change the person's catheter bag. There was no guidance to staff on how to prevent complications associated with catheters or who to contact if there were any concerns.
- Risk assessments were not available to guide staff when people needed equipment or support to move and position. Care plans lacked information and referred staff to read the associated risk assessment, although one had not been completed. One person's care plan highlighted a risk of falls when moving between rooms. There was no guidance to staff on how the falls could be prevented. The same person's care plan stated they could stand with support, however, staff told us the person was unable to stand or weight-bear. The care plan did not reflect the person's needs, leaving them at risk of receiving inappropriate or consistent support.
- Pre-service assessments forms were incomplete but were intended to contribute to other assessments.

For example, the pre-service assessment form highlighted people's medicines to be listed; this information contributed to the falls risk assessment, such as, whether a person is prescribed a medicine which caused drowsiness which could be a falls hazard. Without full information, people's risk of falls were not fully assessed, and risks could not always be mitigated or managed.

The provider failed to ensure care and treatment was provided in a safe way or risks to people had been mitigated. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. At the last inspection medication administration records (MARs) did not contain enough information for staff to administer medicines safely. At this inspection, improvements had been made, however, further concerns relating to medicines were identified.

● Some staff were administering medicines to people without the appropriate training. One staff member told us they had been shown how to administer medicines during their shadow shift but had not received any training. Some staff members told us they had completed an online course but had not had their competencies assessed before administering medicines to people. Training records evidenced a number of staff had not completed their medicine training. People were at potential risk of being administered medicines by untrained staff.

● Conflicting documentation was in place for people regarding their medicines. One person's assessment form stated they were prescribed an anticoagulant medicine, but their care plan did not reflect this. The registered manager told us the medicine had been stopped. We reviewed the electronic medication administration records (eMARs) which showed the person was still receiving this medicine. The anticoagulant medicine had not been recognised as a risk. Anticoagulant medicine thins the blood which poses as a risk of excessive bleeding in the event of an accident or emergency.

● Information regarding medicines was not always accurate which posed a risk staff would not know how to support people safely. One person's pre-service assessment form documented they had an allergy to certain antibiotics. This information was stored at the provider's office and had not been transferred to the person's care plan for staff to access.

The provider failed to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff recruitment was not carried out safely. Staff had not fully completed application forms or provided evidence of full employment histories. Gaps of employment were not explored by the provider, so they could not be assured of the reasons behind gaps of employment.

● Pre-employment checks on people's suitability to work in a care setting were not always carried out. Disclosure and Barring Service (DBS) checks were not always undertaken before staff were deployed. At our inspection 11 staff members were working without verified DBS checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions and protect people from the risk of being supported by unsuitable staff.

● References were not routinely applied for. Nine staff members did not have any references in place. Where references were applied for, they were not verified and checked by the provider. A staff member had one reference in place, the dates of their employment had not been checked. There was an obvious date error on the reference which had not been clarified.

● The registered manager had not considered risks associated with staff working directly with other family members. There was no policy or risk assessment in place to support decision making of family members working together in people's homes. The registered manager told us one staff member always worked with their spouse as their command of English was not good, therefore, their spouse could translate for them. This left people at risk of a closed culture amongst staff.

The provider had failed to operate robust recruitment procedures and ensure that relevant pre-employment checks for new staff were undertaken. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We sought some urgent assurances from the provider around risk assessments, pre-employment checks and DBS disclosures. The registered manager confirmed the existing staff would not be supporting people until their employment checks were received.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always protected from the risk of harm or abuse. During the inspection, an incident was highlighted, where a person had fallen and sustained a head injury. Staff supported the person with personal care but did not call an ambulance. The person's relative was informed after personal care had been provided, and the relative requested an ambulance was called, the person was taken to hospital and required treatment. The delay in seeking medical intervention for the person had not been recognised by the registered manager as a potential safeguarding concern and had not been reported to the local authority and CQC.
● Appropriate learning had not been taken forward following the delay in seeking medical attention. The registered manager documented they had reminded the staff member to call an ambulance in the event of an emergency. However, they did not identify a training need for the staff member or take further action to mitigate reoccurrence.
● Some staff had not received safeguarding training and were not able to explain who they would escalate concerns to outside of the provider. Some staff told us they did not have access to the safeguarding policy. One staff member said they would use an internet search engine to find out who to contact if they suspected a person was at risk of abuse.

The provider did not ensure that systems and processes operated effectively to prevent abuse. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe and they were comfortable to speak up if they had concerns. One relative told us, "[Person] feels safe when they come to sit with [person] for me to go out, there are no problems and [person] is not worried." One person told us, "The manager could resolve the problems."

Preventing and controlling infection
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely. Staff told us they had access to PPE. We saw large amount of PPE stocks were available.
● COVID-19 testing was carried out in accordance with government guidance. Staff told us they completed regular testing and test kits were available to them.
● We were assured that the provider's infection prevention and control policy was up to date.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● At our last inspection, the registered manager did not practice the principles of the MCA. Best interest decisions made on people's behalf had not been rationalised nor documented. The registered manager told us they would undertake training to support their understanding of the MCA. At this inspection, improvements had not been made. The registered manager had not carried out capacity assessments for people, they told us everyone who used the service had capacity, however, people's care records contradicted this.
● Where a person's care record contained information that they lacked capacity, no capacity assessment was in place to support this. The registered manager showed us a form they used to assess capacity, the contents of the form was not appropriate or relevant to a domiciliary care setting. Not all staff received training on the mental capacity. One staff member said, "MCA training? I've not had any. It might be on the training list as they add stuff to that."
● Consent forms were incomplete and inaccurate. The consent forms used had been completed for one person who used the service and were populated with dates relevant to them. The provider asked other people to sign a copy of the same form; dates and decisions were not specific to them. Some people did not have completed consent forms on record, although staff told us they always requested permission prior to helping people.
● Where a person lacked mental capacity, the provider had not taken steps to confirm whether their relative had the legal authority to make decisions for them. A consent form was completed on the person's behalf and signed by their relative, the form was incomplete and did not specify whether the signatory was a legally

appointed representative. Records confirmed the provider had not seen the lasting power of attorney documentation. Without robust procedures, people were at risk of decisions being made for them unlawfully and outside of their best interests.

The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff did not always receive training prior to supporting people. Staff told us they had not received moving and positioning training before assisting people with equipment such as hoists. Staff told us the training they received was either online or they were shown by another staff member. Some staff who were new to care had not received any training and were supporting people to move and position.

● Records of staff training were incomplete and only referred to six staff training records. Following the inspection site visit, we identified 20 staff were supporting people with personal care. We asked the registered manager to send details of training for 11 staff. The registered manager was unable to evidence these staff had completed mandatory training. Without mandatory training, people were at risk of not being supported safely.

● Training overview records were inconsistent with training certificates and what staff told us. One staff member told us they had completed safeguarding training, yet their training record did not confirm this. Another staff member told us they had not completed medicine training, their training record indicated they had completed the course within the last month. A staff member's training record showed completion of mandatory training throughout the year. However, the registered manager sent copies of their certificates, which were dated after the inspection site visit.

● Staff induction varied. One staff member told us they were new to care before joining Hands of Compassion, they had received one evening and one morning shadow training session before working alone without being assessed as competent. New staff were not invited to complete the Care Certificate or a similar induction programme. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● Supervisions and spot checks on staff were inconsistent, staff were not always given opportunities to discuss their progress or discuss issues. One staff member said, "Because I'm working with double ups (with team leaders), mostly it's to sign paperwork and to see if I'm up to date with training." One staff member told us they had not received a spot check or supervision for eight months and said, "The company that distributes the training email me. If I decided not to train at all it would not be followed up."

The provider had failed to ensure that staff had the training and induction they needed to support people effectively. This was a breach of Regulation 18 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

● People's needs were not robustly assessed before they used the service. Team leaders visited people's homes to complete assessment paperwork. Assessment forms were incomplete and vague. Where people had advancing health conditions, their assessments did not reflect this. This is an area in need of improvement. The registered manager told us they would arrange additional training for staff in respect of carrying out assessments.

● People's oral hygiene was not fully considered during the assessment process. Information was vague and did not include the level of support people required or whether they had natural teeth of dentures.

● The registered manager told us they found out people's protected characteristics under the Equality Act 2010 such as age and religion once staff started to support people. Where possible people were matched with appropriate staff. For example, one person had strong religious beliefs, their regular care staff member shared their faith so they would prayer together.
● People told us where they specified a preference for a female or male carer, their wishes were respected. One person told us, "I have asked not to have males for washing. A female and a male is fine, but not males alone. Yes, they have stuck to this."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The registered manager gave an example of a person who had physiotherapy involvement and told us staff encouraged them with exercises. The person's falls risk assessment mentioned exercises, but further information and guidance to staff on the frequency and type of exercises was not transferred to the person's care plan. Staff had not recorded they had supported with exercises in the person's care notes.
● The registered manager told us there had been limited opportunities to work with other agencies. People and their families engaged with healthcare professionals without the need of support from staff.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

At our inspection on 22 January 2020, we imposed conditions on the providers registration. The conditions included the provider must a send monthly report to the Care Quality Commission. The report must include the results of audits and actions taken undertaken for the management of medicines, care plans, risk assessments, missed calls and accidents and incidents. The provider had not complied with this condition since the last inspection.

At our last inspection the provider had failed to ensure systems or processes were operated effectively to assess and improve the quality and safety of the service. The provider had failed to maintain securely a complete and contemporaneous record in respect of each service user. This was a continued breach of Regulation 17 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.

● At our last inspection, quality assurance processes did not identify ongoing shortfalls in people's care records, such as, health needs and the lack of risk assessments. At this inspection, improvements had not been made, care records lacked information and were inconsistent.
● The provider did not evidence continuous learning and failed to improve and sustain improvements. During the inspection, the provider and registered manager were unable to evidence a strategy or development plan was in place to address the failings from the last two inspections. The provider had not routinely submitted reports of audits to CQC as part of their imposed conditions. The registered manager told us they had lapsed with their quality assurance processes following the last inspection of the service. This is the third inspection of the service and they have consistently been rated less than good with consecutive breaches of regulation 12 and 17.
● Governance processes failed to identify risks to people were not assessed and mitigated. Where people had health conditions, or equipment in place, the provider failed to assess the associated risks. For example, catheter care and moving and positioning. Staff told us they did not have access to people's risk assessments and relied on people to tell them how they wished to be supported. One staff member said,

"We don't get to see the risk assessments, I think we need to see them, it would be helpful, it would be better if we had them in the folders."

● The provider could not demonstrate the effectiveness of their audits. Government processes did not identify shortfalls found throughout the inspection. For example, consent forms were ticked as present on the audit, although at the inspection, consent forms were not all present. Audits did not highlight people were referred to as a different gender in care records and the majority of documentation relating to people's care and staff recruitment was undated and unsigned. Medicine audits were not routinely completed, the registered manager told us the provider carried out regular audits of the eMAR charts although they were not available at our inspection. Without regular quality assurance processes, shortfalls could not be shared, addressed and learned from.

● The lack of systems to monitor the quality of the service and provide effective managerial oversight did not allow for lessons to be learnt, or actions taken to drive improvements. The provider's policy states for at least one quality audit to be carried out monthly. There were gaps of over seven months between audits. The registered manager told us following our last inspection and during a monitoring activity call, they would increase the regularity of quality assurance processes, this had not happened.

● The registered manager did not always demonstrate transparency with the inspection team. For example, they did not disclose the full staffing team until this was queried. The provider was asked for information in relation to recruitment and training of staff but provided a delayed and incomplete response. The registered manager did not acknowledge the potential risks of related staff working together and staff working without robust recruitment checks.

● The provider failed to demonstrate understanding of their responsibilities with regulatory and legislative requirements. During the inspection, we identified an incident which had not been reported to the local authority safeguarding team. This meant the provider could not be assured all incidents had been reported to appropriate bodies and as a result had failed to ensure these had been managed safely or provided assurance of how they acted on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● The registered manager did not demonstrate a knowledge of the duty of candour to be open, transparent and provide an apology when things went wrong. When describing their responsibility, they told us, "It is not what you say but how you say it. Having a difficult conversation about something that has been noticed. Sometimes people can be difficult, we have one (person) which we had to hand back as they were very rude to staff."

The provider failed to ensure there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. The provider failed to maintain records in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to send to the Commission, when requested, a report of actions to comply with the conditions imposed on their registration. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service did not always promote a positive and inclusive culture which involved people. The majority of

care related paperwork was unsigned and undated, the provider was unable to evidence how they included people. For example, pre-service assessment forms had not been signed by the person and lacked person-centred information. Where a person lacked capacity, it was not evident whether the service was working in their best interests as appropriate assessments and checks had not been carried out and decisions had not been documented. Care records did not reflect people's needs and the support provided by staff.

● The registered manager was unable to evidence how they sought the views of people and relatives or acted on any feedback. Some people told us they had previously completed a survey about the service. Feedback surveys were undated, the results had not been analysed and were unavailable during the inspection. We were shown one example of undated feedback; the person who completed it provided a comment saying they had not seen nor contributed to their care plan. The registered manager told us they had not replied to the person or addressed the feedback.

● Staff and people told us the registered manager was not always easily contactable and there could be delayed response to queries. One person said, "It can take a bit of time to get through." Staff told us, "[Registered manager] is not that easy to reach, not many of them (managers) are. This can make situations difficult, sometimes clients can't get hold of managers." And, "There is a lack of communication sometimes, it can take some time for them to answer the phone, so I solve the problem."

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives felt confident to raise complaints with staff and management. A relative told us, "If there were some problems, I would talk to the care staff. I've never given a thought who to complain to. I don't know who the manager is." A person said, "I honestly don't have any complaints. If I had any problems, I would call up the manager."

● Staff gave mixed feedback about the registered manager. Comments included, "As a person, they are amazing, as a manager they have been fantastic, the communication of the management needs improvement." And, "I think they (managers) need to be more organised and communicate better. From what clients tell me, they think some of the staff don't know what they are doing."

● People told us staff were kind, caring and knew them well. Comments included, "The ones (staff) that come to me I am happy with them, I am very lucky, they are very kind and very good." And, "I have been happy with the people and the care I have been getting."

Working in partnership with others

● The service held a membership with the Registered Manager's Skill for Care network and was also a member of the United Kingdom Home Care Association. The registered manager told us they used these resources to keep up to date with regulations and legislation, however, they were unable to demonstrate a knowledge of their regulatory responsibilities, such as, the MCA and duty of candour.

● The registered manager told us there had been limited opportunities to work in partnership with others. The registered manager described a working relationship they had with a local registered manager, where they would offer mutual advice and support.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that systems and processes operated effectively to prevent abuse. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff had the training and induction they needed to support people effectively. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure care and treatment was provided in a safe way or risks to people had been mitigated. The provider failed to ensure the proper and safe management of medicines. 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 enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. The provider failed to maintain records in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Varied a condition

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate robust recruitment procedures and ensure that relevant pre-employment checks for new staff were undertaken. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice