Care Quality Commission

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1st React Healthcare - 1st React Healthcare Domicilary Care Agency

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
1st React Healthcare – 1st React Healthcare Domiciliary Agency is a domiciliary care agency based in Exmouth. The service provides personal care to adults in their own homes. 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 the inspection, the service was supporting 59 people with personal care.

People's experience of using this service and what we found
Robust systems were not in place to ensure staff attended calls in a timely way for the commissioned length of time. People and relatives all told us they did not know which staff were visiting and when. They told us staff did not always stay for the correct amount of time and this was confirmed by daily records. Daily notes often stated that people did not want anything else doing when there was a short visit, but people and relatives told us the staff voiced to them they were busy and short staffed and so were reluctant to ask them to stay. This meant that tasks were sometimes not completed despite specific health conditions and care plan instructions and staff did not have time to talk to people.

All staff, people and relatives spoken to voiced concerns about missed visits and the difficulty in contacting the service. The registered manager said there was not an issue with missed visits, but this was a theme in each person's feedback to us. We saw messages sent to the office by one relative in July, September and October 2022 not being answered in a timely way asking where the carer was for their husband. This person should have had a morning visit for support with washing and dressing, but their December schedule had visits booked between 10.30 and 14.00.

Robust risk assessments were not in place in relation to people's health conditions and security to ensure they received safe care at all times.

Medicines were not being managed safely as people did not always have Medicines Administration Record when staff were supporting with medicines. People's records did not always have a list of the medicines they were taking.

Pre-admission assessments and care plans did not involve people to ensure people's preferences with support and care were captured. The service did not carry out their own assessments prior to accepting care packages but waited for local authority assessments.

Care plans lacked evidence that people were being involved in decisions about their care. Staff said they did not always know what people needed when they visited them, and people did not see regular staff. One person had 12 different staff in a 7-day period.

Robust quality assurance systems were not in place to identify shortfalls and take prompt action to ensure

people received safe and effective care at all times. The core issue of a lack of staff to cover the care package hours, poor scheduling and people not receiving allocated times they preferred had not been addressed.

Staff did not feel supported in their roles and told us they were unable to deliver the support people required.

People had choices during mealtimes, but people spoke of missed visits meaning they had no meal.

People were supported to access healthcare services, but short-term conditions such as pressure sores or chest infections were not monitored within records to ensure timely referrals or monitoring.

People were not always given the time commissioned to be encouraged to be independent and to carry out tasks without support.

Pre-employment checks had been carried out to ensure staff were suitable to support people.

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

Rating at last inspection
The last rating for this service was Good, published 14 September 2021.

Why we inspected
We had received concerns from staff, ex staff and relatives and a whole service safeguarding process was in place. Therefore, we wanted to visit people to see what their experience of the service was.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, training, person centred care and good governance. Please see the action we have told the provider to take at the end of this report. 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the 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 six 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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

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Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by three inspectors and two Experts 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 is a domiciliary care agency. It provides personal care to people living in their own homes.

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 announced the inspection and gave the provider 72 hours' notice prior to visiting people in their own homes so we could gain their consent. We did not give notice prior to the office visit due to our concerns

about the management of the service.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we already held about the service and provider. This included information from the ongoing whole service safeguarding process with the local authority and external health professionals.

During the inspection
We spoke with 9 people that used the service, 15 relatives, the registered manager, the provider, the deputy manager and 2 care staff in person. We also were contacted by 4 current care staff and 3 ex-care staff. We sent staff questionnaires to 10 further staff but only received one response.

We reviewed documents and records that related to people's care and the management of the service. We reviewed 16 care plans and 3 staff files, which included pre-employment checks. We looked at other documents such as training, medicine and quality monitoring records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection, this key question was rated as Good. At this inspection, this key question has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● There were not enough staff to deliver commissioned care packages in a timely and organised way to meet people's needs and preferences. There were 22 staff on the training matrix with 2 of those on maternity or long-term sick. The provider had failed to ensure robust systems were in place to ensure staff attended calls on time.

● There were no effective systems in place to monitor time keeping ensuring staff attended calls on time. This placed people at risk of harm. The service used an online call monitoring system to monitor staff timekeeping and attendance. Staff logged in and out of visits electronically. This showed when they had attended and left their visit after carrying out personal care.

● Records showed the planned time that staff were supposed to attend call visits. Staff monitoring data continued to show on a daily basis many calls had not been attended on time or were short.

● The system to organise staff schedules each day was not working effectively. Staff schedules showed staff were given a list of people to visit, often with more than 1 person scheduled for the same time. One daily note said, 'walk not done today as overlapping visits'. There was no travel time allocated and staff were expected to visit people across Exmouth and Budleigh. Staff said their route had not been thought about and staff told us they changed the schedule to suit people where they could. This meant schedules were not person-centred or at the time they were commissioned and resulted in people not knowing when staff were coming. Often people were visited too late or past 12 midday for assistance to get up and get dressed. This had resulted in one person not having assistance to wash for some time and developing a pressure sore.

● Staff all said they did not have time to stay the correct amount of commissioned time as they had lots of people to visit. One staff member told us they had 19 people to visit one evening in January 2023 which they felt was not do-able. They said, "Even staff who want to do a good job can't." Daily records showed many visits recorded as 'no-one in'. For example, one person required an 11.00am visit but 11 of 27 visits recorded no-one home with visits attempted at 12-12.30 or later. One staff member said they had found a person with black unwashed feet as staff had not been completing their wash due to time constraints. Another staff member sent us their schedule for a weekend day where they had 29 visits which is over 14 hours of deliverable care. Only 9 hours of care were given.

● People and relatives told us carers did not arrive on time, stay the correct amount of time or complete the tasks they required. Comments included, "The staff say they are short staffed and have to rush so I let them go", "I asked a carer to stay for a chat but they couldn't and said, complain if you like" and "How can they do a full wash for mum in 15 minutes, it's all a rush." The local authority did not commission visits less than 30 minutes, which meant people were commissioned enough time to meet peoples' needs.

● Daily notes consistently showed short visits across each person and widely varying timings. One person said, "I like an early visit and when they come at gone 11am I've already tried to get dressed", "I open the door at 7am and wait. Sometimes it's more like 12 when they come" and "It's so embarrassing if I have a

visitor and I'm still in my night clothes late morning." People and relatives all said they were not informed when staff were coming. This was because the schedules did not allocate preferred given times and staff visited people based on four-hour approximate slots.
● Relatives also told us carers did not stay the required times. This was clearly confirmed by the electronic monitoring system. One person was supposed to have a task of being supported to mobilise and walk with support. Only 2 named staff had recorded they had supported the person to mobilise to improve their mobility for 15 out of 42 visits in December 2022. including assistance with mobility in order to maintain the person's independence. All the other visits had ticked that the task had been completed on the online record system, but the two staff told us they were the only staff who completed and recorded this task. One person's care plan stated, "[Person's name is to have] visits every morning for 30 minutes to assist with a full body wash, change vest, pants and assist back to bed. [Person's name] is at high risk of falls due to mobility [and a lung condition] so it's imperative they are not rushed and benefit from a full 30 minutes of care". This person during December 2022 received an average of 15 minutes daily for a full body wash, creams and chat with most visits around midday.
● People and relatives, we spoke with also commented on numerous missed visits where no staff turned up at all and they were not informed. Daily notes showed 5 missed visits for one person in December 2022. One relative said, "There were lots of times no carer came at all and [person's name] had no breakfast or lunch. A couple of times [person's name] had been incontinent".
● Missed visits had not been addressed by the service. One staff member said, "On my days off, I knew with certainty that people would not be looked after and the clothes I left them with a few days earlier, they would still be wearing on my return. Food left in the fridge for days, food delivered from outside agencies still left in the hall, so nobody had been in lunch time nor tea-time."
● The registered manager said there was not an issue with missed visits, but this was a theme in each person's feedback to us. We saw messages sent to the office by one concerned relative in July, September and October 2022 asking where the carer was for their husband. This person should have had a morning visit for support with washing and dressing, but their December 2022 schedule had visits booked between 10.30 and 14.00. The service was unable to provide support regularly in the mornings.

The above concerns meant that effective systems were not in place to ensure people received safe, good quality care in a timely manner. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Records showed that relevant pre-employment checks, such as criminal record checks, references and proof of identity had been carried out. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This ensured staff were suitable to provide safe care to people.

Assessing risk, safety monitoring and management
● Risks were not always managed safely because risk assessments had not been completed in full for some people to ensure they received safe care at all times.
● Risk assessments had not been completed in relation to people's health conditions. For example, some people had specific medical conditions that may place them at risk such as a history of anxiety and depression, diabetes, known medicine non-compliance with health consequences, skin pressure damage risk, security measures and self-neglect.
● Four people we looked at and spoke to had daily notes referencing sores. There were no risk assessments or care plans so the sores could not be monitored other than reading the daily notes. One person was assessed as at risk of skin deterioration and this information was repeated in their 'About Me' care plan, but

there was no mention of their skin integrity status in their daily notes.
● We heard from 1 staff member and an ex staff member that key-pad safes had been found open with the key and code exposed and we visited another person where this was the case during the inspection. An ex staff member said this had been happening regularly in 2021. Risk assessments had not been completed in these areas to ensure staff were aware on how to support people safely.

Risk was not always assessed or managed to ensure support and care was always delivered in a safe way. This put 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.

Using medicines safely
● Medicines were not managed safely.
● Medicine Administration Records (MARs) were not in place in 8 of the 18 medicine files we looked at despite daily notes showing staff were either prompting or administering medicines. One person had no MARs, but staff were administering a controlled drug, which is subject to strict legal controls. The care plan stated the person was independent with this, but the local authority assessment in the 'About Me' section said they were not. One person had a specific medical condition and they told us they were unable to safely administer their own liquid medicine. Another person's MAR showed medicines not given in the morning and signed for as given in the evening, but the care notes said the person had had them in the morning. This meant people were at risk of not receiving their correct prescribed medicines.
● People who required topical medicines either did not have a MARs or there was no information about where that topical preparation was to be used. One person told us they needed a pain relief gel on their back but had no MARs. They told us care staff did not always put this on leaving them with pain. Another person had a MAR, but it stated for cream to go on their legs whilst the daily notes had a task for back cream. Therefore, information was not clear for staff to follow exposing the person to the risk of not receiving their required topical medicines.
● Where staff were administering or prompting medicines from blister packs there were no MARs, which are required. Therefore, there was no supporting evidence people received the right medicines at the right time in accordance with the prescriber's instructions.

Medicines were not being managed safely to ensure people received their medicines in a safe way. This put people at the 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.

Learning lessons when things go wrong
● Lessons had not been learnt to prevent the occurrence of pressure sores for example. One person had not been assisted with continence for 24 hours despite 4 visits a day which had resulted in pressure sores. Daily notes also showed the person had only 11 visits out of 70 over 30 minutes despite the visit time scheduled for 45 minutes. Many daily notes showed short visits and all the people and relatives we spoke to commented on 'flying visits' or no visit or call and that staff did not stay the correct amount of time, but this had not been addressed.

Systems and processes to safeguard people from the risk of abuse
● Records showed that staff had been trained in safeguarding and understood how to safeguard people from harm. A safeguarding and whistleblowing policy was in place. Whistleblowing is a person who informs a person or relevant authorities regarding abuse or unlawful activity. However, all staff said they were not comfortable raising concerns especially about management or office staff because they said a counter grievance would be raised against them and nothing done about the concerning issue.

- People, staff and relatives told us they did not feel safe as they did not know when or who would be delivering their care. Some staff worried about people's care when they were not working and gave examples where care was not completed such as one person's daily walk to maintain their independence or unwashed feet. All staff commented they were not certain all visits were being done.
- The service safeguarding records showed that there were safeguarding referrals made in relation to poor hospital discharge or escalating support when people's needs increased.

Preventing and controlling infection
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through good hygiene practices.
- We were assured that the provider's infection prevention and control policy was up to date.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Robust systems were not in place to assess people's needs and choices.
● Pre-assessments had been carried out remotely without visiting and involving the person requiring care, and the deputy manager said they used local council assessments which were copied into the 'About Me' sections on the electronic system. This did not ensure the service had the capacity to provide person-centred support to people, that met their needs. Commissioners told us, "When providers consider packages of care, they are asked to submit an offer of a visit time between those times but still specify an approximate time with the normal half an hour leeway either side." Packages of care had not been discussed with people to agree a time and ensure the service had capacity. Information taken from local authority documentation raised health issues such as risk of pressure damage and concerns about medicines and mental health but there were no corresponding care plans to inform staff.
● People, relatives and staff told us they had not received a pre-assessment in person so they could discuss their needs and formulate a care plan. People said they had never seen a care plan. People said their first visit was from a care worker who did not know what their needs were. Staff told us they often visited people with very little information about what tasks were to be completed. For example, we fed back during the whole service safeguarding meeting in December 2022 that one person did not have a MAR for their topical pain relief cream. One relative said, "I have to tell staff what to do". This person's loved one was living with a number of pre-existing conditions but there was no information about how staff were to deliver care.

The above concerns meant that robust pre-assessments systems were not in place to ensure people received safe, person-centred care at all times. This was a breach of Regulation 9 (Person centred care) 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their

liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● MCA assessments had been completed to determine if people had capacity to make certain decisions. However, people said they had not seen care plans and the pre-assessments were completed without involvement of the person. Where people were assessed as not having capacity, best interest decisions were not made on their behalf, for example when people at high risk of pressure damage declined care or how to manage self-neglect. One person's visits were very short despite a 45-minute commissioned visit and did not leave time to discuss and explain to the person who lived with a learning disability why they needed to change position for example due to being assessed as high risk of pressure damage. The provider said the service user was able to mobilise slightly by moving their body in her chair and would change position when they chose. However, this was still not monitored. Some staff had received training on the MCA but 6 staff of 22 had no record of recent training. We received information from the provider following the inspection that the training matrix was not updated when sent to us. However, we were unable to confirm with staff that training was done at that time.

● People and relatives told us tasks on the system had not been discussed with them to ensure that was the support they wanted.

Staff support: induction, training, skills and experience

● Staff had been trained to perform their roles in some areas. Staff said this training was in a workbook format online with questions they had to Google which were then marked by the management. We found concerns with the management of pressure area care but there were no records of staff receiving any training in this topic. Staff said they were given training workbooks to complete in their own time at home unpaid. Staff said they did not feel that the training was effective and there was no opportunity to discuss what they were expected to learn or how they preferred to learn it.

● Not all staff were up to date with training. For example, 9 of 22 staff had not received up to date medicines training but continued to administer medicines, often with no Medicine Administration Records to refer to. This included the provider, registered manager and one staff member who had not had training since 2016. This placed people at significant risk of unsafe care.

● Of the 22 staff, 13 had not had training in dementia care, 15 had not had food and nutrition training, 9 staff had not had training in mental health care and 12 had not had first aid training. One person's care plan stated, 'carers need an understanding of mental health and how to appropriately manage personal support alongside reassurance'. They had no mental health care plan or information about how to manage the person's ongoing health consequences from their behaviours. This exposed people to the risk of unsafe or inappropriate care. Of the 22 staff, 7 had not received mental health training.

● We were sent an updated training matrix on 14 January 2023. The registered manager said manual handling training was done annually or if there was a new piece of equipment. The matrix showed most staff had completed manual handling training. However, we spoke to 3 current staff, who had been recorded as having completed training in 2022. , and 1 ex staff member. Two staff said, "We haven't had practical manual handling training since around 2020 and then it was at a client's house for 45 minutes about hoisting. Never had training in a stand aid. We sometimes get sheets of questions to answer, no moving people, bed to chair, use of frames." The ex-staff member said, "We've had no practical since early 2021, then it was at a client's house with most staff watching over video." Another staff member said, "We don't get training on how to work catheters etc. We get sent online videos, but no-one knows if we've watched them." The provider told us after the inspection mandatory training was up to date, the matrix was completed incorrectly and not updated before being sent. However, we were unable to confirm this with staff at that

time.
● Staff did not feel supported in their roles. Records showed most staff were up to date with appraisals and supervision with management and there was evidence of competency checks. It was unclear why fundamental concerns such as staff workload, training, timings and lengths of visits and quality of care had not been addressed.
● People and relatives said they did not think staff always knew what to do as they were so rushed. One person said, "They're the worst carers I've had in my life. If it wasn't for the shopping, I wouldn't have them [for personal care also]" and another person said, "The carers always just ask me what I want. I haven't seen a care plan. They often forget my pain gel. I forgot to ask today. It's mostly someone different."

There was a lack of comprehensive training to ensure that staff knew what to do. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● People were supported to eat and drink to maintain a balanced diet. However, people, relatives and staff told us about missed visits including to one person with insulin dependent diabetes who did not receive a tea-time visit in 2021 and a similar situation for another person in in 2022. They told us that community nurses had been concerned about the person's low blood sugars. Relatives and staff commented, "Sometimes food is not touched because staff haven't stayed very long. I told staff to sit with [person's name] and then they would eat but they don't have time", "Lots of times I would get home, and no-one had been to do lunch".
● Care plans did not include the level of support people required with meals or drinks or their likes and dislikes.

Supporting people to live healthier lives, access healthcare services and support
● Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health.
● Records showed the service worked with professionals such as GPs when a health issue was identified. However, the short length of most visits, lack of care plan details and people's preferences for staff and remote assessments did not ensure that staff knew people well or that people received the care they required.

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 Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Leaders and the culture they created did not assure the delivery of good quality care. Staff schedules were organised for people to have visits between 7am-11am, 11am-3pm, 3pm-6pm and 6pm-9pm. People were not regularly sent rotas and when sent they were not effective as there were gaps or those named staff did not carry out the visit. This meant people and relatives did not know when or which staff were visiting them.
- Robust quality assurance systems were not in place to ensure shortfalls were identified and prompt action taken to ensure people received safe and effective care at all times. Audits did not identify shortfalls we found stemming from the unorganised staff schedules, lack of in-person assessments prior to care commencing. Daily records consistently showed short visit times, random timings through the week and that tasks on the care plan were not carried out. There was a culture of carrying out visits where and when staff could and staying as little time as possible due to the workload. Daily records did not always reflect that tasks had been completed adequately with staff repeatedly recording 'lovely chat' when the visit had been under 10 minutes for a 45-minute scheduled visit. There was no audit of daily records or visit times to analyse why so many visits were shorter than the commissioned times.
- People and relatives all commented staff talked about being in a hurry and being short staffed. Therefore, they told staff they could leave before their visit was completed. One relative said, "They're [staff] always saying they are short staffed or have sickness or got lots to do. I'm happy [person's name] lives with me so I can keep an eye on her." Another relative commented, "[Person's name isn't able to get up until 11am and sometimes only stay 6 minutes. Staff come and put [person's name] to bed at 3pm.
- The provider said they had commenced a contingency business plan with the visits being scheduled within 7-11am, 11-3pm, 3-6pm and 6-9pm during the pandemic due to being short staffed. This had continued and during this inspection had not returned to being focussed on meeting peoples' needs. This meant that people were not receiving their commissioned care at the right times or in a timely way for the length of time commissioned. Despite knowing about being short staffed, the service had taken on 11 new care packages since August 2022 and the staffing levels had not improved.
- Staff said the 'runs' were not do-able with too many people, no travel time and not the times that people liked. For example, one staff member said a person scheduled or 8pm but they knew they liked 6pm, another person was down for 8pm for tea which was too late to eat so they went earlier. Staff spoken to felt unsupported by the office, had no time to deliver care or read about people, didn't see other staff and often met a second carer for the first time at a person's house.

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

characteristics; Continuous learning and improving care

● Staff meetings were not held regularly to share information, allow for discussion about any issues and keep staff updated.

● People's beliefs and backgrounds were not always recorded, and staff were not aware of how to support people considering their equality characteristics.

● The service did not obtain regular feedback from staff and people about the service. Recent surveys with people showed people were 'very satisfied' which did not reflect our findings. Staff, people and relatives all told us they had difficulties contacting the office and messages were not responded to in a timely way. People, relatives and staff were consistently not positive about the service. Comments included, "We never know who is coming or when every day", "We don't get regular carers and I have to tell staff what to do" and "I feel really let down, sometimes the office ring to say can I help with double care because there aren't enough staff." Staff said often people were called to say would you be ok at an earlier time because there weren't enough staff, if the person said no, the visit was cancelled by the service.

● We heard multiple examples of where people had tried to contact the office or on- call relating to a missed visit. One ex staff member told us that when they had raised a missed visit, despite the person receiving care being insulin diabetic, they had been told the visit had happened but this could not have been correct as another family member was home. One staff member said if they raised a concern, they were blocked from the online system which meant they missed three visits. One relative said, "I constantly complain about late visits." There were no records of all these calls and no on-call monitoring system to show that calls had been answered and actioned.

● Another 2 ex-staff members told us how a counter grievance had been raised against them when they had raised concerns about missed visits and the concern had not been addressed.

● Staff who spoke to us did not feel confident in raising concerns. Two people had been served a warning letter for their behaviour to staff. They both told us they had been angry because they did not know when staff were coming, and they did not feel their complaint had been listened to.

Working in partnership with others:

● The service worked with health professionals. For example, raising issues where people's needs had become difficult to manage in their homes or about miscommunication on discharge from hospital. However, contact with health professionals was reactive and the provider's quality assurance system did not ensure people received their care and support in a timely way, in the way people wanted support or for the time commissioned. For example, pressure care was poor and not preventative, people with diabetes and mental health needs were not monitored through care planning.

● A health professional manager told us and sent us an email from a social worker which evidenced, "Instructions were given about supporting a service user with their documents, but this was not recorded on the service user's tasks or About Me care plan. The action was not happening, and documents had been removed from the service user's home without a clear audit trail or evidence of consent."

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 was aware that it was their legal responsibility to notify the Care Quality Commission of any allegations of abuse, serious injuries or any serious events that may stop the running of the service and be open and transparent to people should something go wrong. However, they had not contacted CQC or the local authority to say that they continued to follow a contingency plan or that there were issues with being short staffed meaning that timely visits could not be fulfilled as commissioned.

This meant the service had failed to ensure that adequate quality assurance systems were in place to identify shortfalls and ensure people received safe care. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.