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?	**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

About the service

Hands of Compassion is registered with the Care Quality Commission as a domiciliary care agency. It provides the regulated activity of personal care to adults living in their own homes, including older people and people with dementia. At the time of the inspection there were 8 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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

People's experiences of the service were directly impacted by widespread and significant shortfalls in service delivery.

People's levels of satisfaction with the service were mixed as they did not always receive consistent, timely care and support from familiar staff who understood their needs. Most people did not have a regular carer and some staff were task focused only providing 14 or 16 minutes of support during a 30 minute call. As a result only half of the people and relatives we spoke to said they would recommend the service to others.

Governance processes remained ineffective in identifying potential risks. Lessons had not been learned which had resulted in the same shortfalls found at the inspection in July 2022 being found at this inspection, a year later. These shortfalls were: Staff did not have guidance to ensure people with specific health needs such as catheters remained healthy. People were at risk of not receiving their medicines as prescribed as the provider was not following safe practices in administration. Staff recruitment processes were not robust due to gaps in employment having not been explored.

When shortfalls had been identified action had not been taken to make the necessary improvements to ensure quality of care. Surveys in May 2023 had identified that action needed to be taken to improve communication. However, there was no evidence of any steps that had been taken to address this shortfall.

Staff continued not to be adequately trained nor have all the skills, knowledge or competency required for their roles. Staff had not received practical training in how to move people safely despite the provider informing us in their action plan, after the last inspection, that this was being addressed. Staff relied on other untrained staff showing them how to move people and manage their medicines which had resulted in people using unsafe practices including the secondary dispensing of medicines. One staff member could not speak English to a sufficient level to discuss their training and another staff member who supported people was not listed as having had any training.

The provider had not met their responsibilities and legal requirements in regularly submitting reports in sufficient detail, as they were required to in their condition of registration. Nor had they notified us of their provider and location change of address.

People were usually 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.

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 15 February 2023) and there was a breach of regulation 18 (Staffing). The provider completed an action plan after the last inspection to show what they would do and by when to improve with regards to regulation 18 (staffing). At this inspection we found the provider had not done all the things that they said they had done. The provider remained in breach of regulation 18.

The provider has a condition on their registration due to a continuous breach of regulation 17 (Good governance). These conditions are the registered provider must send monthly reports to the Care Quality Commission. These reports must include the results of audits and actions taken for the management of medicines, care plans, risk assessments, missed calls and accidents and incidents, the oversight and implementation of mental capacity assessments, recruitment records and staff training and competence. The provider had not always sent these reports in sufficient detail, nor on a regular monthly basis.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified a continuous breach with regards to staff training and inadequate monitoring of service quality. In addition we have identified a new breach due to shortfalls in staff recruitment, the management of medicines and assessing risks.

We will continue to require the provider to send monthly reports as set out in the condition of their registration.

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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This is the

third time this service has been in rated 'Inadequate' and in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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 always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not 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 2 inspectors.

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. The registered manager was also the provider of the service.

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 4 September 2023 and ended on 18 September 2023. We visited the location's

office on 4 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gained feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. 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 this information to plan our inspection.

During the inspection
We spoke with 1 person who used the service about their experience of the care provided and gained feedback from 5 relatives. We spoke with 4 members of staff including the registered manager/provider, 1 senior carer and 2 care workers.

We reviewed a range of records. This included 8 people's care records and 2 people's medication records. We looked at 2 staff files in relation to recruitment and staff training and staff supervision. A variety of records were reviewed relating to the management of the service, including their medicines policy and audits and checks.

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. The rating for this key question has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People were at risk or harm because the service was not clear about its responsibilities in relation to medicines and did not follow national best practice guidelines.

● At the last inspection, areas for improvement had been identified in the management of medicines. People's support needs, as identified in their care plans, did not always correlate with the practical support staff were giving people with their medicines. In addition there was no record of what each medicine was for or any side effects. At this inspection neither of these shortfalls had been addressed. We found additional shortfalls in the management of medicines which put people at risk of not receiving their medicines as prescribed.

● Medicines administration did not follow the providers' medicines policy nor national guidance. Staff had removed 1 person's medicines from the container in which they had been received from the pharmacy and put them into a different container prior to administration. This is known as 'secondary dispensing' and national guidance only recommends this in exceptional circumstances due to the inherent risks. If the person giving the medicines does not have the original container with the label they cannot be sure that each person received the right dose of the right medicine at the right time, as prescribed. A risk assessment had been completed. This stated that 2 staff would be present when putting the medicines into a different container and the person's medicines administration sheets would be audited monthly to ensure stock levels were accurate. However, a staff member told us that they transferred the medicines themselves and medicines audits did not include stock counts.

● Staff were administering medicines to another person that had been secondary dispensed by a family member. This had not been identified as a risk and was avoidable.

● The provider's medicines audits had identified that there were clear instructions for staff to follow to administer medicines. We found this was not the case. For example, instructions for 1 person's medicine used to treat a build-up of fluid in their body were: 'One to be taken in the morning with a glass of water' and 'take TWO tablets three times a day'. There was no record of the amount of the drug that should be given to ensure staff gave the correct amount.

● There was inconsistent practice in the clarity of instructions for staff in the use of topical creams. Topical creams were often referred to in people's care plans as 'creams' which could be confusing to staff when people used more than 1 cream. For some people staff had written guidance and a body map to direct them to which part of a person's body a cream should be applied. For other people there was no guidance on where to apply the cream or how much to apply.

●There continued to be a discrepancy between people's assessed medicines support needs and how staff supported people in practice. At the last inspection we had identified that 1 person had been assessed as only requiring staff to prompt them to take their medicines. However, their medicines records showed that sometimes they were prompted and at other times staff administered their medicines. At this inspection we

found this same situation with another person. There had been no review of their management of medicines to assess the best way to manage their medicines long-term due to their fluctuations in abilities. For another person it had been assessed that the person's family were responsible for all their medicines. However, staff were applying a gel for pain relief. Staff were not guided on how much to apply or where to apply it.

● There continue to be a lack of information for staff about what people's medicines were for or any side effects. Staff were guided to look at each person's patient information leaflet (PIL) to gather this information. However, this information was not easily accessible, especially when people's medicines had been secondary dispensed into another container so neither the name nor instructions for the medicine were listed.

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

Assessing risk, safety monitoring and management

● Practices at the service placed people at risk of harm.

● At the last inspection we recommended the provider sought advice and guidance from a reputable source about ensuing the safety and maintenance of equipment. At this inspection the provider had checked that equipment such as a hoists had been serviced, so they were safe to use by people and staff. However, they had not put in systems to make regular checks of equipment to give assurance that equipment remained safe to use and fit for purpose.

● People were at risk of harm as information about risks and safety was not always available or understood by staff. Some people used a catheter or a stoma to help remove urine and/or faeces from their bodies. The potential risks of infections or blockages had not been identified to staff in risk assessments or staff guidance. At a team meeting on 23 August 2023 it was identified that one person's catheter 'does not always let the urine flow'. A staff member told us the tube needed to be pulled and straightened when this person went to bed to avoid the risk of kinks. This guidance to avoid the risk of the tube becoming blocked had not been shared with staff in the meeting notes nor in the person's risk assessment or care plan.

● The provider and staff had a lack of knowledge about the potential risks for people who used a catheter. The provider said the signs and symptoms that may indicate a person had a urinary tract infection (UTI) were not listed as they differed between people. They said staff were trained in infection control and care plans and risk assessments reflected the services infection control procedure with regards to catheter care. However, we found this guidance was missing from care plans and risks assessments. In addition not all staff had an understanding of infections in relation to catheter care. When we asked 1 staff member about the signs of infection for a person they supported with a catheter they responded, "Infection. What is an infection? Is it Covid?" They did not have sufficient use of English to understand basic questions about potential risks.

● There was inconsistent or limited action to reduce other potential risks to people in relation to their physical health and well-being. Some people had diabetes. Staff were not always guided about how to recognise and what action to take if someone had too much or too little sugar in their body. Some people suffered from depression. For 1 person staff were guided to 'look for signs of depression at each visit'. There was no guidance about how to recognise when a person was depressed, what to do or if any professional advice needed to be sought.

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

Learning lessons when things go wrong

● There was little evidence of learning from events or action taken to improve safety.

● The providers policy on 'Accidents and Incidents' stated that, 'All accidents and incidents will be fully investigated'. There was little evidence that the provider's policy had been followed.

● 1 person had fallen whilst about to use their stair lift. The actions as a result were for 'Staff to be vigilant' and 'Not to rush'. There had been no investigation into the cause of the fall such as if there was uneven flooring, if suitable footwear had been worn or if they were using their walking aid. Another person had been found on the floor by a staff member. The cause of the fall had been identified as the person endeavouring to be independent. The recommended lessons learned were for the person's family to speak to the person about ceasing to be independent which was contrary to the values of the organisation. There had been no investigation into how the person could take steps towards being independent in a safe way.

● The majority of people said that although a rare event, they had had missed calls. One relative told us about an occasion in 2023 when a staff member did not arrive for an evening call. They told us that the provider, "Would not have known unless I called them. My relative is not able to say if staff do not come". Another relative told us," There have been a couple of occasions in the last 2 years when there have been some mix ups and no staff come, but it is ok as I am here". The provider had started to monitor missed calls to help them identify if there were any patterns or trends that needed to be addressed.

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

Preventing and controlling infection

● People could not be assured they would be protected from the risk of infection as not all staff understood how to identify and response to any potential infection.

● Although staff had undertaken training in infection control there was a variation in staff knowledge. 1 staff member was not on the staff training matrix and another staff member did not understand the word 'infection' due to their limited knowledge of English.

● Staff were not consistently provided with personal protective equipment (PPE), such as gloves and aprons. One relative told us staff had visited without any PPE. The relative told us they advised staff to use the PPE at their family members home and then 'eventually' staff brought their own box of gloves.

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

Staffing and recruitment

● Required staff recruitment checks were not always undertaken to ensure suitable staff supported people.

● Although the provider told us 2 new staff had been recruited since the last inspection there were 3 new staff on the staff rota. We were not given any evidence that any recruitment processes or checks had been carried out on this 3rd staff member to ensure they were suitable to support people unsupervised in their own homes.

● For the remaining 2 new staff, neither had had their employment history checked to identify the reasons for a number of gaps in their employment history. 1 staff member's risk assessment had identified they had no gaps in their employment, which was not accurate.

● References had not been verified and checked by the provider to ensure they were fit for purpose. For both staff members the dates of employment recorded on their application forms did not match the dates given by their referees. This had not been identified or checked by the provider. In addition 1 referee was not listed

on a staff members application form. There was no information about in what capacity the referee knew the applicant or for how long they had known them. Due to these inconsistencies it could not be assured the information given was credible or reliable as a check on the applicants suitability for their role supporting people unsupervised in their own homes.

The provider had failed to ensure the safe recruitment of staff. This was a breach of regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People felt safe but they could not be assured they would be protected from the risk of abuse as not all staff understood how to identify and response to the signs of potential abuse.
- Although staff had undertaken training in safeguarding and safeguarding was discussed at team meetings, there was a variation in staff knowledge of how to keep people safe. 1 staff member was not on the training matrix so there was no evidence they had undertaken any appropriate training. Another member did not have sufficient understanding of English to demonstrate they understood the signs of abuse or how to seek external support. For example, they did not understand the word 'bruise' which is a potential sign of physical abuse which would require further investigation to ensure people's safety and physical health. Other staff were able to demonstrate their competency in recognising and acting appropriately if they were concerned about a person's health or safety.
- People and relatives told us they trusted staff to keep them safe. However, the provider had not identified the significant gap in some staff's understanding in safeguarding people.

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 our last inspection we rated this key question Requires Improvement. The rating for this key question has remained This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure 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.

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

● Staff continued not to be adequately trained nor have all the skills, knowledge or competency required for their roles.
● People and staff were at risk of harm as staff who assisted people to move using equipment had not been adequately trained to ensure they did so safely. Staff supported people using hoists and slide sheets but had only received on-line training to move and handle objects not people. After the last inspection the provider told us in their action plan, 'Staff will be enrolled in face-to-face training, to get accurate demonstrations on how to use the online training in real life scenarios'. However, staff had not received any practical moving and handling training nor been assessed by a trained and competent person. Staff were shown how to move and handle people by a staff member who told us they had not received practical training in moving and handling from the provider.
● People were at risk of harm when being supported by staff with their medicines. Staff had only received on-line training in medicines management and had not had their practice assessed by a qualified person. The National Institute for Health and Social Care Excellence (NICE) recommends that learning for medicines for community-based staff is refreshed and knowledge and competence assessed at least annually. Staff had either not had their competency assessed or they had been assessed by the provider. However, the provider's on-line medicines training was out of date and was not at the required level to give them the skills to be able to assess other staff's medicines competency.
● There were gaps in staff training and knowledge in specialist areas such as catheter and stoma care and supporting people with diabetes and epilepsy. No staff had received training in stoma care. 3 staff who supported people with a catheter had not received any training. This was contrary to information provided to people in the 'Service User Guide.' In the guide catheter care was listed as a 'specialist task' and it was advised, 'We at Hands of Compassion Care will provide staff with specific training, something which will then be certified by a trainer with a relevant qualification.' However, staff told us they had been guided by a staff member. Two staff who supported people who had diabetes had no training in diabetes. Two staff who

supported a person who had epilepsy had not received the necessary training.
● The service had not ensured staff had the skills, knowledge and experience to deliver effective care. 1 staff member who provided support was not on the staff training matrix and so it could not be assured they had had any training necessary for their role. A 2nd staff member had completed online trainings but their knowledge of English was not sufficient for them to be able to discuss the topics covered in these trainings.
● Practices to ensure staff followed the correct procedures and provided the right standard of care were not always effective. Staff supervisions had not identified significant gaps in staff knowledge and training nor supported staff to keep up to date with best practice. Although shortfalls in staff practice had been identified in spot checks it could not be assured action had been taken to make the necessary improvements. For one staff it had been recorded in August 2023 they must remember to write people's daily notes correctly as they had been, 'Spoken to a few times regarding this'. There was no record of this shortfall in the previous spot checks in April and May 2023. Nor was there any evidence the staff member had been given additional training or supervision to improve their report writing skills to the necessary standard.
● Some improvements had been made to the staff induction. New staff continued to shadow existing staff and in addition had a face to face meeting to ensure they had access to the service's policies and procedures. However, the provider had not assessed their induction against the Care Certificate. 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.

The provider had failed to ensure staff had the knowledge, competence, skills and experience to support people effectively and safely. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● People were supported by staff, the majority of whom had received training in the principles of the MCA 2005.
● People had been assessed if they had capacity to make day to day decisions. Where people had a power of attorney it was recorded whether this was for finances or health and welfare or both. A power of attorney is a legal document that allows someone else to act on a person's behalf in a specific capacity.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs were comprehensive and included all aspects of people's health and well-being.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

- The service had a limited role in supporting people to access health care and maintain a balanced diet as people's families were involved in their care.
- Staff were provided with information about people's health care needs, including their oral health.
- Some people required support with being encouraged to drink and making breakfast and this was recorded in their care plans.

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 our last inspection we rated this key question Good. The rating for 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.

Ensuring people are well treated and supported; equality and diversity

- People did not always receive consistent, timely care and support from familiar staff who understood their needs.
- Most people and relatives told us they did not have a regular carer. The provider told us this was because there had been staff changes. They told since the last inspection 4 staff had left and 2 new staff had been recruited, with one staff member on long term leave. One relative described staff support as, "A lottery" as they never knew which staff member was coming to support their family member. Another relative said, "We do not know which staff are coming but my family member is very laid back and doesn't mind". Continuity of staff helps people and staff to form trusting, positive relationships.
- People and relatives told us that staff were kind and caring. One relative told us, "Carers really do care". Some people and relatives told us there was some inconsistencies in staff's approach. 2 relatives told us about staff, "Only one or two are very good".
- Staff did not all have the essential communication skills they needed to support people in the way they expected. 1 staff had limited ability to understand and speak English. People expected that staff would be able to listen and understand what they had to say so they could be provided with the care, company and emotional support they needed. Some people's care plans indicated they enjoyed talking to people, others that they confused or upset. Therefore, it could not be assured that all staff had the skills they needed to provide the emotional support to these people as necessary.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Some staff were more focused on tasks than on their well-being.
- People did not always receive care and support for the amount of time they had been assessed as requiring. Monitoring records showed that some staff only supported people for 14 or 16 minutes on a 30 minute call. A relative told us calls to their family member were often between 10 and 15 minutes. There were no details in these people's call records that they had asked staff to leave their call early. In one person's care plan it had been recorded that they liked to chat with people. However, these short visits evidenced that staff did not sit and talk to people for a meaningful length of time to ensure their well-being.
- People had been involved in decisions about their care. People's care records detailed what people could do for themselves and when they required assistance to promote their independence.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. The rating for this key question has changed to Requires Improvement.

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

- Care plans were inconsistent in providing up to date information and guidance in sufficient detail for staff to respond to people's care and support needs.
- People's preferences and choices had been sought to guide staff but other necessary information was missing. For example, for one person staff were guided how to use pillows to enable them to sit on their preferred side. But essential information about how to support them with their toiletry requirements was not up to date nor accurate. For another person, staff were guided they had an interest in gardening and liked a chat. But essential information about what support they required with their diabetes was not available.
- People did not consistently receive personalised care that met their preferences. Relatives told us discussions had taken place about people's preferred call times during the assessment process. However, one relative told us, "Staff turned up when they wanted to turn up and not when we wanted them to. There was a 1 hour difference". This relative explained that this issue had been addressed but that they, "Had to speak to them more than once about it".

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.

- Information for people could be made available in other formats, such as large print, if this was assessed as required. This included the service user guide and people's care plans.

Improving care quality in response to complaints or concerns

- Information about how to complain about any aspect of the service had been shared with people and relatives.
- People had been given a 'Service User Guide' which set out how the service handled comments, concerns, complaints and compliments. People and relatives told us if they had a concern they spoke to the senior carer who discussed and sorted things to their satisfaction.
- Complaints were dealt with by provider. They kept a record on what the complaint was about, how it had been resolved and if there had been any patterns or trends.

Supporting people at their end of life

- People were supported to experience a comfortable, dignified and pain-free death.

● People had been asked about their wishes at the end of their lives and their decisions recorded in their care plans. This included who they would like to be with them, the management of pain and any funeral arrangements. The amount of detail reflected how comfortable people had felt in sharing this information.

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. The rating for this key question 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had 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. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There were widespread and significant shortfalls in the way the service was led. This is the third time the service has been rated Inadequate.
● The provider continued to not understand the principles of good quality assurance. The provider's programme of audits and checks continued to be ineffective in identifying shortfalls and risks in service delivery. The provider had not identified the shortfalls in assessing risk, staff recruitment, staff training, management of medicines and care records, as highlighted in this report. There was inconsistency in the quality and detail of people's care notes. Some people's daily care notes were blank, others were copied from one day to the next. The effectiveness of the care delivery was not evaluated regularly to ensure people were receiving the right level of support.
● There was no evidence of learning lessons to drive service improvements. At this inspection we found the same shortfalls that had been identified at the inspection in July 2022. These included staff having no guidance about potential risks to look out for when supporting people to use a catheter; not assessing staff's competency in administering medicines; and gaps in employment not being explored when recruiting new staff. Call monitoring was not used effectively to ensure people were visited at their preferred times and stayed for the required amount of time. Although call records evidence a number of calls were significantly less than the intended 30 minute duration, there was no evidence any action had been taken to address this with the staff concerned.
● The provider had not routinely submitted reports of audits to CQC which covered all necessary areas, as part of their imposed conditions of their registration. This was despite the provider being reminded to submit these reports together with the specific areas they needed to cover. These areas were the management of medicines, care plans, risk assessments, missed calls, accidents and incidents, the oversight

and implementation of mental capacity assessments, recruitment records and staff training and competence. At the inspection the provider told us they understood they needed to submit audits to CQC but was not able to tell us what areas these should include.

● The provider had not always notified CQC of important events. The address of the location of the service and provider had changed. Although the provider had told us about these changed they had not registered these changes with us so their certificate of registration could be updated so it was accurate.

● The provider had not ensured they had received the training necessary to carry out their role in a timely manner. The provider told us they had recently applied to undertake a Level 5 Diploma in Leadership and Management for Adult Care. Skills for Care states this is the core qualification for social care managers.

● Roles, responsibilities and accountabilities were not clear which meant systems for communicating risks were ineffective. The registered manager worked in their role on a part time basis and so was not always contactable when needed by the senior carer and care coordinator. Team meetings were held where risks, accidents and incidents and people's well-being was discussed. However, this information had not been recorded in the accident log or people's risk assessments or care plans to ensure these were taken into consideration with providing care.

● The leadership and governance did not give assurances of the delivery of high quality care. The registered manager/provider did not lead by example. Although they worked directly with people they had not received all the essential training they needed for their role. Their medication training was due to be refreshed and they had received no training in how to move people safely. The provider was not aware that they had not followed their own policy with regards to the management of medicines and secondary dispensing.

● There was inconsistency in people's experience of the service. Feedback from people and relatives about how the service was managed were mixed. Half of the people we spoke to said they would recommend the service due to kind or regular staff. The others were not sure they would recommend it due to a lack of regular staff and short calls from some staff. When the provider had received feedback directly from people it had not been acted on to improve the service.

The provider had failed to ensure there were adequate systems to assess, monitor and improve the quality and safety of services provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's feedback had not been used to drive improvements in the service.

● Feedback form people via questionnaire surveys in May 2023 was mixed. There were a number of positive comments about staff, their friendliness and quality of care provided. Positive feedback included 'All the care we receive is considerate and responsive to any changes in their health and 'A high standard of care from staff who go 'above and beyond'. Other comments included, 'Office staff don't communicate well and not able to speak to the manager'; and ' A lot of carers don't advise in good time that cream is due to run out until it's too late'. The provider had analysed the findings and concluded, 'The biggest area of improvement is to enhance communication with clients'. The action the provider took as a result was to send surveys every 3 months rather than to try and address the specific issues raised by people. There was no evidence the findings of the surveys had been shared with staff or people and no evidence of discussions about how they could improve.

Working in partnership with others

● The local authority told us they had spent time supporting the provider to understand the actions they needed to take to improve. They said the provider did not always respond to requests for information in a

timely manner.

● The provider, who was also the registered manager, told us they held membership with the Registered Manager's Skill for Care network and they were a member of the United Kingdom Home Care Association. However, the findings in this report evidence they had not used these resources to keep up to date with regulations and legislation.

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 understood the duty of candour to be open, transparent and providing an apology when things went wrong.