Global Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Global Care Ltd is registered to provide personal care and support to people 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 provided care and support to one person.

People's experience of using this service and what we found
People were not always treated in a caring and compassionate way. This was because they were not always treated with dignity and respect and their independence was not always promoted. A relative described care staff as, "Caring but not consistent."

People were not protected from abuse because management were not aware of their individual responsibilities to prevent, identify and report abuse. Arrangements in place to assess and manage risks were not robust enough to keep people safe from harm. Work practices relating to recruitment of staff and administration of medicines did not ensure people's safety. People were not kept safe from the risk of infection as the provider failed to follow their policy and government guidance in relation to COVID-19. Staff did not understand their responsibilities to report safety incidents internally and the provider's internal audit processes was not able to identify when things went wrong.

Peoples' care and support needs were not regularly reviewed to ensure they were met and care plans were still relevant. People received care from staff who were not appropriately trained and supported to fulfil the requirements of their role. The provider did not make sure they obtained consent lawfully and the staff member who obtained consent had the necessary knowledge and understanding of the care and support they were asking consent for. People were not effectively supported at mealtimes, we have made a recommendation about this. The provider did not always work effectively with other agencies to ensure people were effectively cared for and supported. We have made a recommendation about this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; as the policies and systems in the service did not support this practice. We found the service failed to act in accordance with the Mental Capacity Act 2005.

People's care was not always personalised and responsive. We have made a recommendation about this. The provider did not have effective systems to make sure all complaints were investigated without delay.

Managers and staff were not clear about their roles, and understanding quality performance, risks and regulatory requirements. The provider did not ensure quality assurance systems and processes used to assess and monitor the service were effective. The provider failed to notify us of an incident as they are

legally required to do and did not promote a culture that encouraged candour and openness. We have made a recommendation about the Duty of Candour. The provider did not use feedback received to improve the quality and delivery of care. The provider did not have a systematic approach to working with other organisations to improve care outcomes.

We found multiple breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rating at last inspection and update
This service was registered with us on 2 July 2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the delivery care in relation to manual handling, administration of medicines and nutrition. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all the sections of this full report.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified multiple breaches in relation to person-centred care, safe care and treatment, dignity and respect, how consent was obtained, safeguarding service users from abuse and improper treatment, notifying the Commission of change and incidents, receiving and acting on complaints, good governance, staffing and fit and proper persons employed.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Global Care Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service is required to have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection the service did not have a registered manager in post.

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

Inspection activity started on 3 November and ended on 11 November. We visited the office location on 3 November 2021.

What we did before the inspection
The provider completed a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and information we held about the service and what people had told us. We sought feedback from the local authority and a health and social care professional.

During the inspection
We spoke with a relative, two care workers, the manager and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed one care plan and daily records for May, July, August and October 2021, medicine administration records for the month of October 2021, two staff recruitment files and the service's staff training matrix. We looked at a variety of records relating to the management of the service, this included the service's policies and procedures. We received feedback from a health and social care professional.

After the inspection
We continued to seek clarification from the provider to validate evidence found. All information received was used as part of our inspection.

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 for this newly registered service. This is the first inspection for 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

- Management were not aware of their individual responsibilities to prevent, identify and report abuse. A safeguarding policy was in place to instruct staff on procedures they should follow if they suspected abuse or they received allegations of abuse. However, the provider failed to follow this.
- For example, records showed the manager had received information of concern that alleged due to staff work practices, a person was placed at risk of choking. The manager told us, and records confirmed they had spoken with staff about the concern, but they did not understand this concern met the criteria of an allegation of abuse and therefore, did not report it to the local authority. Records showed the concern was brought to the manager on two further occasions, but no appropriate action was taken by the manager to address it and therefore the person was placed at increased risk of harm.
- Care staff did not always attend at the agreed times or remain the duration of scheduled calls. A health and social care professional told us they had arranged essential manual handling training for staff at 2.45pm on 10 October 2021, at the person's home. However, when they arrived at 2.50pm, they found care staff had already attended the call earlier at 2.20pm and left at 2.45pm. Care staff had told the health and social care professional, the regular call time visit was 2.45pm to 3.15pm.
- A view of daily care records showed this was not an isolated incident as short visit calls were recorded on 20 May 2021,1 August 2021, 3 August 2021, 19 August 2021 and 25 August 2021, for example. This meant people could not be confident they would always be safe from harm as staff did not always follow the agreed times for delivery of care.
- Minutes of staff meetings showed the manager had spoken to staff about leaving calls early but had taken no action when this practice continued.

We found the person was not harmed but arrangements in place were not enough to keep the person safe from negligent care and support. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- A relative expressed concern about staff using unsafe moving and handling practices and commented, "I do struggle to see if they (staff) are trained, this has been observed when I am present. I have always been open and honest about this with the manager who said he will talk with staff."
- The provider did not do all that was reasonably practicable to identify and mitigate risks to the person's health and welfare. This was because they did not complete risk assessments and management plans in order to move the person safely, reduce their risk of falling, choking and ensure staff could identify when to get urgent medical attention due to the side effect of a prescribed medicine.

● A health and social care professional told us whilst conducting an assessment with the relative's family member, they had observed staff carrying out unsafe manual handling practices. For instance, they were not lifting the person by the under arm correctly.
● A manual handling care plan was in place which showed the person had poor mobility and required two staff to support them when mobilising. There was no information or guidance for staff on how to the move the person safely and how to prevent the person from falling. Care records also stated the person was prescribed a medicine to prevent blood clots. However, staff were not provided with information about what dangerous symptoms could result from taking this medicine and what action they should take when this happened. Management and staff told us they were not aware of what the medicine was, and possible risks associated with it.
● We received information of concern about care staff leaving food on the person's bed, so they were laying on it. A view of the person's care plan stated the person tended to choke and would need to be supervised during mealtimes. No information relating to the level of risk, how staff should support the person to avoid choking and what do in the event of a choking episode was documented.
● Staff told us the procedure they would follow when reporting any accident/incidents but stated they had not had to report any. However, a view of a daily care record entry dated 20 July 2021 stated a person had slipped and fallen and the emergency service was contacted. The manager told us they were not aware of this incident.

We found the person was not harmed but the provider had failed to assess risk and do all which was practicable to mitigate those risks. 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
● People were not supported by staff who had been recruited safely. This was because the provider did not carry out all required checks stated in the relevant Regulation. For example, Job applications were not always fully completed and there were no explanations for gaps in employment history.
● The provider accepted references without company details provided and had not verified the references obtained were authentic, for two staff members who had been recruited two years ago.
● We were informed by staff and a relative, two agency staff members also provided regular care to a person. This ensured there was enough staff to look after the person. The manager did not make us aware of this. When we requested to look at the agency staff members' profiles, they did not comply. This information was not received during or after our visit. Eventually upon further request and follow-up, the manager told us they did not have the requested information. This meant the person was placed at potential risk of harm because the provider did not ensure agency staff members, had the necessary knowledge, skills, qualifications, training and had completed all relevant recruitment checks.

We found no evidence people were harmed. However, the provider's recruitment systems were not robust and therefore did not protect people from risk receiving unsafe care. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our visit the manager had obtained references from the two staff members previous employer and we saw proof they had been verified.

Using medicines safely
● The provider's management of medicines did not ensure safety, quality and consistency of care. This was because the provider did not follow their own medicines policy, national guidance and best practice.

● For example, the provider's medicine policy, which was last reviewed on 20 October 2021, stated only staff who had received medicine training at Global Care Ltd and had been assessed as competent, could administer medicine. The manager told us staff's competency to administer medicine was checked during unannounced spot checks. However, spot check records only documented if medicines prescribed to people were up to date and did not address staff competency.
● Before our visit we were made aware of safeguarding concerns relating to how medicines were administered to a person. Although the manager was aware of these concerns, they had not taken action to re-assess the competency of care staff to ensure medicines were administered safely to the person.
● We viewed medicine administration records (MAR) completed for the month of October 2021. Care staff did not follow the provider's medicine policy and had written notes of additional medicines administered on the MAR. This did not include the full names of the prescribed medicines, the dosage, route and frequency. For example, one medicine was called "Eye drop" and another one referred to as "Antibiotic". It was not clear if these medicines were prescribed for 'as and when required' and no additional guidance was available for staff on when and how to administer 'as and when required' medicines.

We found no evidence people had been harmed. However, the provider had failed to ensure safe work practices relating to the administration of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not always kept safe from infection. The provider had a Covid Testing and Policy and Procedure policy that was last reviewed on 29 September 2021. In line with Government guidance, the policy stated staff should undertake weekly COVID-19 tests. We requested to see records of tests undertaken however, the manager stated they had not been monitoring this consistently and had no records of any test results for staff. Care staff confirmed they had not undertaken weekly tests.
● We found no evidence to show people had been harmed however, the provider's failure to follow their policy and government guidance, meant there was a potential for people to become infected with Covid-19.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● A relative said staff consistently wore personal protective equipment (PPE), such as masks, aprons and gloves. This was supported by a staff member who commented, "The manager brings PPE every month. We have to wear gloves, masks and aprons and change our gloves in between tasks."

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Assessments of peoples' care and support needs should be reviewed regularly and whenever needed throughout their care and support. We found this did not happen. Care records showed the last documented review of a person's care and support needs was held on 23 July 2021, two years after their initial assessment. The person's relative had informed us of a change in the person's health that happened after the latest review meeting and, how staff's care practice in response to this change had negatively impacted the person.
- Although the manager had responded appropriately by making a referral to the relevant health and social care professional in order to address this issue, they had not made any changes to staff members' care practices. This meant people's care and support needs were not regularly reviewed to ensure they were met and still relevant.
- The person's care plan did not fully identify if they had any needs which related to their protected characteristics as outlined in the Equality Act 2010. For example, race, preferred language, faith, religion, and cultural considerations.
- When speaking to a staff member about whether the person had any religious or cultural preferences they responded, "We don't interfere in this." This showed there was a potential for the person to be discriminated against and receive unfair treatment.

This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff were not appropriately trained, supervised and appraised. Staff told us and training records confirmed they had not received appropriate refresher training. For example, one staff member's last essential training was on 25 March 2019. They told us, "We have had no training since the lockdown." Although another staff member was up to date with their medicines training and theory in moving and handling, all other relevant refresher training had not been updated since 30 November 2019.
- Care staff did not attend planned moving and handling training because the registered manager forgot to notify staff. We have reported upon the impact on the person under the 'safe' domain.
- Records showed supervisions were conducted in the form of monthly staff meetings and unannounced spot checks. We looked at minutes of staff meetings held on 22 April 2021, 20 May 2021 and 22 July 2021. These showed the manager failed to take appropriate action where issues of concern had been raised on three separate occasions relating to two staff member's care practices.

● Both staff members had been working for the provider for two years, but the manager confirmed they had not received annual appraisals. This demonstrated staff's training, learning and development needs were not identified, planned for and supported.

This meant people received care from staff who were not supported to fulfil the requirements of their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA.

● The nominated individual and manager did not understand relevant consent and decision-making requirements of MCA legislation and guidance. There was no documentary evidence to show whether people or those who represented them had given consent to various aspects of care. Such as, consent for care to be delivered, consent for medicines to be administered and consent for peoples' personal details to be shared with relevant agencies, for example.
● A person's care plan recorded who had legal powers to represent them and what those powers were but there was no documentary evidence to validate this. We noted the manager had tried to get this information a day before our visit. However, they had involved the relative in decision making and obtained their consent in relation to health and social care matters, which was not covered by those legal powers. This meant the provider obtained consent from people who did not have the legal powers to give it.
● The MCA makes provision where third parties do not have legal powers to make decisions on people's behalf. The MCA's Code of Practice clearly states the person's best interest must always be paramount when third parties are involved in the decision-making process, and how those decisions should be recorded. We found the service did not routinely record or hold best interest decision meetings or discussions on behalf of people who were unable to consent to care and support.
● The provider had carried out a mental capacity assessment to assess the person's ability to make decisions. We found this was not completed in accordance with the MCA as it did not, show consent had been obtained, identify what specific decision was being considered and had concluded the person did not have capacity and this was 'permanent'. This meant the provider did not make sure staff who obtained consent from people were familiar with the principles and codes of conduct associated with the MCA and, were able to apply those when appropriate.
● Care staff stated they had received the relevant training but were unable to demonstrate a satisfactory understanding of the MCA.
● The manager and the nominated individual lacked a good understanding of the MCA and confirmed they had not undertaken relevant role specific training. Therefore, they would not have been able to identify if they were not acting in accordance with the MCA and its Code of Practice.

The provider did not make sure they obtained consent lawfully and the staff member who obtained consent had the necessary knowledge and understanding of the care and support they are asking consent for.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not appropriately supported at mealtimes. Daily records showed they received adequate support with hydration however, staff did not always follow the person's care plan and supervise them at mealtimes.
- For example, the person's care plan stated they needed to be supervised during mealtimes due to potential harm however, staff would not always do this and would leave food on the person's side table or on their bed, in the event they wanted more food to eat. This meant the person's nutritional needs were not effectively met.

We recommend the provider seek current guidance and best practice in relation to staff supporting people at mealtimes.

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

- The provider did make appropriate referrals to relevant health and social care professionals, but they did not always work effectively with them to ensure people were effectively cared for and supported. For example, the manager did not take prompt action to reschedule staff's essential practical manual handling training with a health and social care professional.

We recommend the provider seek best practice and current guidance on how to work effectively with other agencies.

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
● A relative told us staff showed they cared and knew their family member well. This was confirmed from our discussions with staff. However, the relative went on to say the care provided was "Not always consistent."
● The relative explained surveillance cameras were situated in their family member's home and told us due to this, "They (staff) don't talk to her often but this changes when family are visiting. The relative felt care delivered was at times task focused with little engagement. As a result, they could see their family member was visibly disturbed when this happened.
● Training records showed staff had undertaken training on equality, diversity and human rights(EDHR) but this was over two years ago and had not been refreshed. Daily care records viewed showed, most of the times staff only recorded care tasks that had been delivered.

People were not always treated in a caring and compassionate way. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they would ensure the person's privacy was protected when carrying out intimate care. The person's relative supported this and commented, "They (staff) do preserve her dignity when carrying out personal care."

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
● People were not always treated with dignity and respect and their independence was not always promoted.
● Staff told us they involved people in care decisions by giving them choice. For example, what clothes they would like to wear. However, a relative told us they made sure a wide variety of food was available and commented, "I do ensure there is choice for three different types of breakfast, but the carers always give her the same."
● The relative told us they found staff to be disrespectful at times and commented, "There has been occasions where they (staff) speak to each other in their own language which is not respectful". The relative told us when this happened their family member would become, "Very frustrated."
● The relative said despite their family member's health challenges, they were still able to eat independently but needed to be supervised at mealtimes. However, staff would directly feed the person. We noted the person's care plan stated, the person, 'Wanted to be as independent as possible'. This meant people were not always supported to maintain their autonomy and independence in line with their needs and stated

preferences.

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

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 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's care was not always personalised and responsive. Examples included, staff not promoting a person's independence in accordance to their wishes and not attending calls at the agreed scheduled call times.

We recommend the provider seek current guidance and best practice on how to deliver person-centred care.

● Care records did contain a brief summary of a person's life story, people important to them, interests, likes and preferences. Staff demonstrated they had a good understanding of the person's life story and had developed good working relationships with members of their family.
● The provider sought people's preferences and wishes relating to end of life care.

Improving care quality in response to complaints or concerns
● The provider did not have effective systems to make sure all complaints were investigated without delay. A complaints policy and procedure was in place but, the manager was not knowledgeable about its process.
● For example, records showed a relative had repeatedly raised a concern on 16 August 2021, 16 October 2021 and 2 November 2021. The complaints register did not show the relative had been kept up to date, informed of the status of the complaint and its investigation.
● There were no records to show investigations had been carried out to identify what might have caused the complaint and action taken to prevent similar complaints.
● We found appropriate actions were not taken without delay to respond to any failures identified by complaints.

This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider worked in accordance with the AIS and documented people's communication needs, this included speech, hearing, sight difficulties and how they should be supported. For example, due to medical condition a person's speech had become impaired. Staff were instructed to be patient and give the person time to communicate.

End of life care and support

● The provider sought people's preferences and wishes relating to end of life care.

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.

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

- It is a legal requirement for providers to inform us in writing of specific changes in the running of the service. This includes if a person other than the registered person carries out the regulated activity.
- The provider failed to inform us, in a timely manner about the management arrangements put place after the registered manager had left in May 2021.
- At the time of our visit we found the provider did not notify us the regulated activity of personal care was no longer being carried out at the specified location address, which is a condition of their registration. This meant CQC could not be assured the provider would take appropriate action when changes within the service happened.

This was a beach of Regulation 15 (Notice of change) of The Care Quality Commission (Registration) Regulations 2009.

- The provider did not ensure quality assurance systems and processes used to assess and monitor the service were effective. For example, the manager told us they had not undertaken any audits of the service. Our review of, the assessment and management of risks to people's safety and welfare; safeguarding concerns; accidents and incidents; staff recruitment; infection control; medicine administration; staff training; mental capacity assessments; various aspect of delivery of care; handling of complaints and reporting of incidents confirmed this. This meant the provider was not able to identify where quality and safety had been compromised and improvements were needed.
- The provider did not have effective systems and processes in place to enable them to identify risks to people's health, safety and welfare.
- The provider's call monitoring system was ineffective as the manager could not monitor in 'real-time' where staff were. Interim arrangements in place to address this were not effective as daily records showed staff, continued to end care calls before their scheduled times despite the manager's instructions not to do this. The manager took no action in response to this.
- Care records relating to care, and support were not always legible, kept up to date and contemporaneous. For example, daily care records viewed were of poor quality as we could not always read what care tasks had been performed and how staff engaged with a person. The manager addressed this in staff meetings, but no action was taken by them when this poor practice continued. The provider's staff training matrix failed to record dates training was completed, expired and needed to be refreshed.

This meant records were not always fit for purpose and the provider did not ensure they had an effective audit and governance system. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us and provided supporting evidence showing a new call monitoring system had been purchased and they were enrolled for training. However, as it was not in place at the time of our visit, we could not assess its effectiveness.

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people.
● A local authority informed us of an allegation of abuse which the provider had been made aware of in August 2021. However, the provider failed to notify us of the incident as they are legally required to do. This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour (DoC), which is their legal responsibility to be open and honest with people when something goes wrong
●The provider did not promote a culture that was person-centred, open, inclusive and empowering, which resulted in good outcomes for people. This was supported by our view of care records, discussions with a person's relative, staff and management.
● Minutes of staff meetings and unannounced spot checks, used as forms of supervision, did not show how the provider encouraged and promoted a person-centred, transparent and open culture for staff.
● The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Where notifiable incidents had happened, the provider did not have systems that ensured staff knew what to do when things went wrong with care and support. The nominated individual and manager lacked understanding of the DoC.

We recommend the provider review their understanding of the DoC and seek current guidance and best practice.

● Staff spoke positively about the manager and said they felt supported and listened to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● The provider did not use feedback received to improve the quality and delivery of care. Feedback had been sought and received from regular communication with a person's relative, when reviewing their family member's care and support needs and when complaints were raised.
●We found systems in place to capture and respond to complaints were not effective as they did not capture all complaints raised. However, feedback was not used to improve service delivery. The provider did not always respond appropriately to feedback received and failed to analyse and use feedback received to drive improvements. Therefore, the provider's quality and monitoring systems did not allow for continuous learning and improvement in care.
● The provider did access external partners when necessary, such as GPs and emergency services, However, we found further improvements were required to enhance collaborative work to ensure people's health and social care needs could be met. For example, the provider not taking prompt action to ensure staff had received relevant training from a health and social care professional to be able to support a person's

mobility needs. This meant the provider did not have a systematic approach to working with other organisations to improve care outcomes.

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

● The service did have a statement of purpose (SOP). This described what the service did; where they did it and who they did it for.
● It is a legal requirement for providers to notify the CQC when there are changes with information in the SOP. The provider failed to notify us internal changes to its managerial structure.
● The nominated individual acted promptly when we brought this to their attention and sent an updated SOP during visit.

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 15 Registration Regulations 2009 Notifications – notices of change The provider did not notify inform us of managerial changes and changes to its location address. CQC could be assured the provider would take appropriate action when changes with the service happened. Regulation 15 1 (a), (e).

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify us of the incident as they are legally required to do. Regulation 18 (1)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always provided with personalised and person-centred care. Regulation 9 (1), 3 (a).

Regulated activity	Regulation

Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and their independence was not always promoted. Regulation 10 (1), 2 (b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were supported in line with the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse because management were not aware of their individual responsibilities to prevent, identify and report abuse. Regulation (1), (2), (3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have effective systems to make sure all complaints were investigated without delay. Regulation 16 (1), (2).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider's recruitment systems were not robust and therefore did not protect people from risk of harm. Regulation 19 (1) (a) (b).

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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and processes used to assess and monitor the service were effective. Audits were not undertaken, call monitoring system was ineffective as the manager could not monitor in 'real-time' where staff were. Care records relating to care, and support were not always legible, kept up to date. Systems in place to capture and respond to complaints were not effective as they did not capture all complaints raised. Quality and monitoring systems did not allow for continuous learning and improvement in care. Improvements were required to enhance collaborative work to ensure people's health and social care needs could be met Regulation 17 (1) (2) (a), (c), (d), (f).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not appropriately trained, supervised and appraised. Regulation (2) (a).

The enforcement action we took:

Warning Notice