Care Quality Commission

Promises of Care Limited

Promises of Care

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?	Inadequate

Summary of findings

Overall summary

This inspection was unannounced and took place on 21 and 24 November 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own home. It provides a service to older adults, younger disabled adults and children.

On the days of our inspection visit the agency was providing a service to 12 people. All of these people were receiving personal care.

The agency had a registered manager who was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection on 12 and 13 April 2017, the provider was rated inadequate and was therefore placed into special measures. We issued a warning notice so the provider was aware of the areas where improvements were needed to ensure people received a safe and effective service. The provider submitted an action plan on 30 June 2017, to tell us what action they would take to improve the service and to comply with the regulations.

We undertook this inspection to check whether improvements had been made and found the provider had not taken sufficient action to improve the service provided to people or to ensure their safety.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

inadequate for any of the five key questions it will no longer be in special measures.

Quality assurance monitoring systems remained ineffective to reduce the risk of people receiving inappropriate care and support.

People remained at risk of harm because the provider had not taken sufficient action to ensure people were appropriately supported to take their prescribed medicines.

The risk of potential abuse to people had not been managed effectively because the registered manager failed to recognise abuse and to take appropriate action to safeguard them. Risk management was ineffective to monitor accidents and to avoid a reoccurrence.

Staff's practices needed to be improved to promote hygiene standards to reduce the risk of cross infection as the inappropriate use of personal protective equipment placed people at risk.

The provider was unable to demonstrate how they worked with other relevant healthcare professionals to ensure people received a safe and efficient service. However, staff were able to recognise when people required urgent medical attention and acted on this promptly. Action was needed to ensure all staff were aware of how to support one person with their meals to reduce the risk of choking.

People's dignity was not always maintained as their decision to have staff of their preferred gender care for them was not always respected. However, people were involved in planning their care and in most cases care was delivered by individual staff members in a kind and caring manner.

Complaints were not always managed effectively as staff did not always share people's concerns with the registered manager to enable them to address them.

Assessments and care planning of people's needs did not include equality, diversity and human rights to ensure the service was specific to the individual.

People were cared for by staff who received one to one [supervision] sessions and who had access to training to enhance their skills. However, skills learnt by staff were not always put into practice to ensure people received the appropriate care. New staff were provided with an induction to support them in their role.

The provider had taken action to reduce the risk of missed calls to ensure people received consistent care and support. There were sufficient numbers of staff provided who had been recruited safely to meet people's assessed needs.

People's consent was obtained before staff assisted them with their care needs. The registered manager demonstrated a better understanding of when a mental capacity assessment needed to be carried out to determine a person's ability to make their own decision.

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 consistently safe.

People were not always assisted appropriately by staff to take their prescribed medicines. Potential abuse was not always recognised by the registered manager to ensure action was taken to safeguard people. The inappropriate use of personal protective equipment placed people at risk of cross infection. Accidents were not managed effectively to reduce the risk of a reoccurrence. Sufficient numbers of staff were provided who had been recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's care may be compromised because the provider did not always work with other healthcare professionals to ensure their specific care and support needs were met. Action needed to be taken to ensure all staff had the skills and understanding about how to support a person with their meals safely.

People's consent was obtained prior to care being provided. The registered manager had a better understanding of when a mental capacity assessment should be carried out.

People were cared for by staff who had access to training to enhance their skills and were supported in their role by the registered manager. People could be confident that staff would recognise when urgent medical assistance was needed to ensure their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was compromised because their decision to have the same gender as themselves provide care and support was not always respected. Equality, diversity and human rights were not incorporated during the assessment and planning of care.

People's involvement in their care planning enabled them to tell staff how they would like to be cared for. In most cases individual staff members were kind and caring when providing care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints were not always managed efficiently to resolve people's concerns. People's involvement in their care assessment gave them the opportunity to tell staff how they would like to be cared for.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken sufficient action to ensure people received a safe and effective service. Quality monitoring systems were ineffective in promoting good standards and ensuring people received safe care and support that met their needs and preferences. People continued to be at risk of not receiving appropriate care and support. The provider had not addressed all outstanding breaches of the regulations identified at their last inspection visit.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site visit activity started on 21 November 2017 and ended on 24 November 2017 and was unannounced. The inspection team comprised of one inspector. The inspection included talking with one person who used the service, five relatives, three staff members and the registered manager. We visited the office location to see the registered manager and to review care records, policies and procedures and records relating to quality audits. This service is a domiciliary care agency. It provides personal care to people living in their home. It provides a service for adults and children.

As part of our inspection we spoke with the local authority about information they held about the agency. We also looked at information we held about the provider to see if we had received any concerns or compliments about the agency. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the agency.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 12 and 13 April 2017, the provider was rated Inadequate for this key question. We found that the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not taken sufficient action to ensure the safety of people who use the service and remained in breach of this regulation.

At our previous inspection people were not assisted to take their prescribed medicines safely. Since then and prior to this inspection, we spoke with a relative who shared their concerns about how staff supported their relative with their medicines. The person had been prescribed medicated patches for pain relief. Staff had failed to follow instructions and the person was found wearing two medicated patches instead of one. Due to their concerns about the care and support provided to their relative, they stopped using the agency. The registered manager acknowledged the poor medication practices and the risk of an overdose posed to this person. We asked the registered manager what action had been taken to reduce the risk of this happening again. They confirmed they had not taken any action to improve medication practices. This meant people remained at risk of not receiving the necessary support to take their prescribed medicines safely.

People were not supported to receive their prescribed medicines safely. Discussions with another person's relative and information contained in a care record showed the person required oxygen therapy. A staff member said, "I don't touch anything I just make sure the tube is in place." Another staff member told us they had not received training about the use of oxygen. Discussions with the registered manager and the care record we looked at, confirmed staff were not provided with sufficient information about the safe use and storage of oxygen. This placed the person at risk of harm as too much oxygen could cause breathing difficulties and disorientation as well as other risks associated with the use of oxygen. The registered manager was unable to explain why their staff team had not been provided with relevant information about the safe use of oxygen. The registered manager told us staff were responsible for turning on the oxygen cylinder and to ensure the nasal tube was in place. The lack of knowledge from staff who were responsible for administering oxygen therapy to this person placed them at risk of harm.

The same person had a health condition that required them to be positioned in a specific way whilst in bed. Failure to follow these instructions could compromise their breathing. The person's relative raised concerns that not all staff were following this instruction. The registered manager initially told us they were unaware of these concerns. However, we observed this concern had been recorded in the person's care record on 13 October 2017. We asked to see the person's care plan but the registered manager told us it was not located in the office. They told us they had carried out a care review with the person on 20 November 2017, and their care plan had been updated. However, the person's relative could not confirm the undertaking of this care review taking place. On the second day of our inspection visit the registered manager showed us the person's care plan. This did provide information about how to position the person whilst in bed. We asked the registered manager what action they had taken to ensure the staff member was aware of how to safely position the person in bed. They told us they had addressed the concern with the staff member responsible. However, they were unable to provide immediate evidence of this. On the second day of our inspection visit

the registered manager showed us a record of discussions held with the staff member about how to safely support the person to bed. This demonstrated that action had been taken but not in a timely manner to ensure the person's immediate safety and comfort.

We spoke with another person whose relative used the service. They told us their relative had been prescribed creams for a dry skin condition. However, they said they had to consistently remind staff to apply these creams. We spoke with a staff member who confirmed they supported people with their medicines. They were unsure whether information was contained in people's care records about how to manage medicines safely. We asked to see this person's medication care record. This information was not made available to us. Two out of four records we looked at in relation to people's prescribed medicines, did not provide staff with information about their prescribed medicines or the support required to take them safely. The registered manager acknowledged the absence of this information to support staff's understanding. However, they were unable to explain why this information was not in place. This meant staff were not always equipped with the knowledge and understanding about how to assist people to take their medicines safely.

We looked at how the provider managed accidents involving people who used the service. The registered manager said all accidents were recorded and we saw evidence of this. However, further discussions with the registered manager identified that accidents were not audited in way to identify trends. Accidents reports did not show what action had been taken to reduce the risk of this happening again. The registered manager was unable to tell us what action they had taken to prevent a reoccurrence. Hence, people remained at risk of further accidents. However, we did not find evidence of people having repeated accidents.

This is a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Practices did not always safeguard people from the risk of potential abuse. For example, prior to our inspection we spoke with a relative of a person who used the service. They told us about bruising their relative stated had been sustained whilst staff assisted them with their mobility. Although this information had been shared with the registered manager, they did not share this information with the local authority safeguarding team to be investigated. The registered manager was unable to explain why they had not shared this with the local authority. However, the registered manager informed us that the staff member responsible had received additional moving and handling training to enhance their skills and the records we looked at confirmed this. The registered manager said this member of staff no longer assisted this person with their care and support needs. However, on 12 December 2017, we received further concerns from the same relative who informed us they had shared information with the registered manager about their relative sustaining more bruises. They told us the registered manager had not responded to their concerns. The relative said they had also shared their concerns with the local authority safeguarding team for them to carry out an investigation. This meant the action taken to safeguard this person from further harm was ineffective.

This is a breach of Regulation 13(2), Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with had a good understanding about protecting people from the risk of potential abuse. Staff told us they would share any concerns of abuse with the registered manager and they were aware of other agencies they could share their concerns with. However, we found that the registered manager did not always recognise abuse. Therefore, appropriate action was not always taken to protect people from the

risk of further harm. The registered manager confirmed they had lacked understanding with regards to safeguarding procedures. However, they informed us they had recently undertaken further safeguarding training. They told us they were more confident in recognising when people were at risk of potential abuse and when to share concerns with the local authority safeguarding team.

Discussions with a relative of person who used the service said their relative felt safe and comfortable with one particular staff member. They said other staff were not as attentive to their relative's needs and tasks that needed to be carried out. For example, ensuring the environment was clean and tidy before the end of their visit. Another relative said, "I feel that [Person] is safe in staff's care and this has taken a lot of pressure off the family."

We looked at systems and practices to reduce the risk of harm to people. Two relatives raised concerns about new staff not wearing a uniform or providing identification. This meant people were not entirely sure whether these people worked for the agency. We shared this information with the registered manager who was aware of these concerns. The registered manager provided evidence of action taken to ensure this did not happen again.

The registered manager said staff had been asked to do visual checks on equipment in people's home before using them and staff confirmed doing this. A record of when equipment had been serviced was maintained to ensure they were safe to use. This promoted both people and staff's safety. Staff told us risk assessments for the safe use of equipment and the safety of the environment were located in people's home and people who used the service confirmed this. We saw evidence of these risk assessments that supported staff's understanding about safe working practices.

We looked at systems and practices that promoted hygiene standards. The registered manager said staff had received infection prevention and control training and staff confirmed this. This training should ensure staff are equipped with the skills to care for people in a manner that protects them from the risk of cross infection. However, two relatives of people who used the service raised concerns about the inappropriate use of disposable gloves. They told us when staff carried out 'dirty' tasks they did not change their gloves. One relative said, "Staff don't wear aprons and I saw one staff member wearing their jacket whilst washing [Person]." The inappropriate use of personal, protective equipment (PPE) meant there was a risk of cross infection with regards to each visit undertaken by staff. Both relatives raised concerns about the inappropriate use of flannels and towels that placed their relative at risk of cross infection. For example, one relative said, "They use the same flannel to wash the bottom and top part of the body even though I provide separate flannels and towels for this." However, all three staff we spoke with confirmed they had access to PPE, such as disposable gloves and aprons. We shared this information with the registered manager so they could take action to ensure PPE were used appropriately. The registered manager assured us this would be addressed with the staff team.

During our last inspection in April 2017, we found that the provider was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, fit and proper persons employed. At this inspection we found pre-employment checks for new staff had been strengthened. The registered manager had introduced a process that they would follow in the event that a staff member with a criminal conviction was recruited to ensure that people were cared for safely. They told us that staff with a criminal conviction would work under supervision until they felt confident they were safe to work alone.

We reviewed the provider's recruitment practices. All the staff we spoke with confirmed they had a Disclosure Barring Service [DBS] check before they started to work for the agency. We looked at three staff files that confirmed the undertaking of these checks. DBS assists the provider to make safe recruitment

decisions. Staff also confirmed references were requested and we saw evidence of these. These safety checks ensured staff were suitable to work for the agency.

At our previous inspection we found people's care and safety had been compromised due to missed calls. At this inspection people informed us that although at times staff may be late they had not experienced any missed calls. A relative of a person who used the service said, "When we first started to use the agency we had a couple of missed calls but this has all been sorted now." The registered manager told us about a new system in place that alerted office staff when staff arrived at a person's home and when they left. This enabled the registered manager to take action if staff failed to attend a visit. However, when we asked staff what systems were in place to ensure calls were not missed; only one out of three staff members we spoke with were aware of this system.

People were supported by sufficient numbers of staff. One person told us their relative required two staff members to assist them with their care needs. They confirmed that this number of staff was always provided. Both the registered manager and the staff we spoke with were confident there were enough staff provided to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection people were not supported appropriately with their meals and this placed them at risk of choking. At this inspection we identified that one person required assistance with their meals. We spoke with this person's relative. They said their relative required soft foods and needed to be fed slowly to reduce the risk of choking. They told us some staff failed to follow these instructions which led to them coughing and spluttering. They said these concerns had been shared with the registered manager who addressed them promptly. However, they still did not feel confident to leave their relative whilst staff fed them.

At our previous inspection visit we found that due to the registered manager and staff's lack of understanding of the Mental Capacity Act 2005 (MCA), these principles were not put into practice. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At this inspection we found the registered manager had an understanding of the principles of MCA. For example, they felt one person did not have capacity to consent to care and treatment. Hence, they had liaised with the person's GP and social worker in relation to the undertaking of a mental capacity assessment. This assessment showed the person did have capacity to make a decision in relation to their care and treatment.

We spoke with one person who used the service and five people who advocated for their relatives. They all confirmed staff always asked for consent before they provided assistance. A relative said, "Staff always asks [Person] before they support them." A staff member told us, "I always ask for people's consent. You often have to explain to people what you intend to do and then obtain their consent." This meant people were able to make a decision about whether they wished to receive care and treatment.

The provider did not work effectively with other healthcare professionals to deliver appropriate care and support. This meant there was not a holistic approach when delivering care and support. For example, one person told us about the importance of staff assisting their relative to do exercises recommended by the occupational therapist and a physiotherapist. They told us the occupational therapist had made them self available to advise staff of the importance of the person undertaking daily exercise as failure to do so would compromise the person's mobility. However, staff had failed to meet with the occupational therapist. They raised concerns that staff did not support the person to carry out these exercises. We shared this information with the registered manager who confirmed this information was in the person's care records and we saw evidence of this. However, the registered manager was unable to evidence that staff had followed these instructions. There were no records maintained of when staff supported this person to exercise. The staff we spoke with were unaware of the need to do these exercises. The failure to work alongside other healthcare professionals placed this person at risk of not receiving effective care and support.

People's care and support needs were assessed before they started to use the service. The registered

manager was able to show us evidence of assessments carried out before offering the individual a service. All the people we spoke with confirmed their involvement in their care assessment.

All the people we spoke with informed us they did not require assistance to access healthcare services. Discussions with staff highlighted in emergency situations they had requested an ambulance and this information had been recorded in the person's care records. This meant people could be confident that staff would recognise when emergency medical intervention was required.

We looked at how the provider supported new staff into their role. All the staff we spoke with confirmed they had an induction when they started to work for the agency. One staff member told us, "My induction involved getting to know people and how to care for them." Another staff member told us they worked alongside an experienced care staff. They said, "This made me more confident to do my job." This showed that new staff were appropriately supported to undertake their role.

The registered manager informed us that since our last inspection visit, they had invested in further training for themselves and the staff team to enhance their skills. The staff we spoke with confirmed receiving further training and the records we looked at evidenced this. The registered manager said observations of staff's work practice were carried out to ensure the skills learnt were put into practice. People and staff confirmed the registered manager routinely carried out unannounced spot checks to observe care practices. Two relatives told us that staff appeared skilled in the undertaking of their duties. However, although there was evidence that staff had received training, skills learnt were not also put into practice. For example, people were not supported appropriately to take their prescribed medicines. We also found that moving and handling practices did not always protect people from the risk of injuries.

Staff were supported in their role by the registered manager. Two out of three staff members we spoke with said they had received one to one [supervision] sessions. Access to regular supervision sessions gives the registered manager the opportunity to talk with staff about their work performance and training required to enhance their skills in providing an efficient service.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found where people had a health condition, care plans did not provide staff with information about how to care and support them appropriately. At this inspection the provider had taken action to address this. We looked at a care plan that informed staff about a person's health condition, possible symptoms and when medical intervention was required. We spoke with one staff member who assisted this person with their care needs. They had a good understanding about the care and support this person required.

We spoke with the registered manager about practices that promoted equality, diversity and human rights. We found this had not been explored by the registered manager. We spoke with a relative who told us how dissatisfied they were that their female relative was cared for by two male staff members. They felt their relative's dignity had been compromised. They said, "If my father was alive he would be so cross with me allowing this to happen." Although they had shared this with the registered manager, they had not taken any action to address this. We found the registered managers' work ethic and practices did not focus on equality and diversity during the assessment process and the planning of care. The registered manager acknowledged this and assured us this would be considered during future assessment of people's needs.

We received mixed comments about staff's approach when delivering care. One person told us their relative lacked capacity. They said whilst staff assisted them with their personal care needs they didn't engage in conversation with them or tell them what they intend to do. We shared these concerns with the registered manager who assured us this would be addressed with staff.

Another relative said, "The staff are wonderful, it's taken a load of pressure off us as a family." They continued to say, "I feel [Person] is safe, they treat them with such respect." They informed us that their relative often refused support with their personal care needs. They said, "Staff do not force them but have a way of persuading them." They told us, "[Person] enjoys the staff's company and looks forward to their visits." They said when their relative started to use the service they had pressure sores. They said with the support and care from staff these have healed. Another relative said, "Staff know how to care for [Person]. They told us that staff always greeted them politely when they arrive. They continued to say, "They talk to [Person] nicely and I hear [Person] and staff laughing."

Another relative said, "The staff are all polite and personal care is always carried out in a private area." Another relative told us, "I am happy with the care provided to [Person] and they always look nice when staff have finished with them." A staff member told us when they assisted people with their personal care needs they ensure they were covered with a towel to preserve their privacy and dignity. This showed that some practices were conducive in promoting people's privacy and dignity.

The registered manager told us people were involved in planning their care and this was confirmed by the people we spoke with. People's involvement in planning their care should ensure they receive a service specific to their needs. However, as identified previously in this report, people choice of who worked with them was not always respected. People told us their care plan and risk assessment was located in their

home and staff confirmed having access to these records. These records assisted staff to understand people's care needs and how to meet them. People also confirmed they were actively involved in their care reviews.

Requires Improvement

Is the service responsive?

Our findings

People could not be assured their complaints would be resolved consistently or that sustainable action would be taken to address their dissatisfaction with the service. Prior to our inspection we received two complaints about the care and support provided. These people said they had shared their concerns with the registered manager who had failed to respond to them. We shared one complaint with the local authority for them to investigate under their safeguarding procedure. Since sharing this information with the local authority, the person confirmed they were satisfied with the action the registered manager had taken to resolve their concerns. However, during this inspection this person raised further concerns of a similar nature. They informed us that the registered manager had not responded to their concerns. The other person told us they remained dissatisfied with the service and no longer used the agency. We spoke with a person who used the service who said, "I have raised a couple of concerns with the registered manager and they dealt with them immediately."

We discussed these complaints with the registered manager who confirmed they now recorded all complaints and responded to them and we saw evidence of this. One relative said they had shared concerns with care staff about the mess their shoes made on their carpet. Another person told us they had spoken to staff about the inappropriate use of disposable gloves and said, "The staff just tutted at me." The registered manager said staff had not made them aware of these concerns. Hence, action had not been taken to resolve them. The registered manager said they would remind staff of the importance of sharing concerns with them so appropriate action can be taken.

The registered manager said an assessment of people's needs was carried out before they started to use the service and the people we spoke with confirmed this. Information obtained from people and the social worker enabled them to develop a plan of care. Further discussions with the registered manager identified the lack of emphasis focused on equality and diversity during the assessment process. This meant relevant information relating to people's cultural, religion, sexuality and past history had not been considered of which could have an impact on the quality of service provided to the individual. The registered manager assured us this would be taken into account when undertaking further assessments and the review of people's care needs.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that the service was not well-led and was rated inadequate in this key question. The provider was in breach of six regulations of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice identifying areas that required improvement to ensure people received a safe and efficient service. The provider sent us an action plan to tell us what they would do to comply with the regulations.

At this inspection we saw that the provider had taken some action to improve the quality of the service provided to people. However, sufficient action had not been taken to ensure people's safety. Therefore, the provider continued to be in breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not supported appropriately to take their prescribed medicines. One person required specific support from staff to take their prescribed treatment. However, the registered manager and the staff we spoke with confirmed they had not received training to equip them with the skills to assist this person safely with their treatment. This placed the person at risk of receiving inappropriate support with their prescribed treatment which placed their health at risk. The review and audit of the person's care records failed to identify that staff did not have sufficient information or the skills to assist the person safely.

We found that the provider's governance was ineffective to ensure all care plans provided staff with information about how to support people to take their prescribed medicines. This meant people remained at risk of inadequate support to take their medicines.

The provider's governance was ineffective in ensuring all complaints were responded to promptly or to demonstrate changes to the service to improve the quality of care and support provided. For example, a relative had raised concerns about medicine management. Discussions with the registered manager confirmed medicine management for this individual was unsafe. However, they did not take any action to safeguard this person from further poor practices.

The provider's governance was ineffective in reviewing the risk of potential abuse. Hence, they remained in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where concerns of potential abuse had been shared with the registered manager, they were unable to demonstrate what action had been taken to safeguard the individual from further harm. For example, prior to our inspection visit a person raised concerns about inappropriate moving and handling practices they alleged had caused injury to their relative. The registered manager confirmed they had not shared this information with the local authority for an investigation to be carried out. After our inspection visit we received further concerns from the same person about alleged injuries. This meant the provider's governance did not review the lessons learnt or to take action to avoid a reoccurrence. Therefore, this person continued to be at risk of further harm.

The provider's governance was ineffective in the review and management of accidents. For example, the registered manager was unable to demonstrate that accidents were reviewed and monitored for trends.

They also confirmed they had not taken any action to avoid a reoccurrence.   Hence, people remained at risk of further accidents. However, the provider's records did not identify any reoccurring accidents.

The provider's governance was ineffective in reviewing the quality of care and support provided to one person where other healthcare professionals were involved in their care. The registered manager was unable to demonstrate that exercises recommended by an occupational therapist and physiotherapist had been carried out by staff. The person's relative told us the failure to carry out these exercises would have an impact on their relative's mobility.

Systems that promoted quality standards were ineffective to ensure staff practices reduced the risk of cross infection. Two relatives had raised concerns about the inappropriate use of personal protective equipment (PPE) that could place their relative at risk of cross infection. Although the registered manager told us they carried out unannounced spots checks, they said they had not observed poor practices in relation to the use of PPE.

People told us they were provided with a quality assurance questionnaire. However, further discussions with them confirmed they were not provided with feedback in relation to information collated or whether the service would change due to information shared with the provider.

This is a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As previously identified in the contents of this report the registered manager was also the registered provider. We issued the provider a fixed penalty notice, for failure to conspicuously display their rating on their website. Prior to and after this inspection visit we found the provider had not taken action to comply with this regulation. On the first day of the inspection visit to the office we did not see the provider's rating displayed in the office. We asked a staff member where this was displayed and they said they didn't know. On the second day of the inspection the registered manager said it was displayed on the notice board. However, we found this had not been displayed conspicuously as we did not see it on the first day of our visit. The provider remains in breach of this regulation because they have not taken any action to ensure their rating was conspicuously displayed on their website.

This is a breach of regulation 20A, Requirement as to display of performances assessments, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the registered manager routinely carried out spot checks to observe staff's practices. During these checks people confirmed the registered manager talked with them to find out if they were happy with the care and support provided. For example, we saw concerns had been identified about staff's working practices. The registered manager was able to tell us and provide evidence of action taken to improve the care provided for the individual.

The registered manager said regular telephone calls were made to people to find out if they were happy with the service provided and the people we spoke with confirmed this. This gave people the opportunity to tell the provider about their experience of using the service.

All the people and staff we spoke with were aware of who the registered manager was. One relative said, "The registered manager is very approachable." A staff member said, "The registered manager is kind, supportive and understanding." They told us the registered manager allowed them to continue further education. This enabled them to enhance their skills in providing a better service for people.

Since our previous inspection visit the provider had introduced a new system that alerted them if a visit had been missed and people confirmed not having any missed calls.

Discussions with the registered manager identified they had a better understanding of when to send us a statutory notification which they required to do by law. Our records showed the registered manager had informed us of an incident that placed a person at risk of harm.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not taken sufficient action to ensure people receive the appropriate care and support. People were not provided with the necessary support and guidance to take their medicines safely. Accidents were not managed effectively and action was not taken to avoid it happening again.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13, Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of potential abuse and continued to be at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not take appropriate action to comply with the breaches of regulations identified at our previous inspection visit. This meant people continued to be at risk of inappropriate care and support. Systems that monitored the quality of the service provided were ineffective in promoting good standards of care. People's safety and wellbeing continued to be at risk.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Regulation 20A, Requirement as to display of performances assessments, of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has not taken action to comply with this breach of regulation and continues to fail to conspicuously display their rating on their website.

The enforcement action we took:

The provider will be issued a fixed penalty notice.