Verrolyne Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Verrolyne Services is a domiciliary care agency located in the London Borough of Havering. It is registered to provide personal care to people in their own homes. At the time of the inspection, approximately 151 people were receiving support. CQC only inspects domiciliary care agencies where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do receive personal care, we also consider any wider social care provided.

People's experience of using this service and what we found

People were not always supported in a way that was safe. Risks to people such as those with specific health conditions such as diabetes, panic attacks and breathing difficulties were not always assessed and managed. This meant staff did not have the necessary guidance on how to support people with these conditions, should they experience symptoms.

Staff were monitored to check they had arrived for their visits to people and completed their tasks. However, we noted instances where staff did not always complete 'double up' visits together as planned. Some staff, people and relatives did not feel there was enough travel time and we found some calls were arranged too close together. People told us staff did not always attend calls at planned times. We were not assured staff were being deployed in the community to carry out their roles effectively.

We did not find evidence people had been harmed but there were concerns of neglect and that people were not sufficiently protected from abuse. We have made a recommendation for the provider to implement more robust safeguarding training for staff.

Assessments of people's needs were sometimes not suitable nor carried out effectively. People did not always receive person-centred care. Care plans were sometimes inaccurate and inconsistent, which meant people's needs may not be met and understood by staff. Care plans lacked information for staff to meet people's needs safely.

Incidents and accidents were reviewed and analysed to prevent re-occurrence. Staff followed infection control procedures and people were protected from the risk of infections such as COVID-19. Staff were safely recruited and received training and an induction. Staff told us they were supported by the registered manager and received supervision to discuss their performance. Most staff told us they could raise any concerns they had, although some staff told us they did not want to raise their concerns. The provider had in place a whistleblowing policy and told us staff could raise their concerns during supervision meetings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and relatives told us staff were respectful and caring and supported them to maintain their independence. Staff respected people's privacy and people's needs were met in relation to equality and diversity issues. We have made a recommendation for the provider about describing people's needs in a more dignified way.

The provider had systems to make improvements to their training processes, but more work was needed to ensure quality assurance systems were robust and effective.

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

Rating at last inspection
The last rating for the service was Good, report published on 26 March 2019.

Why we inspected
The inspection was prompted in part due to concerns and complaints received about the reliability and safety of the service, the punctuality of staff and the way the service was managed.

A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this report.

The provider has begun to take steps to improve the service. During our inspection, the provider shared their service improvement plan for our assurances, and they had started to make improvements to the care and support provided to people. However, the concerns we identified meant people could be at continued risk of unsafe care.

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

We have identified breaches in relations to safe care and treatment, good governance, staffing and person-centred care. We also made some additional recommendations.

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 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below

Verrolyne Services Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience, who made phone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Verrolyne Services 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
The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 28 June 2022 and ended on 1 July 2022. We visited the provider's office on both these dates.

What we did before the inspection
We reviewed the information we already held about the service. This included the last inspection report and notifications. A notification is information about important events, which the provider is required to tell us

about by law.

The provider was asked to complete a Provider Information Return (PIR) prior to this inspection but they were not required to submit it before the inspection took place. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection.
During the inspection, we spoke with the director, the operations manager, the recruitment officer and four care staff. The registered manager was not available during our inspection, but we contacted them after the inspection. We spoke by telephone with 15 people and 12 relatives or friends of people who used the service for their feedback.

We reviewed documents and records that related to people's care and the management of the service. We reviewed ten care plans, which included risk assessments. We looked at other documents such as medicine management, incident records, complaints, quality audits, feedback from people and infection control procedures. After the inspection, we continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated Good. At this inspection, this key question has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Systems to monitor staff who visited people in their homes to provide care were not effective. The provider used an electronic call monitoring system. Staff were required to log in to calls by scanning their smartphone device against a barcode and then log out after completing their visit, before visiting another person.

● Staff had mixed views about travel time. Some staff told us they had enough time to travel in between each visit, because they worked within an assigned postcode area. A staff member said, "It only take me 5 to 10 minutes. There is no issue." However, another staff member said, "There is not enough time at all. Sometimes I have had to go to another borough, it's not possible."

● We looked at the call monitoring data from April to June 2022. We found some occasions where the scheduled travel time between calls was not sufficient. For example, one staff member had no travel time in between three visits they had in one morning, which meant people were at risk of receiving late calls.

● We also noted staff who were required to work in pairs to support people to transfer or move using hoists did not always log in at the same time as required. There were instances when they logged in and out at different times indicating they were not working together. For example, one staff member had logged out a few minutes before the second staff member logged in. This meant we could not be assured people were receiving safe care that met their needs and there was risk of neglect to them.

● People did not always know when to expect staff to attend and people were not always receiving care at their preferred times. People told us the service was not always consistent or reliable. One person said, "The times are all over the place. It varies on who is coming in." A relative told us, "We have had conversations with them [provider] because the calls are too early or too late. Well out of the window of times we discussed. Then they also put the calls too close together." Another relative said, "I don't think the staff get travelling time included, so when they are at one client's home and then have to wait for a bus, they are not given time in between to travel, so they can't be at the other person's house at the time allocated."

● The provider's policy for call times stipulated that care staff have an allowance window of up to one hour before the start time and one hour after the start time to attend the visit. Data we analysed showed that on many occasions staff were more than 45 minutes late, but the policy meant this was acceptable.

● People were informed of the policy prior to starting using the service and they had signed an agreement. The provider informed us this was in response to the COVID-19 pandemic and staffing shortages. However, there was a potential risk to people if they needed to have medicines at a specific time.

● During our inspection we were informed by the local authority who commissioned the service that improvements in the delivery of the service needed to be made.

These concerns meant staff were not being effectively deployed to ensure people received a reliable and

safe service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We addressed our concerns with the provider. The registered manager explained the possible reasons for discrepancies. For example the simultaneous log ins in the call monitoring data were because the software had recently been updated. The data we analysed included suspended or cancelled visits, as well as the visits which were attended to. They also told us staff sometimes had technical issues and some people who required two staff did not always require moving or transferring. However, we were not assured staff were being monitored effectively due to the number of discrepancies we found.
● The provider had an approved arrangement to recruit staff from abroad such as students and professionals with a health or social care background. Records showed staff were recruited appropriately. This included carrying out criminal background checks, obtaining references, proof of their identify, and eligibility to work and live in the UK, such as their work permit or visa.
● The management team told us the majority of their staff were recruited from abroad due to the current recruitment and retention issues within the health and social care sector.

Assessing risk, safety monitoring and management
● Risks to people's health and safety were not always assessed adequately. Staff told us risk assessments helped them to support people safely. However, we found inconsistencies within the information about people's specific needs and how to mitigate risks to protect them from coming to harm. For example, for certain health conditions that had been identified, such as diabetes, chronic obstructive pulmonary disease (COPD) and panic attacks, there was a lack of guidance on what actions staff needed to take, should the person experience any symptoms of these conditions.
● For one person with COPD, a part of their assessment stated they did not have breathing difficulties, despite this condition affecting people's breathing. The same person had other conditions related to their breathing, which meant some of their risk assessment was inaccurate. A section of another person's assessment stated they had no medical conditions despite them having a brain injury and having a physical disability.
● We found similar errors in other care records. Another person was noted as having a medical condition that could lead to a stroke. However, this condition was only mentioned once in their care plan and did not include what it meant for the person and how to spot the signs of a stroke.
● Another person was described as having a 'worsening heart condition' but staff were advised to only 'monitor [person] at all times', without setting out any specific guidance, such as what signs or symptoms to look out for and what action they should take.

Risks to people were not adequately assessed to ensure people's safety was managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had safeguarding processes to protect people from the risk of abuse. Staff had received some training about safeguarding, but not all staff were clear about what safeguarding actually meant.
● Training records showed the subject was included within the Care Certificate induction training but it was not included with other mandatory training as a singular topic.
● Prior to our inspection and during our inspection we were alerted to concerns of possible neglect from the service when providing people with care. Some concerns were substantiated by the local authority, which meant the provider was not always ensuring people were protected from abuse.
● The management team took action to investigate concerns and complied with recommendations set out

by the local safeguarding authority.
● Most people and relatives told us they felt safe within the care of the service. One person said, "Yes I do feel safe. They are nice people." Another person said, "I do feel safe with them yes."

We recommend the provider looks at best practice guidance and explores how to deliver safeguarding training to staff as a stand-alone mandatory topic.

Using medicines safely
● A procedure for medicines was in place. People told us staff supported them with their medicines and had no concerns. One person said, "They shower me, help me dress and do my medication." Another person told us, "Yes they support me. I have my medication in a blister pack." However, due to the concerns we found with inconsistent care records, it was also not always clear if some people were independent with their medicines or required support.
● Staff had received training in how to administer and record medicines and their competency was checked by senior staff, such as field care supervisors, during spot checks. Spot checks are observations of practice to ensure staff followed procedures and provided people with safe care.
● Staff completed medicine administration records (MARs) on their devices which was sent to a central system and could be accessed by the management team.
● We looked at six people's medicine records and saw that they were completed as per the provider's procedures.
● The registered manager completed audits of MARs and took action, for example if errors had occurred or people had missed their medicines. A recent audit had identified that protocols for 'when required' medicines, known as PRN, was needed for some people and some staff needed competency checks because they were overdue. Records showed these actions were completed.

Preventing and controlling infection
● There was an infection prevention and control policy in place to ensure people and staff were protected from the spread of infection.
● Staff used Personal Protective Equipment (PPE) and there was sufficient stock of PPE to ensure people and staff were protected. They told us they washed their hands before and after supporting people with their personal care.
● People and relatives confirmed staff wore PPE and maintained hygiene and cleanliness. A relative said, "The staff wear plastic aprons and gloves, things on their feet and face masks. They change their gloves as well."

Learning lessons when things go wrong
● Following incidents and accidents that occurred in the service, lessons were learned by the staff and management team, in order to prevent re-occurrence. This included incidents that led to safeguarding investigations.
● Records showed the registered manager investigated incidents after they had been reported. They drew lessons from incidents. For example, providing additional training to staff who were from overseas and were not familiar with certain household appliances or foods, which led to people not being given their preferred meal.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated Good. At this inspection, this key question has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; working with other agencies

- People's needs and choices were not always assessed effectively before they started using the service. An assessment took place to determine if the service would be suitable and the person could be supported with their personal care.
- Assessment records and care plans were stored digitally and a paper copy was provided to the person to keep in their home.
- The assessments were separated into a full care needs assessment and a health assessment. However, the information contained in each did not always correlate and was inconsistent. For example, one person had a specific mental health need but later in the record, it stated they did not have a mental health need. Due to people's health conditions such as diabetes, they required district nurses to administer insulin, but on some assessment records there was no mention of this. The only heath professional mentioned was the person's GP.
- Another person's assessment did not mention their moving and handling requirements despite evidence later on saying the person needed support and was very immobile without aids and staff.

These issues meant the provider was not effectively assessing people's needs and choices which could lead to an inconsistent service and put people at risk of unsafe care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to access their local GP and there were contact details available in most care plans. Records showed they escalated to concerns with relevant health professionals, such as social workers.
- Staff told us they could identify if people were not well and knew what action to take in an emergency.

Staff support: induction, training, skills and experience

- Staff received training to help them develop the necessary skills to support people. Staff told us they completed an induction and training programme. The induction included shadowing experienced staff. A staff member told us, "The training was good and I enjoyed it."
- Staff completed training on infection prevention and control, medicine administration, moving and handling and the Mental Capacity Act 2005. Adaptation training had recently been introduced to help oversees staff adapt to living and working in the UK and supporting people in their own homes.

● Refresher training was provided to staff to aid their development and update their knowledge of important topics. However specific safeguarding adults training was not included within mandatory training.
● Staff were supported in their roles. They told us they had opportunities to discuss their work, their performance and concerns with the registered manager or other members of the management team. Records showed the registered manager held supervision meetings with staff to assess their performance, discuss training needs and assist with any problems they encountered.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with food and drink to maintain their health. Staff were mostly required to reheat meals made by relatives or prepare snacks and hot drinks.
● Information about people's nutritional needs were included in their care plan. It was not always clear if people with diabetes for example, required diabetic diets, because care plans were not always comprehensive. One person told us, "They [staff] heat me a meal at lunch and make drinks." Another person said, "Yes I do get food and drink when I need it." A staff member said, "For my client, I give them breakfast, lunch and dinner."
● Some people told us staff did not know how to prepare food and drink for them. One person said, "They [staff] need food training. If you're a carer you need to know a bit about the people you care for. One didn't know what a jacket potato or baked potato was. Then when I asked for cheese on toast, the cheese went in the toaster along with the bread!"
● These issues were discussed with the provider and we saw this was included as part of the recently introduced adaptation training following similar complaints from people. The training was used to enable staff to understand the types of food people liked to eat in the UK and how to prepare them using appliances such as a microwave.

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 followed the principles of the MCA. People's ability to consent to decisions made about their care was assessed and recorded.
● Records showed if people had lasting power of attorney arrangements in place, for example if decisions about their care could be lawfully made by their representatives. One relative said, "The staff always ask [family member's] consent and tell them what they are going to do and if it is OK."
● Staff had received training in the MCA and told us they asked for people's consent at all times before providing them with support. A staff member said, "I ask for my client's consent and permission before I do personal care."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated Good. At this inspection, this key question has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● People told us the staff were caring and respectful. One person told us, "Yes, the carers are very nice people." Another person said, "They are respectful, and we can have a laugh together." However, we noted that people's needs were not always described in a dignified way. For example, on one person's care plan, their speech abilities were assessed as 'mute'.

We recommend the provider seeks best practice guidance to ensure people's needs are assessed with dignity and respect.

● People's privacy was respected by staff ensured. Staff told us they made sure doors and curtains were closed when providing people personal care. One person said, "The staff close the curtains when I am getting ready."
● Care plans contained information about people's levels of independence. For example, their ability to walk independently and dress themselves. One person said, "I am starting to get a bit better and be more independent."
● Staff told us they understood confidentiality and not putting people's personal information at risk, such as sharing information with unauthorised persons.

Ensuring people are well treated and supported; equality and diversity
● We received some mixed feedback about how people were treated and how people felt about their care. Some people and relatives told us the staff did not always speak with them or chat with them. One relative said, "I don't think the staff make enough effort to engage or communicate and develop a relationship with [person]."
● Other people were not always happy about the times staff arrived for their visits, as they were either too early or too late, which meant people's preferences were not always respected. The provider told us they aimed to respect the preferences of people where possible but the COVID-19 pandemic and recruitment issues in the sector had impacted their ability to accommodate specific times. However, one person said, "Yes, the staff are friendly and caring. They are not over caring or under caring, just reasonable. They have got to know me though." Another person said, "The staff are really nice, and we get on like a house on fire."
● Staff we spoke with told us they had got to know people well and had developed positive relationships.
● The provider told us they had reached out to people by telephone during the COVID-19 pandemic to offer companionship and help prevent social isolation and loneliness. They continued to offer this to people when needed.

● People's equality characteristics were understood, such as their race, religious, cultural and spiritual beliefs and disabilities. These were recorded in their care plans.
● Staff understood equality and diversity procedures and were aware of what discrimination was. Staff told us they respected people's beliefs. A staff member said, "I treat people equally. I would not show discrimination, we have to treat people like our family."

Supporting people to express their views and be involved in making decisions about their care
● People were supported to express their views and make decisions for themselves as much as possible.
● People told us they had seen their care plan and signed it. One person said, "My social worker helped me out with that as I couldn't sign it, my hands don't work." A relative told us, "As far as I know we saw it and signed it." However, people's care plans did not accurately reflect their needs. There was not always a person-centred approach towards involving people in making decisions about their care.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated Good. At this inspection, this key question has changed to Requires Improvement. This meant people's needs were not always met.

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

- People's care needs were not always set out in a personalised way in their care plans. This meant people were at risk of not being supported to achieve good outcomes for their care.
- Care plans were stored on a digital system that all staff could access and update with daily notes using their devices. They were also stored as paper copies in people's homes. We looked at how the provider compiled the information for people in a folder.
- We saw that the digital system was user friendly and easy to access. Care plans contained risk assessments, needs assessments and a staff task schedule, all within subheadings or subtabs in the system. Within people's care plans there was a section called 'Important things to know about me' and others that included the types of things the person enjoyed doing. However, the information recorded was very brief. One person's interests were only noted as, "Watch TV, word search game."
- Care plans and other records were not always accurate and contained contradictory information about people's needs. For example, one person was said to be in use of a catheter but later in the record, there was no mention of the catheter. The management team confirmed the person did not have a catheter when we raised this with them. Another person's care plan stated they did not have capacity but later there was information stating they were independent and could manage their own medicines. A third person's record said they needed help with walking and managing the stairs but on the next page it said they did not require a moving and handling assessment. This showed care plans contained information that could be confusing, contradictory and inaccurate.
- Some assessments had not been reviewed regularly for some time. For example, one person's moving and handling risk assessment had not been reviewed since 2018 and was therefore, out of date.

People were not receiving a person-centred service because their needs were not accurately reflected in care records. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they communicated with each other to ensure people received the support they needed and that care plans were helpful.

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.

● People's communication needs were set out in their care and support plans. Staff told us they followed the person's communication plan. Staff told us were able to use signs and gestures to communicate with people who were less verbal.
● The provider supplied people with information about the service in a format that was suitable for them to understand, such as how to contact the service or make a complaint.
● Some people told us staff struggled to communicate with them due to language or cultural barriers. We discussed this with the management team who told us staff from overseas had to pass an English language and literacy test before being recruited. We saw records to confirm this. The director said, "Sometimes people find it difficult to understand someone with a different accent but hopefully with the adaptation training we can iron out these issues."

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure should people wish to make a complaint if they were not happy with aspects of the service. Complaints about the service were logged and investigated.
● The registered manager investigated complaints and provided people and relatives with an outcome for their complaint. They apologised for any errors and took action to resolve concerns and make improvements. However, feedback about the responsiveness of the provider was mixed.
● Some people told us contacting the provider was difficult as they didn't always pick up the phone and there was no answering service. One person said, "I have complained before, but I would say this company do not listen to feedback and staff need more training." A relative said, "I can't really complain, just timings maybe." The provider told us that they had experienced faults with their phone system and had recently resolved these issues.

End of Life care and support
● There was a policy in place for people requiring end of life care and support. People's wishes for end of life or palliative care and support were assessed and respected.
● Staff had received training in end of life care, which helped to ensure they had the knowledge and skills needed to deliver care to people nearing the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not have effective systems to provide safe care that was person centred and that people's needs were accessible and clear to staff.
- The provider had not identified some of the shortfalls in the service. Quality assurance processes were not robust or effective to ensure people's health and safety was effectively monitored. People's needs and risks were not always assessed appropriately and we found people's care plans to be inaccurate and inconsistent.
- Recent audits of care plans, records and risk assessments in April and June 2022 had not identified any concerns, which meant the audit process was not always effective.
- The provider's systems had not identified that risks had not always been identified or assessed to keep people safe. People did not always have an up to date and contemporaneous record of their needs. This potentially put people at risk of unsafe care.
- Systems were in place to monitor staff using the electronic call monitoring system, to ensure they were carrying out their visits in accordance with the provider's procedures, but they were not always effective. The provider told us staff had completed their visits as required. However, call monitoring data we analysed showed some discrepancies with how staff logged in and out of calls.
- The provider was not always ensuring staff had enough time in between visits, which could put people at risk of receiving care and support that did not meet their preferences and their needs.
- The provider worked with health and social care professionals, such as commissioners. However, the provider told us they were trying to resolve issues around invoices and call monitoring systems, and we noted that they had agreed to meet with the relevant professionals from the local authority to discuss a way forward.
- The provider was aware of their legal responsibility to notify the Care Quality Commission of any allegations of abuse, serious injuries or incidents involving the police.

The provider's quality assurance systems did not ensure the safety or quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, concerns were raised by the local authority, where people lived and who the provider supported. An action plan was put in place by the local authority for the provider to make improvements and learn lessons when things had gone wrong. This included reviewing processes and records for medicines, care plans, training, safeguarding and complaints. The action plan was in progress and included the timescales for improvements.
● The provider was implementing learning from complaints and incidents to drive improvements. For example, additional training, ensuring staff understood their responsibilities and reviewing people's preferences for their call times.
● The registered manager was supported by the operations manager and the director to help manage the day to day service. Senior staff in the office also monitored the service and care staff told us they felt supported in their roles.
● Staff told us they were clear about their roles and responsibilities and were supported by the management team to carry out their roles. One staff member told us, "[Registered manager] is approachable and professional."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● Staff told us there was an open-door policy and they could approach the management team with any issues. A staff member said, "The managers are very nice and helpful." However, feedback we received from people and relatives and the issues found during the inspection, highlighted there was not always a positive culture to help people receive person centred care that was empowering and achieve good outcomes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People and relatives told us they were contacted by the service to check how they were and if they had any issues. One relative said, "The agency phone us to ask if we are happy with the service." Another relative said, "They give a good service."
● We saw records of telephone monitoring to check staff were providing a safe service to people. Comments from people and relatives indicated they were generally satisfied with their care staff but did not feel involved in the running of the service. One person's comment was, "I just tolerate the company because when I phone up with queries they don't respond or know what to do." Another comment from a relative was, "They don't let you know if there is a change in carers generally. Just had one call when carer was off sick."
● Staff meetings were used by the management team to share important information and discuss any issues.
● People's equality characteristics were considered and recorded in their care plans.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not delivered in a person-centred way, that met their needs and preferences. Regulation 9(1)(a)(b)(c)(2)

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The provider was not assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems to assess, monitor and improve the quality and safety of the service. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and maintain an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff in order to support service users.

The enforcement action we took:

We issued a warning notice to the provider.