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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Global Care Limited is a domiciliary care agency registered to provide personal care and support to people in their own home and supported living services. The service was not specifically for people with a learning disability and/or autistic people, however at the time of our inspection the only person using the service had these needs. The service had not commenced providing personal care to people in supported living settings.

People's experience of using this service and what we found
Systems to protect people from abuse were not implemented. Staff were not trained on how to recognise and report abuse and staff recruitment checks were not carried out prior to supporting people.

Staff skills were not matched to people's needs and mandatory and specialist initial and refresher training was not arranged by the provider. Staff were not trained to administer emergency medicines which put the person at increased risk of harm. Systems were not in place to protect people from the risk of infection. For example, staff did not use personal protective equipment (PPE) effectively and safely.

Initial assessments to identify people's needs and risks were not completed prior to care commencing. Care plans were not in place to provide staff with guidance about how to support people according to their needs and preferences.

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; the policies and systems in the service did not support this practice.

Senior staff did not understand or demonstrate compliance with regulatory and legislative requirements. The management of people's records did not ensure they were protected and stored safely. The service did not complete audits or checks to monitor the quality and safety of care provided.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Right Support:
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; the policies and systems in the service

did not support this practice. Care plans were incomplete and did not contain enough information about how to support people.

Right Care:
People were not always supported with care that was person centred and promoted people's dignity, privacy and human rights. The service failed to ensure there were enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services led confident, inclusive and empowered lives. The service failed to evaluate the quality of support provided to people or ensure risks of a closed culture were minimised.

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 inadequate (published 8 March 2021). 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 the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the governance of the service including not meeting the conditions of registration. A decision was made for us to inspect and examine those risks. We also undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

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

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 breaches in relation to person-centred care, safe care and treatment, dignity and respect, consent to care, 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.

Please see the action we have told the provider to take at the end of this report.

We took urgent action to place restrictions on the provider's registration which involved stopping any new admissions to the service. We took action to cancel the provider's registration, so they are no longer registered to provide the regulated activity personal care.

Since the last inspection we recognised that the provider had failed to display their rating. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our well-led 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 Health and Social Care Act 2008.

Inspection team
Two inspectors carried out the inspection.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses. This service was also registered to provide care and support to people living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of the inspection the service was not providing this type of care.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection on the first occasion we announced the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection. However, the service did not respond and did not ensure staff were at the office premise. We gave the service seven days' notice the second time we announced our inspection to ensure staff would be available.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
One person was using the service at the time of our inspection and we spoke with their relative. We spoke with the only care assistant employed by the service, an external consultant and their assistant and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We asked for a list of operational staff and their contact details to speak with, however this was not provided by the nominated individual.

We reviewed available records at the office location. This included policies and procedures, staff files, risk assessments and a person's care plan. Not all the information we required was available during our site visit and we asked the nominated individual to provide this electronically after our inspection. However, the service did not submit this evidence.

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 inadequate. At this inspection the rating for this key question has remained 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

At our last inspection we found arrangements in place were not enough to keep people 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.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 13.

• Staff did not receive initial or refresher safeguarding training. This meant staff may not know how to identify or report safeguarding concerns to protect people from abuse.
• After our inspection visit the nominated individual told us they acted to ensure a staff member completed online safeguarding training. We spoke with the staff member who confirmed this and said they would report concerns to a manager. However, they could not tell us which external agency they would report to.
• The staff member told us they had not read and were not aware of the service's safeguarding policy or procedure. This showed the nominated individual had not taken enough action to ensure systems to protect people were followed.
• An external consultant had written a safeguarding policy and procedure, dated 1 September 2022, which the service did not implement. For example, the policy stated safeguards were in place to protect people such as, staff training and recruitment checks. However, we found both areas were routinely omitted. The safeguarding policy included a list of types of abuse, which was not in line with national legislation and meant signs of domestic abuse or modern-day slavery may not be recognised and escalated appropriately by staff.
• We reported our concerns about the lack of safeguarding procedures and the person at risk to the local safeguarding authority, who accepted the referral and commenced a safeguarding investigation.

We found no evidence people had been harmed. However, the lack of systems to protect people from abuse placed them at increased risk of abuse. 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

At our last inspection we found 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.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 12.

• The service failed to assess or monitor risk to the person receiving care, which put them at increased risk of harm. There were no documented risk assessments from the time care commenced for the person in November 2021. An external consultant told us a bank staff member had commenced an assessment 13 September 2022, however they told us the assessments were insufficient and they were not confident with the staff member's competency to conduct a robust assessment.
• The person's care plans written by the external consultant, dated September 2022, did not clearly identify the likelihood or severity of risk or improve the safety of the service. For example, there was no written emergency protocol for the person's prescribed medicines in the event of an epileptic seizure. Their positive behaviour support plan stated the person should sit in the back seat of a vehicle for safety, however, there was no information about what the risks were. This meant staff did not have access to enough information about how to anticipate and respond to risk to protect the person from harm.
• The nominated individual did not pass on information about risk to the staff member responsible for supporting them, such as the person's distress reactions or risks associated with their health conditions. The staff member who supported the person told us they had never seen any care plans or risk assessments.
• The person's care plan stated they were at risk of choking and "staff to cut food into small pieces". This care plan did not make any reference to the Speech and Language Therapy (for swallowing) guidance which, the person's relative told us was in place for a minced and moist diet. In addition, the care plan stated if the person started to choke then staff should call 999. It gave no directions to staff to apply first aid in response to choking. This meant staff did not have access to enough information to protect the person from the risk of choking.

We found no evidence people had been harmed. However, failure to assess and act to mitigate risk increased the risk of harm to people. 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

At our last inspection we found people were not supported by staff who were safely recruited. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 19.

• Unsafe recruitment practices placed people at potential risk of harm. During our last inspection, we found the provider accepted job references without company details provided and had not verified the references obtained. During this inspection, we found no further improvement had been made and similar concerns were found. The provider had a 'employing fit and proper persons recruitment' policy but failed to ensure this policy was followed in practice.
• Two job applications we were given access to were not fully completed. For example, there were no explanations for gaps in employment history and the dates on the 'personal declaration' and 'health questionnaire had been altered without any explanation. The other staff member's application was not dated. Employment and character references for one staff member were sought in June and September 2022 which was after they commenced delivering care in April 2022. Interview records were for the

nominated individual's recruitment agency and not the care provider. The interview was carried out by another care worker, rather than a manager and there was no evidence they were competent to do this role.
• 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. However, a staff member had been supporting a person since April 2022 before the provider applied for a DBS check in September 2022, which had not been completed at the time of the inspection. Another staff member who had supported the person between November and April 2022 did not have their DBS checked by the provider. There were no documented risk assessments completed to show how people were protected from the potential of harm, until the result of DBS checks were known.
• The nominated individual told us a registered nurse had recently begun an assessment for the only person receiving care. We asked to see their recruitment records, however, the only records available stated their identify check and DBS check were 'pending'. No other recruitment records or evidence of checks into their nursing registration were available and the nominated individual failed to submit this evidence after our site visit as requested.

This is a continued breach of Regulation 19 Fit and Proper Persons Employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found, 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. This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 12.

• Safe medicines systems were not established or implemented. The nominated individual lacked knowledge of national medicine guidance and failed to have a medicine policy and procedure to instruct staff on how to manage and administer medicines safely.
• A staff member was expected to administer a person's emergency medicines if required, in response to epileptic seizures when supporting the person in the community. There was no medicines protocol for the staff member to follow and they had not received any specialist medicines or epilepsy training. Neither had their competency been assessed prior to supporting the person unsupervised. This meant the person was at risk of not receiving appropriate emergency treatment and put them at risk of harm.
• The nominated individual failed to ensure people had medicines care plans. This meant staff did not have enough information about people's medical conditions, medicines prescribed to treat them, and how to respond to any side effects. A person's care plan for skin integrity directed staff to 'moisten' their skin following personal care, however there was no further information about prescribed or over the counter topical creams in relation to this.
• After we announced our inspection visit the nominated individual (NI) arranged for a staff member to complete online basic medicines administration training. During our inspection visit we found the NI had not considered specific specialist medicines training for emergency medicines or acted to assess the staff member's competency. This demonstrated the NI did not understand what was required in accordance with national medicines guidance and best practice.

We found no evidence people were harmed. However, unsafe management of medicines practices placed people at increased risk of harm. This is a continued breach of Regulation 12 Safe Care and Treatment of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After our visit the NI told us they would take action to ensure the staff member was fully trained and assessed in relation to medicines administration. However, they failed to respond to our request for supporting evidence to show progress.

Preventing and controlling infection

At our last inspection we found, the service did not follow their COVID-19 testing policy. They failed to monitor staff were taking regular COVID-19 tests and did not keep records of any results. This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 12.

• There were no risk assessments or procedures for preventing, detecting, and controlling the spread of infections. The nominated individual failed to monitor whether staff were regularly taking COVID-19 lateral flow tests in line with government guidance until 8 September 2022. This placed the person receiving care at increased risk of infection.
• Staff failed to wear personal protected equipment (PPE) when delivering care. A relative told us a staff member did not wear masks, gloves, or apron when supporting their family member. We spoke with the staff member who confirmed they had not used any PPE since that started delivering care in April 2022. The nominated individual failed to provide staff with PPE or infection prevention and control/ COVID-19 training.
• PPE supplies were not easily accessible for staff and the nominated individual was not able to show us they had enough PPE supplies. They assured us PPE were stored in people's homes but a relative and staff told us this was not the case.
• An infection control policy and procedures dated 1 September 2022 had been written by an external consultant, but we found the provider failed to ensure this was implemented. There was no COVID-19 contingency plan, such as staffing if staff needed to self-isolate.

We found no evidence people were harmed. However, people remained at risk of catching infections. This is a continued breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
• Systems were not established to ensure staff reported incidents or near misses in order for the service to manage risk or learn lessons to improve care.
• The staff member responsible for delivering the person's care told us they were not aware of and had never completed an incident report. They told us there was a risk of the person falling from garden equipment and there had been two occurrences of injury near misses. The staff member had not reported this to managers or the nominated individual and there was no risk assessment to lessen the chance of reoccurrence.
• The service did not investigate whistle-blowing concerns, which was out of line with their whistle-blowing policy and procedure, dated 1 September 2022. During our inspection we received two anonymous whistle-blowing concerns about poor management, poor treatment of staff and management of risk. We informed the nominated manager about these concerns who denied the issues, without first acting to investigate and gather information. We prompted the NI to investigate and provide us with an update, which they failed to

do.
• The nominated individual was not able to show us any evidence about how they checked or responded to patient safety alerts.

There was no evidence of the service learning from events or taking action to manage risk and improve safety. This was a breach of Regulation 17 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 people's care, support and outcomes.

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

At our last inspection people were not always provided with personalised and person-centred care. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 9.

• People's care and support needs were not assessed before their package of care started. We found the person in receipt of care since November 2021 has not had their needs assessed by the service until 13 September 2022. In addition, an external consultant told us they were concerned with the quality of the assessment and did not have enough information to complete robust care plans.
• The local authority had carried out their own review of the person's needs in January 2022. The service had not taken timely action to captured any of this information in care plans or risk assessments. For example, the person's goals of initiating communication and expressing concerns and emotions was not captured on the person's communication care plan, dated September 2022.
• An incomplete positive support care plan, dated September 2022, referred to the person as liking 'sensory things', however there was no assessment to inform staff about the person's sensory needs. There was no reference to the person's dislike of specific noises, which was identified in their communication care plan.
• The person's 'social activity' care plan, dated September 2022, instructed staff to use a 'positive parenting approach' when engaging with the person. This is not a recognised, evidence-based positive behaviour approach for care workers to use when supporting people.

Care and support was based on ill-informed, incomplete assessments. This is a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found people were not always treated with dignity and respect and their independence was not always promoted. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 10.

• The service had not assessed the person's protected characteristics, such as religion, disability or sexual orientations, in accordance with the Equality Act 2010.
• The person's relative described a situation in which the staff member supporting the person did not recognise how to protect their dignity in the community.
• Staff did not receive training in relation to privacy, dignity or equality and diversity. The nominated individual only acted to ensure the staff member responsible for the person's needs completed online after we announced our inspection in September 2022, five months after the staff member had been delivering care. We were not assured the nominated individual had effective systems in place to monitor how the staff member implemented training such as privacy and dignity.

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

• The person's relative provided positive feedback about the staff member's personable approach and positive engagement with their family member.

Staff support: induction, training, skills and experience

At our last inspection we found staff were not appropriately trained, supervised and appraised. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 18.

• People received care and support from staff who were not suitably qualified, skilled, and competent to meet their needs.
• 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. We found a staff member new to care who commenced employed in April 2022 had only completed three of 15 Care Certificate standards on 12 September 2022. They had not completed any specialist training such as epilepsy or mandatory learning disability training to meet the person's needs.
• There were records to show the provider had assessed the staff member's competency during the training. This is a requirement of the Care Certificate and meant the provider could not be assured staff had understood and could confidently put into practice what they had learnt.
• The staff member told us prior to the 12 September 2022 they had not received any training and only shadowed an experienced care worker for two weeks before they were allocated to support the person. We found the other care worker did not have up-to-date training or competency assessments. This meant the nominated individual could not be assured they were implementing their training correctly.
• There were no records to show staff members received regular support through supervisions. The provider was unable to provide evidence, during and after our inspection to confirm they had supported the staff. This showed staff's training, learning and development needs were not identified, planned for, and supported.
• The person's positive behaviour care plan, dated September 2022, instructed staff to use a specific physical stance to keep the person and themselves safe. However, the nominated individual confirmed they had not arranged the training required for staff to learn this technique.

The provider failed to ensure staff were effectively trained and supported. This is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider did not make sure they obtained people's consent or ensure that staff 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.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• The service did not ensure that people's capacity to make decisions was assessed. There were no documented mental capacity assessments or best interest decisions recorded.
• The person's care plans all stated they had capacity to consent. However, this was contrary to other information we found that indicated the person potentially did not have the mental capacity to consent, which needed to be explored through assessment. For example, the person's medicines care plan dated 17 September 2022 stated they were unable to 'deal' with any aspect of their medication from ordering to administering.
• The external consultant who was involved in writing the person's care plans told us they were concerned the nurse who was contracted by the service to assess the person's needs did not have the knowledge and skills to understand MCA requirements. We asked the nominated individual to show us what training the assessor had but they said they had not checked as the staff member was a nurse. This was not in accordance with the provider's responsibility to ensure staff members had up to date training and understanding of requirements.
• The staff member who was responsible for delivering care to the person told us they did not know what mental capacity meant. They had not received mental capacity training prior to our inspection visit. They completed online training including mental capacity after our visit but told us they could not recall this information. This showed the provider did not act to ensure MCA training was effective, understood and applied by the staff member.

The service failed to obtain consent to care in line with legislation and guidance. This was a breach of

Regulation 11 (Person centred-care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we recommended the provider seek current guidance and best practice in relation to staff supporting people at mealtimes. At this inspection not enough improvement had been made.

• The staff member we spoke we told us they had not seen the person's care plans and were reliant on the person's relative telling them how to support the person with eating and drinking.
• There was no assessment of the person's nutritional or hydration needs prior to care being delivered. The first documented nutrition and hydration care plan, dated 19 September 2022, was written by an external consultant ten months after care commenced in November 2021.
• The same care plan stated the person could "get upset" when eating and directed staff to use distraction techniques and provide assistance at mealtimes but did not provide any further information about how to do this. The care plan also stated the persons weight should be monitored monthly, however, the nominated individual told us this was not in place.
• Additionally, the nutrition and hydration care plan stated staff were to encourage the person with a good fluid intake every day but did not indicate how much or what the person preferred to drink. This meant the service could not be assured the person's nutrition and hydration needs were effectively identified or met.

The service did not monitor or manage the risks associated with poor hydration and nutrition. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we recommended the provider seek best practice and current guidance on how to work effectively with other agencies. The provider had not made improvements.

• The service did not ensure that care and support was effectively coordinated. We received feedback from the person's relative they had to directly arrange the staff member's rota around the staff member's other commitments. This was because they found office staff were unresponsive.
• The nominated individual did not ensure that relevant information was provided to the staff member responsible for delivering the person's care. For instance, no care plans or policies and procedures were provided to the staff member to read in order to understand the person's needs.
• The person's nutrition and hydration care plan stated staff were to "ensure oral care is done daily to avoid any oral infection". No further details were provided about how staff should support the person. The staff member told us they did not support the person with their oral hygiene. This meant the provider could not be assured whether the service was meeting the person's oral health needs.
• The person's relative informed us speech and language therapy guidance for swallowing was in place. However, this guidance was not considered by the service or captured in the person's care plans. The same person's 'special medical condition' care plan dated 17 September 2022 referred to generic signs of a certain type of epileptic seizure, but it was unclear whether this was relevant to the person's specific needs. In addition, the care plan did not cross reference with any clinical guidance about the person's health condition or how to safely support them.

The service did not effectively co-ordinate support or have due regard for supporting the person to live a

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

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained the same. 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

At our last inspection the provider did not notify us of managerial changes and changes to its location address as required. This was a breach of Regulation 15 (Notice of change) of The Care Quality Commission (Registration) Regulations 2009.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 15.

• The manager who the nominated individual had previously told us was overseeing the service, informed us they had not been employed and were not responsible for the day to day management. The nominated individual failed to notify us of this change to provide details about who was responsible for managing the service until a registered manager was appointed.

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

• Prior to our inspection we found the service had failed to display the rating of the previous inspection report on the provider's website. This was a regulatory offence and we issued a fixed penalty notice, which the provider paid.
• During this inspection we found the provider had not taken enough action to comply with displaying their rating on their website. For example, the date of the rating was not included and there was no link to the report on CQC website as required.

This was a continued breach of Regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider failed to ensure they had an effective audit and governance system and did not manage records effectively. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 17.

• The service had been without a registered manager since May 2021 which was against the conditions of their registration. The nominated individual had not taken satisfactory steps to address this in a timely manner.
• The nominated individual was unable to demonstrate that they or any other operational staff employed had the knowledge or experience of the regulations to provide safe and quality care to people.
• The service was not operating from their registered location address, which was against their condition of registration. In addition, the new address the nominated individual provided was for a different company owned by them. We found Global Care Ltd only held a 'virtual office' and no physical premises for their registered service. This showed the nominated individual failed to understand or comply the conditions of registration to have a physical address.
• Records of people's care and the management of the service were incomplete, inaccurate and were not contemporaneous. For example, care plans were insufficient in capturing the person's needs and risk and had not been completed in a timely manner.
• The staff member responsible for the person's care told us they had not recorded any daily notes about the person's care between April and June 2022. The nominated individual said they could not locate all daily notes and only provided notes for August 2022. These notes did not appear to be contemporaneous and did not provide accurate information about care provided. For instance, the notes referred to medicines being given to the person, however, it was unclear whether this was by the staff member or the person's relative. We received other information from the staff member and relative that staff were not responsible for administering regular medicines. This meant daily records did not provide an accurate picture of care provided.
• We checked the storage of people's care records and found they were not secure, which meant staff from a different company who used the same office space could potentially access people's personal and sensitive information.

The service failed to ensure there were effective systems for identifying, capturing and managing organisational risks. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the nominated individual arranged a physical office rather than a virtual office at the same premises for the service. However, it was not possible to register this address until a registered manager application was submitted to CQC in accordance with the conditions of registration.

• The service Statement of Purpose (SoP) did not include all relevant information as required. For example, there were no details of the location where services were carried on.
• The SoP was not up-to-date. The manager listed in the SoP was different to the manager the Nominated Individual told us was responsible for the day to day running of the service.

This was a breach of Regulation 12 (Statement of Purpose) 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; Continuous learning and improving care
• Leadership of the service was inconsistent and weak. We received contradictory information from operational staff and the nominated individual about who was responsible for the day to day management of the service. We had no confidence that a competent manager was in place to monitor whether the service achieved good outcomes for people.

• The concerns we found in relation to leadership indicated a closed culture and the nominated individual was not always open and transparent with us. For example, they told us a staff member who worked for their other company was also employed by Global Care Limited. However, the same staff member told us they were not employed by Global Care Limited. We asked to see the staff member's and three others' job descriptions and terms and conditions of employee contracts, but these were not provided as the nominated individual said they needed time to "get them off the system". We gave them time after our inspection, but they were not provided. Other staff members' contracts were produced, however, contracts referenced the same job titles for different staff and did not match what the nominated individual told about staff roles.
• We found the provider's website did not provide factual information about the service for members of public. For example, information stated the service provided residential care and used an electronic system to check care activities were delivered and for people to access their own care records. However, we found this system was not in place and the service had no experience in running residential care homes. The nominated individual told us information on the website was for marketing purposes. They told us they would take action to ensure it reflected what services were actually provided.
• The nominated individual hired an external consultant ten days prior to our inspection to create a governance framework. They had adapted policies and procedures from a care home provider, which they stated required further review to ensure they were fit for purpose. There was no action plan about who was responsible for this or when. The nominated individual was unable to provide sufficient information about what competent person would implement the policies and procedures. This meant there was a risk that governance systems would not be effectively embedded or sustained.
• The staff member we spoke with told us they had never been given access to any policies and procedures. This meant they did not have access to information about expectations or processes to follow to promote quality and safe care.
• The provider had not completed any audits of the service to monitor the safety and the quality of care provided. This meant risks to people and poor standards of care were not identified or acted upon.
• An action plan dated 7 April 2022 had not been progressed in a timely manner. The nominated individual said this was because the external consultant, who was involved at the time, was not able to carry out any work for the service since April 2022 until more recently in September 2022. This showed the service did not have any internal operational staff capable of driving improvement.

There was no credible strategy to achieve positive outcomes for people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The person's relative was positive about the staff member's caring approach.

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

At our last inspection the provider did not ensure they had effective audit and governance systems and did not manage records effectively. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The service did not invite feedback from people or their relatives. There were no surveys, questionnaires or logs of other forms of feedback, or evidence about whether the service had acted upon others' views.
• The staff member we spoke with told us they were not aware of any staff meetings. The provider sent us

one example of managers meeting minutes in March 2022 which included actions such as reviews of other people's care plans. The nominated individual had told us only one person had received care since our last inspection, however this document indicated otherwise. We asked to look at these care plans and the nominated individual denied the service had provided care.
• There was no evidence of the service working in collaboration with other organisations. During our inspection we raised concerns the staff member was not trained or skilled to deliver care to the person. The nominated individual did not contact the funding authority to inform them in order to work together to ensure suitable staff were available. We contacted the local authority directly to alert them.
• The local authority told us the service was unresponsive to evidence required about how the local authority COVID-19 financial grant was spent to benefit people using the service.
• We announced our original inspection on the 6 September for the 7 September 2022. However, the telephone numbers provided by the service were not answered and our emails to the nominated individual, the provider's email and operational staff were not replied to. When we visited the office premises on the 7 September 2002 there were no staff there to assist us with our inspection and no response to our telephone calls. Since our last inspection in November 2021 we found the service did not respond to our queries in a timely manner and responses were incomplete. This showed the service did not have systems to engage and work in partnership with others effectively.

The service failed to engage with stakeholders effectively or work in partnership with other organisations. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider did not have effective systems to make sure complaints were investigated without delay. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The relative we spoke with had not been provided with information about the service complaints procedure. The content of the local authority's review of the person's needs, dated January 2022, stated there had been difficulties in finding the right staff to support the person during the holidays and the relative had to spend a lot of time with staff to help them understand the person's needs. This had not been resolved and was not acknowledged or acted upon by the nominated individual.
• There was no complaints policy and procedure or log of concerns or complaints about the service.

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

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

At our last inspection we recommended the provider reviewed their understanding of the duty of candour requirement and seek current guidance and best practice. The provider had not made enough improvements, however, we found no evidence of a notifiable safety event.

• The external consultant had written a duty of candour policy, dated September 2022. However, we found systems such as the reporting of incidents were not embedded, which meant the service could not be assured notifiable safety events would be identified.
• We found no evidence that a notifiable incident had taken place, which would require the service to report and apologise where something goes wrong.

At our last inspection the provider failed to notify us of certain events as required. This was a breach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

We found no evidence of a notifiable incident at this inspection and the provider was no longer in breach of regulation 18.

• Systems were not embedded to report or escalate incidents internally or externally. The staff member we spoke with was not aware of incident forms, although they said they would tell office staff of any concerns. In practice, the staff member told us two near misses were not reported to anyone else.
• There was no evidence of incidents that met the criteria for reporting to CQC. An Accident and Incident Policy, dated September 2022, instructed staff about the requirement to notify CQC of incidents.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The service failed to ensure their Statement of Purpose was up-to-date and contained all the relevant information as required.

Regulated activity	Regulation
Personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The service did not notify us of managerial changes as required.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service did not display their rating in accordance with the requirements.

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 9 HSCA RA Regulations 2014 Person-centred care Care and support was based on ill-informed, incomplete assessments of people's needs.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not assess people's protected characteristics or ensure staff understood and protected people's dignity.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not implement the Mental Capacity Act 2005, as required.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to identify or act to lessen risks to people.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014

	Safeguarding service users from abuse and improper treatment The service had not acted to embed systems to protect people from the risk of abuse.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not monitor or manage the risks associated with poor hydration and nutrition.

The enforcement action we took:

We served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service failed to establish systems to receive and act upon complaints.

The enforcement action we took:

We service a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to establish robust governance systems to monitor the safety and quality of the service.

The enforcement action we took:

We serviced an urgent Notice of Decision to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service failed to carry out recruitments checks to ensure staff were suitable.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to ensure staff were skilled and

competent to deliver the regulated activity.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admissions to the service.