Mach Care Solutions Limited

Mach Care Solutions (Birmingham)

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
Mach Care is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection there were 24 people using the service.
At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person.

People's experience of using this service and what we found
The provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks. At our previous inspection in October 2021, the provider was in breach of regulation 17 Good governance. At this inspection we found improvements had not been sustained and the provider remained in breach of this regulation. We also identified new breaches of regulations 9 Person centred care, 11 Consent, 12 Safe care and treatment and 18 Staffing.

There were systems in place for managing complaints, safeguarding concerns, accidents and incidents. However, we found these were not robust and feedback from people and relatives on how the provider managed calls was very poor. The main complaint raised by people and their family members was the lateness, shortness of calls and missed care calls. We found from call records and rota's that short, late and missed calls were occurring. Staff attending people's homes at times were inconsistent which impacted on the support people needed, placing them at risk of harm.

Based on our findings around the continual short, late and missed care calls, staff members were not effectively deployed by the provider to support people.

Two people and their relatives told us some care staff members communication was limited, this was due to language barriers.

Care plans were not fully personalised, and information contained within them had not been reviewed and updated to reflect people's current support needs. Risks to people had not been thoroughly assessed. The assessments themselves did not always clearly reflect what action staff should take in the event of that person becoming unwell or experiencing symptoms of known health conditions.

People's care and support was not always planned in partnership with them and persons close to them. This meant people were not always supported to have maximum choice and control of their lives as they told us they were not involved in care reviews and when they had raised concerns these had not been thoroughly addressed and resolved.

Where appropriate, staff supported people with nutritional and hydration needs, however care plans contained conflicting information for staff to follow.

People were not consistently protected from abuse because the systems and processes in place were not robust to keep people safe. Staff we spoke with were aware of their responsibilities to keep people safe.

People were not consistently supported by staff to take their medicines, however, guidance in place was not clear for staff to follow. Records demonstrated that medicines were not always given as prescribed.

Overall, people and their relatives told us staff members adhered to current Infection Prevention and Control guidance for the correct and safe use of Personal Protective Equipment (PPE).

Pre-employment checks were in place to make sure newly recruited staff were suitable to carry out their role. Staff received induction training. Many people felt staff members had the appropriate skills and knowledge to support them how they wished.

People told us, staff sought consent prior to supporting them and encouraged people to make their own decisions, in the least restrictive way possible and in their best interests; the provider had policies in place.

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 21 October 2021) and there were breaches of regulation. The service has deteriorated to inadequate. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about people not being supported in a safe way, short call times, staffing levels and poor governance systems. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified new breaches in relation to Regulation 9 - Person centred care, Regulation 11 - Consent, Regulation 12 – Safe care and treatment, Regulation 18 - Staffing and Regulation 17 – Good governance which is a continued breach, at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mach Care Solutions (Birmingham)

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 team comprised of three inspectors, one of these inspectors made telephone calls to staff members and two Experts by Experience made telephone calls to people who used the service and their family members. 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 is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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 24 hours' notice of the inspection. Inspection activity started on 06 October 2022 and

ended on 17 October 2022. We visited the location's office on 06 October 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also contacted commissioners of care services for their feedback. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and 14 relatives. We also spoke with 10 care staff, three office staff members and the registered manager who is also the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We contacted three health professionals but only received feedback from one. We reviewed eight care plans and a selection of call records, daily notes, medicine records, risk assessments, audits and policies and procedures. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider, following the site visit.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were at risk of abuse and neglect and were not consistently protected.
- We found multiple examples of safeguarding concerns which had not been actioned robustly. This included the impact of people being exposed to missed calls resulting in them not receiving support for long periods of time and potentially having missed medicines and meals.
- Incidents had not been consistently recorded or acted on. For example, although there were records that staff discussions had taken place to consider some management of incidents and to discuss more appropriate support and actions, this was not the case in relation to consistently late calls. People continued to receive late and short calls. This meant people using the service were placed at risk from potential further such incidents, as concerns were not always identified, and appropriate actions had not always been taken.
- Staff had not always recognised abusive practice. This and poor systems meant staff and the registered manager had not taken timely action to safeguard people. For example, where calls were significantly late, close together or missed, no actions had been taken to ensure this did not occur again and reduce the potential harm to people. This practice continued for several months before the provider contacted the local authority to advise them, they were unable to meet peoples commissioned calls.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure systems and processes to keep people using the service safe were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke with the registered manager and they advised us they had taken steps to ensure people received their calls as scheduled by reducing the number of people they were now supporting.

Assessing risk, safety monitoring and management

- We found that people's risks were not always effectively managed. for example, where risks to people was known due to their diagnosed health conditions, risk assessments and care plans were not always reflective of their current needs to guide staff on how to support people safely. We found some care plans and risk assessments also contained conflicting information. When these should have been reviewed and updated following changes to people's needs or following incidents, this had not always happened and meant that people were not safe from the risk of harm.
- People who had been assessed by Speech and Language Therapy (SaLT) because they were at risk of choking, did not have the necessary information accurately recorded in their care records for staff to follow. For example, one person's care plan stated they were assessed as needing a specific diet because of their

risk of choking and thickened fluids, their care plan contained conflicting information. However, although care staff we spoke with were aware of the correct support and people received the correct diet, as per their assessed needs, a risk still remained. This meant people were at risk from receiving the incorrect diet or fluids should they be supported by unfamiliar staff members.

● Two other people's care plans indicated they required dietary supplements; however, these were not reflected in their risk assessments. After speaking with their relatives, we established these supplements were no longer prescribed by their GP, but their care plans had not been updated accordingly. We brought this to the immediate attention of the registered manager who gave assurances they would provide clear information for staff to follow.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● At the last inspection we found medicine records indicated people received their prescribed medicines. At this inspection we found some people were not given their medicines at the time they had been prescribed. This was due to calls taking place at much later times than scheduled. This included medicine for the control of diabetes and heart conditions. Although we found no evidence people had suffered harm, continued poor administration of medicines could have long term effects on people's health conditions.

● At this inspection we found care plans and risk assessments to guide staff on the level of support people needed with their medication were not consistent and contained conflicting information. This placed people at risk of not receiving their prescribed medicines.

● The information for staff members to follow, for 'as required' medicines was not always in place or clear. Without clear protocols in place this could lead to staff not knowing when to give these medicines, leading to the potential for too much or too little medication to be given.

● For people who were prescribed creams, we saw these were not included on the Medicines Administration Records (MAR). This meant people were at risk of their skin condition deteriorating. We also found that body maps in place did not provide staff with clear instructions on when, where or how the creams should be applied.

● People who staff supported with their prescribed medicines were happy with how this was managed. However, we found the MAR record for one person indicated staff had given a controlled medicine which should only be given by the district nurse. Staff we spoke with about this medicine gave conflicting information however, this may have been due to their understanding of English. The person's relative confirmed they did not have any concerns in regard to the incorrect administration of this controlled medicine as it was not given by care staff.

● We found staff were not consistent in their recording of medicine administration. Some staff recorded they had administered medicines however, other staff members had recorded for the same person, left with client or self-administered. This meant it was not possible to corroborate if medication had been given by staff members in a safe way and in accordance with the person's needs.

Medicines management was not robust enough to demonstrate that medicines were always managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Some people told us that often they did not receive their calls on time and regularly experienced short

calls. One relative told us, "Sometimes they [care staff] don't come on time, sometimes they are an hour or two late. I ring the company and they get in touch with the carers, but they don't get back to us, so we don't know what's going on. Sometimes they only stay between 10 and 16 minutes, we are paying for something we are not getting (30 minutes)."

● At the last inspection we found there were not enough staff to support people in a timely way. At this inspection we found people were still not receiving their calls on time. The providers own audits had identified people had experienced late calls for many months, however, they had not taken action to rectify this until just before our inspection commenced.

● Staff rotas demonstrated the provider did not always allow them travel time between calls or more than one call was scheduled at the same time. Rota's, we looked at confirmed this. This meant calls would either be shortened or late, impacting on the standard of support people received.

● We looked at a range of care records and staff rotas, these records showed that some calls were recorded as lasting less than a quarter of the commissioned time and records showed that some staff were attending two calls at the same time and people were not supported at consistent times. People and their relatives told us that this caused them anxiety and frustration.

● Some people who required two or three staff to support them told us they experienced times when the incorrect number of staff attended their call, relatives and records confirmed that there were multiple occasions where only one carer attended a two person call. This meant that people were exposed to the risk of harm. One relative told us, "Sometimes I go at the weekend and there is only one carer there instead of two. My relative has a hoist so she hasn't been able to be lifted (from their bed), so she's been left in a wet bed."

● Safe recruitment practices were not consistently followed; one staff member had not had gaps in their employment explored prior to employment commencing. This placed people at risk of harm from poorly managed recruitment systems and processes. The registered manager provided evidence after the inspect that they had taken action to rectify this and held conversations with staff members.

The provider failed to ensure staff were suitably deployed. They did not ensure people using the service were consistently supported ensuring people's needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records demonstrated staff had a Disclosure and Barring Service (DBS) check prior to commencing employment. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Suitable references had been obtained for staff members.

Preventing and controlling infection

● Many people and relatives we spoke with confirmed staff wore appropriate personal protective equipment (PPE). However, others told us staff did not consistently wear masks or aprons when providing their support.

● The provider had a system in place to monitor the correct use and disposal of PPE as they had recently been carrying out spot checks to monitor staff adherence to infection prevention and control practices.

● Staff told us the PPE they needed was available to them. We saw stocks of PPE were available in the office for staff to collect when needed.

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 did not rate this key question. At this inspection the rating for this key question is requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not consistently receive care that met their needs and preferences.
- Some people and relatives told us they were not involved in the initial assessments completed by the provider before starting to use the service nor on-going care reviews. Some people and relatives we spoke with us told us they had not been involved in care reviews or care planning meetings. This meant that we were not assured that all people's care was delivered in a person-centred way and in line with their preferences. The provider provided us with records to demonstrate they had sought feedback via questionnaires and telephone calls, for some people.
- One relative told us, "Nobody has been out until about two months ago and asked us what we needed. They [manager] told me they would print it (care plan) and send it back, but I's still waiting." Records we saw evidenced some people, or their relatives had not been consulted about their care plans or had the opportunity to see and review the ones which had been put in place."
- Calls were often inconsistent, and one relative told us, "Different carers come all of the time. When new ones come, they don't always know what to do. We had about six or seven of them [carers] last week." The Provider Information Return (PIR) sent to us before the inspection stated; 'We ensure that we send carers to the same person to ensure continuity'. We found this was not applied consistently and discussed this with the nominated individual, during the inspection. We were told they had started to reduce the number of people using the service to address the issues around call times. We were unable to assess the effectiveness of this as the reduction in number had only just taken place.
- Care plans and risk assessments were not consistently kept under review to ensure they still meet people's needs. For example; one person's care plan indicated the required specialised equipment and had specific dietary needs. We found there had been a significant change in their support needs which had not been reflected in their care plan. This meant people were at risk of not receiving care in the way they needed it.
- Two people told us some staff members first language was not English which meant people felt communication was not always effective. People told us they could not verbally communicate their support needs or wishes, they had to gesture these.

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

- The provider and staff were not consistent in their approach in working in partnership with people, their relatives and health and social care professionals. One health professional we spoke with raised concerns about the support one person received in regard to their known condition, which had recently deteriorated. This had been referred to the local safeguarding team for further investigation.

The provider did not ensure people's care was appropriate and met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us the care plans were accessible on the provider's computerised system. We found staff we spoke with understood people's support needs and how to provide their care.
● Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency. However, two staff members struggled to explain to us what the signs and implications of one person's health condition were.

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 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.
● For people who were unable to make their own choices and decisions for themselves, the provider had not explored or obtained evidence people making decisions on their behalf had the necessary authority to do so. This meant we could not be assured people were being supported in the least restrictive way and decisions were not being made on their behalf inappropriately.
● Some people and relatives told us they had not been consulted or involved in developing their care plans. They also told us they had not been given the opportunity to read and consent to the information made available to staff members.

The provider did not ensure people's consent was gained prior to support being provided. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We saw evidence for some people that written consent had been gained to provide support with their care needs.
● People and relatives consistently told us staff sought consent before providing care and support. One person told us, "I can make my own choice, I am not restricted at all." A relative told us, "They [carers] always ask her before they do anything; Would you like to do this? Would you like to do that?"
● Staff we spoke with gave us examples of how they gained consent before supporting people with their care and how they acted in people's best interests when they could not make these decisions for themselves.

Staff support: induction, training, skills and experience
● The registered manager was not able to demonstrate all staff had received training to meet people's specialised support needs. However, care staff told us they had received appropriate training and could tell us how they carried out delegated support such as changing dressings.
● We received feedback from people and relatives we spoke with, who were overall satisfied with the level of skill demonstrated by the staff, others felt there was a lack of understanding of people's needs when new staff came to them.
● Spot checks and competency assessments were carried out to ensure staff were applying their skills and knowledge in the right way or if there were any areas for development needed.

● Staff told us when they first started working at the service, they received an induction. This included shadowing other staff members, on-line training and face to face training in the office. The training was in line with 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.
● Staff told us they received supervision and attended meetings and told us they felt supported, by the registered manager and the office staff.

Supporting people to eat and drink enough to maintain a balanced diet
● People's dietary needs were considered and assessed by the local authority however, information shared with staff members via care plans was not always clear for staff to follow. However, staff we spoke with knew how to support people with specific nutritional needs.
● Not all people we spoke with required support with meal preparation or assistance to eat. Where this support was offered feedback was mixed. Some people told us some staff needed further training to be able to prepare simple meals. For example; one person told us, "They [carers] get me what I want for breakfast, but I don't ask them to do my lunch for me now. I have made complaints about carers skills and knowledge how well they make sandwiches." A relative told us, "On the morning visit they [carers] are supposed to take out a frozen meal but they don't always, so sometimes it's not properly warm for lunch."
● Staff records indicated people had access to drinks and snacks before they left and people, we spoke with confirmed this. One relative told us, "They will always give her a fresh drink. If it was left to them [carers] she would never starve or go thirsty."

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 did not rate this key question. At this inspection the rating for this key question is 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 relative told us, "I am not amused with the support. I think they have to understand the meaning of the word care to be a carer. Some of them aren't capable carers. Communication skills are a big thing and punctuality."
- The service supported people and employed staff from multi-cultural and religious backgrounds. People told us and records demonstrated, some people were supported by staff members who were not able to communicate effectively due to their ability to fluently speak and understand English. The registered manager told us they would look at how they could support staff members to develop their language skills to help improve their communication and recording skills.
- Although most people and their relatives told us that privacy and dignity was promoted, one relative said, care staff did not always ensure peoples' dignity was preserved when their personal care was provided. They told us, "The care they receive is as basic as possible. They [carers] put [name] on the commode, take out the bucket and reach underneath, to wash them." The same relative also told us that due to long gaps between care calls their relative was left in a soiled bed which impacted on their dignity.

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

- Some people told us they had asked for access to their care plans and care records which were not easily accessible to people, as these were held electronically. We discussed this with the registered manager who told us they would discuss this with people who used the service and provide copies, where required. They also told us they were looking to implement and updated electronic system to give people access to their care plans.
- People and relatives told us care plans were not always developed with the involvement of people and their relatives and they had never been asked about their care needs and wishes.
- Quality questionnaires had been sent out to some people using the service for their feedback however, there was no overall analysis or action plan to evidence concerns raised had been actioned.
- We saw evidence that telephone calls had been made to some people to gain their views on the service received.
- People's care plans included some information about their preferences and personal histories to help staff get to know them and how they liked to be supported. However, we found these required improvements to give staff more detailed information, particularly for those people who have dementia and limited communication abilities.
- Many people and their relatives told us that staff were kind and friendly. One person said, "They [carers]

are really nice, they care. They see if I am ok and if I need anything and ask me if I am happy with what they have done. I have such a good relationship with them, there is no discrimination. They are like part of the family." A relative told us, "My relatives face lights up when the carers arrive. They seem more relaxed with then than she does with me. When I hear them all laughing and chatting, I know [name] is being treated all right."

● Most care staff we spoke with understood peoples' support needs and told us how they supported people to do as much for themselves as they were able to help them maintain some independence. People and relatives, we spoke with confirmed carers helped them to maintain their independence as much as possible. One person said, "I try to be as independent as I can. The carers try to get me to reach things for myself; they leave things so I can get them. I'm treated as a human being."

● People told us they felt listened to by carers.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we did not rate this key question. At this inspection the rating for this key question is requires improvement. This meant people's needs were not always met.

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

- We saw from records and people and their relatives told us; care plans were not consistently reviewed as people's needs changed. Staff we spoke with told us about people's current care needs although their care plans did not reflect this information to guide staff.
- People and their relatives told us they did not always feel calls took place at times to suit people's needs and preferences. On relative told us, "[Name] should have two carers at 09.30hrs but they are going in at 08.30hrs. The next call should be at 13.00hrs and no numerous occasions it has been 13.30 or 14.00hrs. it leaves too big of a gap when they need support. Older, vulnerable people need to know when carers are coming in."
- Staff told us, and we saw from care records they recognised when a person was unwell and required additional support such as a GP or ambulance. However, we saw that not all care staff always recorded the support they provided correctly. For example; care records were not always reflective of how people were feeling or if they had been taken to hospital. The registered manager told us they had started to address this with staff. As they had only just commenced this, we were not able to assess whether their monitoring and actions would be sustained.

Improving care quality in response to complaints or concerns

- Not all people were confident that their concerns and complaints were listened to when they rang the office as often nobody called them back. Some people told us they did not have a number to contact the office if they had a complaint and had to search online for the contact number. However, the provider assured us their contact details were always given to people when they started using the service.
- The provider's PIR stated, 'We have a robust complaints procedure. The complaints that we have received are to do with carers running late for care calls or carers not cleaning up after their work.' We saw there was a complaints process in place, however, we could see where complaints had been raised, they had not always triggered timely adjustments to be implemented to prevent similar complaints occurring such as; late calls which continued.
- People and relatives told us they were able to raise complaints with the service but not everyone was confident the issues would be dealt with. One relative who told us they had raised concerns and said, "They've [the provider] promised improvement, let's just see if it happens."
- A person using the service told us they had raised concerns about the care staff they had, they said, "Some carers really, really do not want to be here. I did phone [Name] the provider and they get them taken off my calls straight away.

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 care staff, 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 registered manager told us currently, no people using the service required information to be provided in different formats such as speaking, large print or alternative languages. The registered manager told us they would provide alternative formats if they needed to, and people made them aware of alternative formats

● One person who had a hearing impairment prefers to communicate in writing. Staff told us about how they supported this person to communicate in their preferred way.

End of life care and support

● At the time of the inspection, no one supported by the service was receiving end of life care.

● The registered manager told us they understood the need to work closely with people, their relatives and healthcare professionals, including GPs, to ensure people's preferences and choices for their end of life care were acted on and they had the support they needed.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The registered manager is also the nominated individual for this service, although they were not always in the office, they were contactable by telephone or e-mail. There was a service manager and care co-ordinator who worked in the office and reported to the registered manager.
- Lack of management oversight had contributed to the shortfalls identified. The provider had failed to ensure good quality assurance systems and processes were maintained and this meant the service lacked effective improvement.
- Although there was a system to audit aspects of the service, we found these had failed to identify people were not supported safely in a way they chose. They did not identify the concerns with; care plans and risk assessments which required more robust information, inadequate call times such as short, late and potentially missed calls, medication and safeguarding concerns which we identified.
- The management of safety, risk and governance had not been effective. Actions had not been taken by the registered manager to ensure the systems and processes were robust and operated effectively.
- Care records and risk assessments required more detail to ensure information was detailed and current for staff to refer to. The provider's own audits had failed to identify these shortfalls. Although there were records to evidence when reviews of care plans and risk assessments took place, we found they were not effective as the concerns we found had not been addressed. This included; inaccurate information in care plans, lack of information for staff to follow and risk assessments which were not always robust.
- We could not be assured the system used for staff to log in and out of calls and record their notes was safe. Staff could log in to a call when they were not in attendance. This meant there were no assurances staff attended the calls, on time or for the correct length of time.
- Audits had failed to identify the concerns around medicines such as potentially not given at all or given when this was not the care staff's responsibility and the lack of information for safe administration in care plans.
- The provider understood the need to notify us about relevant changes, events and incidents affecting the service and people who used it. However, we found their systems were not always robust and did not identify when their processes had not been followed, until many months later.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a registered manager in post.
● The staff we spoke with were clear about their respective roles and responsibilities and what was expected of them. The service manager and care co-ordinator told us about how they wished to support the provider to develop and improve the service provided.
● The provider had implemented processes to support staff, this included regular supportive supervisions to provide development opportunities and feedback on performance and areas of improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.
● We found from documentation and speaking to people, that the service did not always promote a person centred approach. People's individual needs were not always considered or met. Such as; Communication and the impact of late, short or missed calls had on people's overall well-being.
● Many people and relatives also told us they had not been invited to attend care reviews to discuss the continuing care and support required. This meant the provider could not be assured the care plans and risk assessments reflected people's current needs and wishes.
● Spot checks to confirm staff were working in line with the provider's expectations had recently started to be completed again now that there were less restrictions in relation to the COVID-19 pandemic. Monitoring calls were made to a random sample of people to obtain direct feedback on how well staff were meeting their needs.
● Some staff we spoke with told us that they did not often see the registered manager but said they could call them at any time and knew they would be listened to. One carer told us, "They [the provider] are quite good. The office staff are friendly and listen to any problems we have and deal with it accordingly. If we need support, they help us quickly.
● The provider was displaying their most recent inspection rating as they are required to by law.

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 registered manager told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care.
● However, we found they were not fulfilling this obligation with people using the service as they have not acted consistently on complaints and concerns raised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We found that feedback provided was not reviewed to identify learning for the service and issues to be addressed in a timely way to prevent recurring issues.
● People's preferences were not always considered to ensure their needs could be met resulting in call times not taking place at their preferred time.
● Staff told us they had the opportunity to attend meetings and one to one supervision when information and changes was shared with them.
● Staff told us they felt able to raise any concerns or worries they may have about the care provided. They were confident issues raised with management would be investigated and felt when they reported issues to the office, office staff acted on these quickly.

Continuous learning and improving care
● Complaints which the provider had recorded did not reflect all the complaints people and their relatives

told us they had raised. A relative told us, "There is room for improvement. I have always found it very difficult to get past reception when I call. They say they will get the manager to ring back but they never return my call."

● People and relatives told us that when the care staff had not turned up for the call, they called the office, the office staff addressed this but sometimes this was two hours later. Although people's care calls were monitored, this was not robust. Frequent late calls remained a concern to many people and their relatives. The provider had identified a need to decrease the number of people they supported as a means of ensuring staff punctuality. The effectiveness of this will be assessed at the next inspection.

● Incidents which had been recorded did not demonstrate that any actions had been taken in relation to these concerns. There was no evidence that care plans and risk assessments had been updated, this meant information was incorrect. Reflective practices had not been adopted and no lessons had been learnt in a timely way for issues they had been aware of for many months, such as late calls.

● The provider had quality assurance systems and processes in place designed to enable them monitor and improve the safety and quality of people's care. This included audits of people's call times, accidents and incidents, medicines and complaints. However, we found these were not robust and did not identify some of the concerns we found at this inspection.

● There was evidence the provider had analysed complaints for recurring themes to help them improve the service.

● The management team were receptive to our feedback from the inspection. Following our inspection, they shared further details of actions being taken to address these concerns, including people's late care calls.

Working in partnership with others

● The provider told us they understood the need to work in partnership with and share information with other agencies, including the local authority and community health and social care professionals, to ensure people received joined-up care.

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
Nursing care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that risks to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including; missed, late and short calls to support people, poor medicines management, lack of care plans and risk assessments for peoples known health conditions. As a result, people were exposed to the risk of harm.

Regulated activity	Regulation
Nursing care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that risks to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including; missed, late and short calls to support people, medicines, care plans and risk assessments for peoples known health conditions. As a result, people were exposed to the risk of harm.

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
Nursing care Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were involved in the care planning and the support they received did not meet their needs and wishes. This included; missed, late and short calls to support, medicines and lack of care plans and risk assessments reflective of peoples current needs. As a result, people were not supported in a way which they chose or needed.

The enforcement action we took:

The provider was issued with a NoD to impose conditions on their registration due to multiple breaches of regulations.

Regulated activity	Regulation
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people using the service received safe care and treatment. 1. The provider failed to ensure care plans and risk assessments were in place and completed with enough detail to give care staff the knowledge and information they needed, to be able to support people safely. This included the lack of care plans and risk assessments for people with known, complex, health conditions. 2. The provider failed to ensure people received their medication safely. 3. The provider failed to ensure people received their commissioned length of calls or frequency, placing people at risk.

The enforcement action we took:

The provider was issued with a NoD to impose conditions on their registration due to multiple breaches of regulations.

Regulated activity	Regulation

Nursing care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that risks to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including; missed, late and short calls to support people, medicines, care plans and risk assessments for peoples known health conditions. As a result, people were exposed to the risk of harm.

The enforcement action we took:

The provider was issued with a NoD to impose conditions on their registration due to multiple breaches of regulations.