Care Relief Team Limited

CRT - Derby Extra Cares

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
CRT- Derby Extra Cares is a domiciliary care agency providing personal care to people living in their own flats in 3 extra care settings in Derby; Greenwich Gardens, Parkland View and Cedar House. These flats are within large purpose-built buildings. People supported have a range of needs, including autism, learning disabilities, physical disabilities, mental health support needs and people living with dementia. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection, 122 people using the service received a regulated activity.

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

Right Support
People were not always supported to take their medicines safely. Health-related risks to people were not always mitigated, as a result staff did not always have the information they needed to keep people safe. People's care plans were not always accurate or up to date. People did not always receive their care at the right time and for the right duration.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Although, the policies and systems in the service supported this practice, it had not been embedded.

Right Care
People were not always protected from poor care and abuse. The provider had not ensured all safeguarding concerns were shared with other agencies. We received mixed feedback from people, and their relatives about the care people received. Staff had not always completed required training and were not trained in all areas relevant to the people they were supporting, such as diabetes, learning disabilities, autism and catheter care.

Right Culture
There was not always a person-centred culture in the service. Systems and processes had not been followed for quality assurance and to improve the service people received. Complaints and concerns were not always well managed. Staff did not receive consistent supervisions and appraisals.

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

Rating at last inspection
This service was registered with us on 16 December 2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement
We have identified breaches in relation to safeguarding, safe care and treatment, person centred care, dignity and respect, consent, managing complaints, staffing and good governance.

Immediately after the inspection visit, we wrote to the provider and asked them to take action to address our most serious concerns. Although the provider responded with details of action they were taking, we were not assured that all risks were mitigated. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

CRT - Derby Extra Cares

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
This inspection was carried out by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We sought feedback from local authority professionals that work with the service. We used the information

the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 27 September 2022. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service. We shadowed 2 care calls and observed how staff supported and interacted with people. We spoke with 8 relatives about their experience of the care provided.

We spoke with 15 staff including carers, care managers, the compliance manager, the registered manager and the operations manager.

We reviewed 15 people's care records. We looked at 4 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, quality assurance reports and accidents and incidents.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse and avoidable harm. Although there was safeguarding training for staff, not all staff had completed this training. The service had not always worked well with other agencies to share safeguarding concerns.
- Accident and incident reports documented concerns around neglect, staff conduct and other allegations of abuse which had not been referred to the local authority safeguarding adults team. After our inspection, we shared our concerns with the local authority, who visited the service in response and found further safeguarding concerns had not been reported. This meant safeguarding concerns had not always been independently reviewed to ensure people were protected from abuse and to decide how they should be investigated.
- The provider did not have oversight of all safeguarding concerns. The registered manager had not ensured all safeguarding concerns were documented on the provider's electronic recording system which was not in line with the providers policies and procedures. This meant the provider did not always have oversight to ensure that concerns were investigated appropriately.

The provider did not ensure systems worked effectively to safeguard people from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People were not always supported by staff who followed systems and processes to administer and record medicines safely and in line with best practice.
- Medicine administration records (MARs) contained numerous missing signatures. MARs are signed by staff to confirm people have been given and taken the medicines they are prescribed. A relative told us they had found medicines left in packaging where they had not been given to the person and had reported concerns to the manager. This increased health-related risks to people who may not have received their prescribed medicines.
- Medicines documentation was not always completed in line with best practice. Records showed staff had not always signed handwritten MARs, and best practice was not always followed for a second member of staff to sign handwritten records to ensure instructions were written correctly. In addition, 1 of these handwritten records was illegible. This increased the risk of errors and people not receiving their medicines correctly.
- Protocols for medicines taken by people on an as-required basis (PRN) were not always in place. PRN protocols give guidance to staff about when a medicine can be given, the reason it is prescribed and safety information. This meant staff might not know why and when people needed to have these medicines to

support their health.
● Records did not always detail where topical medicines, such as prescribed creams, should be applied. This meant staff might not know where to use these prescribed medicines for them to be effective.
● Care plans and risk assessments did not always contain complete information about medicines people were allergic to. For example, 1 person's medicines risk assessment did not list all the medicines they were allergic to, and another person's care plans stated they were allergic to 'some antibiotics' rather than providing specific information. This meant staff might not know what medicines people were allergic to, which increased health risks to people if these medicines were consumed.

Assessing risk, safety monitoring and management Learning lessons when things go wrong
● The service had not always helped people to keep safe.
● People at increased risk of falls did not always have these risks assessed or included in their care plans. A person told us they were concerned their care plan stated they were not prone to falls, when they felt they were. They told us in relation to this; "I stumble and fall against [the] door.". Another person was prone to falls due to their health condition and records showed they had fallen 4 times since January 2022, but they did not have a falls risk assessment in place. This meant people were at increased risk of injury when they were prone to falls.
● Care plans and risk assessments did not always contain information about managing specific risks to people. For example, a person's risk assessment stated they could not be transferred using a hoist when they were intoxicated from alcohol, but it did not guide staff on how to judge this to ensure a consistent approach. Records showed occasions when staff refused to support this person with their continence needs due to them being intoxicated. This meant the person was at increased risk of inconsistent support and their continence needs not being met, which increased health-related risks, such as damage to their skin.
● People did not always have risk assessments and care plans reviewed or updated following incidents and accidents. For example, following a recent deterioration in a person's mental health, there had been incidents involving the police, the person had made allegations and put themselves in danger. However, their care plans and risk assessments had not been updated to guide staff on how to support this person's mental health and promote their safety.
● Health-related risks were not always managed safely. For example, an incident and accident form documented a relative had made staff aware a person should have been wearing a support stocking on their leg. However, there was no evidence this information had been reviewed by a manager and included in the person's care plans and risk assessments. Another person's diabetes risk assessment did not inform staff what to do in the case of a related medical emergency. This meant information or guidance was not always available on how to support people with their health needs.

Preventing and controlling infection
● Staff did not always use personal protective equipment (PPE) effectively and safely. People told us staff did not always use facemasks when supporting them. They told us PPE and continence aids were not always safely disposed of and left in their flats. We made the registered manager aware of this, and they confirmed staff should be emptying people's bins after putting PPE in them. We observed a member of staff wearing gloves used to support people with personal care in a communal area. This meant PPE was not always used and disposed of safely, which increased the risk of infection spreading.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate health-related risks, and ensure people received their medicines safely. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not always deployed safely and effectively to meet people's needs.

● People were not always kept up to date about changes in staff scheduling. For example, a person told us, "We can't track down people (staff), staff swap the rota around themselves, we don't get a copy of the rota, we don't know what time they are coming. Originally it said 7:30 am, and it can be anything; it can be 9:30 am. We don't get told they are running that late. I'm there thinking shall I start my breakfast or not?".

● People were not always receiving the care they needed at the right times, and staff did not always stay for the full duration of scheduled care calls. Information from care plans, staff schedules and people's daily visit notes showed many early and late calls and staff not staying for the right duration. Furthermore, A relative told us, "They (staff) miss visits sometimes as they're so busy and sometimes it's nearer dinner time that [Person's] having [Person's] morning call, and then [Person's] medication isn't given on time which isn't good for [Person's] blood pressure, and they seem to not have set routine times for [Person]." This increased risks to people's safety and wellbeing.

The provider failed to ensure sufficient numbers of staff were deployed to meet people's needs safely and effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. The provider had carried out checks by obtaining references from previous employers, right to work documentation and Disclosure and Barring Service (DBS) checks were also contained on staff files. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. This helps providers make safe recruitment decisions.

Inadequate

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received training relevant to their needs.
- Not all staff had completed the provider's mandatory training. Staff training records showed 33 staff members employed since September 2021 had not completed all mandatory training. Staff had not completed training in learning disabilities and autism, a legal requirement of the Health and Care Act 2022. Furthermore, staff did not have training in areas such as epilepsy, diabetes and catheter care despite people having health needs in these areas. This increased the risk of staff not having the skills and training to meet people's needs.
- Staff did not always receive supervision and appraisals. Furthermore, staff did not receive observations and checks to ensure they were competent to support people with their medicines in line with the provider's policies and procedures. This meant staff may not have received appropriate support to reflect on their practice and continued professional development to support people in line with best practices and the standards expected of them.

The provider did not ensure all staff had completed training in line with requirements. Not all staff had received regular supervision and appraisal. This was a breach of regulation 18 (2) 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.

- Information was not always present or well documented about people's capacity to make decisions.
- Care plans identified people who may not have capacity, but it was not clear which decisions people lacked the capacity for. Decision-specific mental capacity assessments relating to people's care or treatment had not always been undertaken. This meant staff may have made decisions for people without confirming their understanding of information relating to specific decisions and ensuring they were least

restrictive and in their best interests. This meant guidance and the law were not fully adhered to concerning the MCA, which increased the risk of people's rights not being upheld.
● Evidence was not kept on records where people had legally appointed representatives to make decisions on their behalf. Some people had lasting power of attorneys (LPA). Under the MCA, LPAs can have the legal authorisation to make decisions on behalf of people, such as those relating to their health, welfare and finances. However, the provider did not keep copies of documents confirming LPAs were legally authorised to make decisions on behalf of people. Additionally, 1 person told us their relatives had LPA, but this was not documented on their care plans.

The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● Risks to people who had specific dietary needs were not always consistently identified. For example, where a person's care plan stated they were allergic to seafood, their risk assessment stated they had no food allergies. Another person's care plan stated they were allergic to dark chocolate, but their risk assessment stated they had 'food allergies' instead of stating what they were allergic to. This increased avoidable health-related risks to people should they have consumed or encountered foods they were allergic to.
● People's initial assessments were not always fully completed. Initial assessments help inform people's care plans to ensure their needs can be met. For example, one person's initial assessment had sections missing in relation to their mobility and environmental safety. This increased risks to people's health and safety.

The provider did not do all that was reasonably practicable to mitigate risks to people. This placed people at risk of receiving unsafe care. This was a breach of regulation 12, (2)(b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did not always get choices about what food staff prepared for them. One relative told us, "they (staff) come at teatime and just make [Person] a sandwich and [Person's] fed up of sandwiches and they don't ask [Person] what [Person] wants".
● Care plans did not always contain accurate information about people's dietary needs and preferences. For example, a person told us their care plan was incorrect as eating food was listed as something they liked to do. However, they told us, "I have a psychological problem with food. I hate eating food, cooking food, goes back to when we were so poor," they went on to tell us their feelings about their care plans; "It's not me at all and it's supposed to be about me. It's so misleading".
● People's records did not always contain information about their cultural or religious beliefs. For example, a person told us, "It ought to be made very clear what [a person's] religion is, but this is left blank. A Jehovah's witness will be very upset if they get wished happy Christmas". This meant care plans did not always contain information important to people's identity which promoted equality and diversity.

The provider did not ensure people received person centred care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The provider supported people to contact health care professionals to help promote their health and wellbeing. There was evidence staff sought medical support when people required it, such as when people had fallen and hurt themselves or when people's needs changed in relation to their mental health.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● A person had been sleeping in an armchair for the past 2 months. They told us they were uncomfortable and wanted to sleep in a bed. A staff member told us they had raised concerns to managers, who had not acted, and felt the person was being neglected. During our inspection the provider spoke with the person and supported them to order a new bed. This meant the provider had not always acted promptly to ensure people were well supported and treated with dignity.

● A relative told us they were concerned a person was not receiving support to change into clean clothes daily. They told us, "[Person] can be in the same clothes for days with stains on, and they don't change [Person]. It's not fair and all they need to say is shall we change it and [Person] would agree but I don't think they have time, so they just rush [Person]".

The provider did not ensure people were always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, there were also aspects of positive feedback about how caring staff were. For example, a person told us "The care service I get is absolutely excellent. They come in the morning to give me my medication and help make my bed and give me my breakfast. Then teatime they come again to give me medication and make me something for tea". A relative also told us; "It's so lovely duck, we have no concerns at all as they're all lovely and treat [Person] very well".

● Staff we spoke with knew how to respect people's privacy and dignity. For example, a member of staff told us when supporting people with personal care, they would ensure doors and curtains were closed and people were covered with a towel while they had a wash. The member of staff was also able to describe to us how they would promote people's independence to maintain daily living skills by letting people do the things they can do for themselves and only supporting where people needed help.

Supporting people to express their views and be involved in making decisions about their care

● We shadowed 2 care calls during the inspection and found staff engaged people in conversation and explained everything they were doing, checking if people were happy with how they were being supported.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

● Complaints and concerns were not always well managed. People, relatives and staff made us aware of complaints and concerns they had made to the provider which had not been recorded on their systems. Complaints and concerns ranged from medicines concerns, late calls, missing items and people not receiving meals. However, there was only 1 complaint recorded in relation to a care plan needing more detail. The provider had not always recorded and responded to complaints and concerns in line with their policy. This meant there was an increased risk of care not improving in response to complaints or concerns.

The provider did not effectively operate systems to receive and respond to complaints. This increased the risk of care not improving following complaints. This was a breach of regulation 16, (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The support people received with communication was not always reviewed with people to ensure it was accurate and accessible to them. Care plans varied in quality in relation to detail included about people's communication needs and how best to support them. People told us information about their hearing and eyesight were not accurately documented and they would have preferred to have received a copy of their care plans in large print to support their eyesight.

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

● A person told us they had only received their care plan on the first day of our inspection. The person told us their care plans contained errors, such as stating they had a good sleep pattern and that they had a preference to the gender of carers that supported them. They also told us, "(they've) not sat down with me, not gone through this, these are not my answers". This meant the provider had not always worked in collaboration with people in relation to their care plans to ensure information was person centred and reflected their needs and preferences.

● People's needs were not always met. For example, a person told us they had not been receiving the

support they needed with their long-term physiotherapy plan to use an exercise bike. They told us, "I haven't been on the bike in weeks. It's got to the stage now that I've stopped asking, as I've had so many fob-offs. This meant people did not always receive support to meet their health and wellbeing needs.

The provider did not ensure people received person centred care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans did contain information about who people were and what was important to them. For example, care plans stated what people used to do for a living and the importance of those closest to them. This meant people's backgrounds were considered and there was information about who the person was as an individual.

End of life care and support

● Care plans did not always contain information about people's end of life plans. Not all care plans included clear information if decisions had been made relating to resuscitation and life-sustaining hospital admissions. In addition, care plans did not always state where these documents were located if they were in place. There was an increased risk people's views and wishes may not be respected in relation to the end of their life was as this was not always documented.

The provider did not ensure people were always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- There was not always evidence a manager had reviewed accidents and incidents. The registered manager did not ensure accidents and incidents were recorded electronically in line with the provider's policy. This meant more senior managers did not have full oversight of accidents and incidents. As a result, the provider could not ensure learning from incidents and accidents took place to improve people's care and safety.
- Systems to ensure staff had completed training were not effective. The provider had not operated their training policy effectively to ensure staff had completed all required training. Legal requirements were not met to ensure staff had received learning disabilities and autism training. Staff had not received training in all areas relating to people's health related needs such as epilepsy, diabetes and catheter care. This increased the risk of people not receiving support from staff with the skills and competence to meet their needs.
- There were no systems operated to monitor when people received their care. The provider told us they were looking into systems to enable staff to clock in and out of care calls. However, interim arrangements had not been made to ensure staff attended care calls at the right time and for the right duration. People and their relatives told us how this had negatively impacted on their experience of the care people received.

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

- Medicines audits had not been carried out consistently in line with the providers policy. As a result, audits had not been used to identify the concerns we found in relation to medicines at this inspection. This meant systems had not been used effectively to ensure people received their medicines safely.
- Accurate, complete and up to date records were not always maintained. Care plans and risk assessments did not always contain consistent information on health-related risks to people. Furthermore, we found people's care plans were not always fully completed. This increased the risks to people's health, safety, well-being, preferences and needs not being met.
- There was not effective oversight of staff practice around the use of PPE. Staff were not following the provider's policy in relation to PPE as we observed staff interacting with people without using facemasks in communal areas. The provider's policy stated staff should be wearing facemasks in these instances. The provider told us their health and safety manager informed them they did not need to wear facemasks; however, policies had not been updated to reflect this or the reasons for this decision.
- Systems to safeguard people from the risk of abuse were not operated effectively. We found the registered manager had not followed the provider's policy to report all safeguarding concerns to the local authority safeguarding adults team. This exposed people to the increased risk of abuse.

The provider failed to ensure systems and processes operated effectively and failed to maintain accurate and up to date records to promote the safety of people using the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

● The provider had failed to submit all statutory notifications to CQC. We found the provider had not made us aware of all allegations of abuse. Providers are required to submit statutory notifications to CQC for key events. This information tells us what the provider has done in relation to concerns and can help inform us of when we will next inspect a service. This meant the provider did not always meet their regulatory responsibility. We will continue to monitor this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Working in partnership with others

● Partnership working with external professionals was inconsistent. Although we saw evidence of staff contacting professionals such as GPs, nurses and social workers. There was an inconsistent approach to reporting safeguarding concerns to the local authority safeguarding adults team and CQC. This meant appropriate information was not always being shared for the benefit of the people using the service.

● Staff meetings were not held regularly. Records showed staff meetings had been held in February, April and July 2022. However, each of these meetings were for a different site which had different staff teams. This meant staff did not have regular opportunities to meet and discuss concerns collectively to improve on the care people received.

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

● There was not always a positive culture in the service. As sighted in other parts of the report, care was not always person centred, which meant good outcomes could not always be promoted for people. In addition, a relative told us they felt managers were not very approachable when they went to pass on a person's concerns. They told us, "We came out of the carers office feeling like 2 naughty schoolgirls."

● The Registered manager told us things felt like "crisis management", and they did not have the "capacity to work on improvements and keep up with the day-to-day running" of the service. However, they felt the provider supported them well and was hopeful the service would be better in 3 months with a new care manager recently joining the team and things being calmer at 1 site.

● People told us they were asked to complete surveys. The provider recorded what actions had been taken in response to people's comments. However, a person told us they had to complete a survey when staff were present, which made them feel uncomfortable. The provider told us they had reviewed how surveys were carried out in response to this.

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 their responsibilities to act on the duty of candour and had policies to promote them meeting their legal responsibilities.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received person centred care which met their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure people were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not effectively operate systems to receive and respond to complaints. This increased the risk of care not improving following complaints.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate health-related risks, and ensure people received their medicines safely.

The enforcement action we took:

We served a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure systems worked effectively to safeguard people from abuse and improper treatment

The enforcement action we took:

We imposed urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes operated effectively and failed maintain accurate and up to date records to promote the safety of people using the service.

The enforcement action we took:

We served a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of staff were deployed to meet people's needs safely and effectively. The provider did not ensure all staff had completed training in line with

requirements. Not all staff had received regular supervision and appraisal.

The enforcement action we took:

We served a Warning Notice.