Eniola Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Eniola Care Ltd is a domiciliary care agency. The agency provides care to people living in their own homes. At the time of the inspection, care was being provided to 53 people. Some people lived with dementia and some people had support needs relating to their mobility or other health needs. Some people were in receipt of end of life care.

People's experience of using this service and what we found
The service was overseen by a manager who was not registered with CQC. The manager had not notified CQC of incidents and events that they were legally obliged to, for example, safeguarding issues. There were no auditing processes in place and quality assurance processes were inconsistent with no analysis of the views of people or their relatives. Similarly, there were no processes in place to capture staff feedback. Supervision meetings were inconsistent, and few records kept. We were shown team meeting agendas but no minutes or actions were recorded.

Staff knowledge of what safeguarding meant and steps they would take if a person was at risk was lacking. Although most people told us they felt safe this was not reflected in what we heard listening to the manager and staff. The manager told us that no safeguarding issues had been raised by the service however we were told by the local authority that four had been raised in the past 18 months. Not all risk assessments were in place to help staff manage risks. For example, dementia, Parkinson's disease and diabetes assessments were missing in some people's care plans. Medicines were not always safely managed with information absent about what the medicines were for and no risk assessments to manage side effects. Not all accidents and incidents had been recorded and no patterns or trends had been identified.

When agreeing to support new people the manager had not thoroughly assessed people's needs. For example some people used urinary catheters but staff had not been trained in catheter management. Staff received a three day induction which included some basic training modules. There was no evidence to suggest any further, effective training was provided for staff after their induction.

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. People had not been supported to attend health and social care appointments but the manager told us the service could provide this support if required.

Some people told us that they had requested female carers but this had never been provided despite repeated requests. Sections within care plans were headed 'About me' but in all cases these were blank.

People told us that the length of care calls varied and that they were not always informed if carers were running late. Care plans were not person centred. Each section began with a heading, 'What I can do.' However, there was no information describing what people could do for themselves but a description of the

support needed. A complaints policy was in place but not everyone we spoke to knew how to raise a complaint or concern. Four complaints were recorded, all related to late calls. Some people supported were towards the end of their lives. There were no end of life care plans and staff had not been trained in end of life care.

There were enough staff and staff had been recruited safely. Infection prevention and control measures were in place. People told us that they were treated with dignity and respect and that their independence was encouraged without compromising their safety. People's privacy was respected. Some people did tell us that they thought the manager was helpful and some staff told us that the manager had supported them well. Some contingency plans were in place and the manager had developed some positive relationships with health and social care professionals.

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 good. (Report published 19 April 2019)

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eniola Care Ltd 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 safeguarding, risk, medicines, training and ongoing staff support, mental capacity assessments, statutory notifications, auditing and quality assurance. We served a regulation 17 warning notice to the provider to be complied with by 30 December 2022.
Please see the action we have told the provider to take at the end of this report.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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

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

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. The current manager was overseeing the service but did not intend to register with the Commission.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 14 September 2022 and ended on 22 September 2022. We visited the office on the 21 and 22 September 2022.

What we did before the 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. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 16 August 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 15 members of staff including the manager, two office staff, 11 carers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with four people that used the service, eight relatives and seven professionals.

We looked at a range of documents including seven care plans, medicine records, six staff files and policy and procedure documents relating to safeguarding, complaints , accidents and incidents. We also looked at documents relating to quality assurance, auditing and contingency planning.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Systems were not in place to safeguard people. Staff knowledge of safeguarding and appropriate reporting processes were poor. Staff were asked to describe situations that would amount to safeguarding and the only example given was medicines errors. We asked staff what steps they would take if they felt a person was at risk of harm. They all responded that they would speak to the manager and to relatives. A staff member said, "If anything is wrong, I tell my manager and report it in the WhatsApp group." (See our well led section for more about the WhatsApp group.)
- Staff were not able to tell us what steps they would take if another staff member or manager was suspected of being involved in the safeguarding issue. They were not aware of alternative appropriate reporting systems.
- Some people and relatives told us that they felt safe when being supported. A person said, "Oh yes, everything is perfectly alright." However, this was not a consistent view. Another person told us, "They are not well trained, they work six or seven days a week and look exhausted when they get here." Staff did not know how to recognise and respond to safeguarding concerns.
- Professionals told us that the manager had not engaged with the safeguarding process when issues had been raised. (See our well led section for more about safeguarding.)

Systems were not in place to demonstrate that staff understood safeguarding or that safeguarding issues had been recorded and investigated. This placed people at risk of harm. This was a breach of regulation 13 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had a safeguarding policy and training records showed that staff had been trained in safeguarding as part of their induction

Assessing risk, safety monitoring and management

- Not all risks to people's health had been identified. We looked at seven care plans. Some risks that had been identified only contained limited information about how the risks were managed. For example, one person had been assessed using a Waterlow assessment tool. This tool provides an estimated risk score for people vulnerable to developing pressure sores. The tool had been completed but not dated or reviewed. There was no risk assessment or other guidance for staff to reduce the risk of the person developing pressure sores.
- Some people were living with diabetes. Assessments stated that blood sugars should be checked daily.

There was no care plan or assessment to tell staff what people's usual blood sugar levels were or what actions to take should levels be found to be outside of usual levels. There was no other information for staff to follow in the event of a diabetic episode. Daily checks had not been completed in all cases which created a risk to people's health.

● Some people had catheters. Staff told us that they emptied catheter bags and that if there were concerns, they would contact a district nurse or GP. There was no risk assessment in place for people using catheters and no information about safe management, for example, how to prevent the risk of infection. Staff had not been trained to support people with catheters.

● We saw care plans that stated that people were living with a number of other health conditions or were vulnerable to other risks. There were no risk assessments or guidance for staff in place for people living with Parkinson's disease, people who were a known risk of falls and there was no documentation relating to environmental risk assessments having been completed in people's homes.

Systems were not in place to demonstrate that safe care and treatment was always provided. The absence of risk assessments placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

● Medicines were not always administered safely. Some people needed support to take their medicines. Care plans provided information to staff about when to give medicines, but there were no risk assessments or other information relating to medicines and any risks they may present. Staff were unable to tell us about the side effects some medicines may create.

● Medicines were provided in blister packs but there was no information to indicate what medicines were being taken. Medicine administration records (MAR) just documented numbers, not the actual name of the medicines. We spoke to staff about medicines and they were not able to tell us what different medicines were for. Staff had received medicines training but they had no information available about the side effects that some medicines may cause.

● We looked at seven MAR charts and they had not always been fully completed. We saw gaps where medicines had not been recorded as being given although care notes recorded that they had. The manager told us that this was due to the mobile application on staff phones failing rather than medicines not being given.

● We saw a medicine assessment that stated that blood thinning medicines had been prescribed. There was no information about the medicines, no risk assessments to identify potential risks or guidance for staff to help keep the person safe from the risk of bleeding.

● Care notes had recorded that a person had been identified as forgetting to take their medicines and that they needed staff support. The assessment noted that the person needed prompting to take their medicines but there was no information about how to do this. On one occasion it was noted staff had left medicines out for the person to take later but there was no record to determine if it was safe to do this. This left the person at potential risk of harm if their medicine had not been taken as prescribed.

● Guidance in how to use as required (PRN) medicines was not available during the inspection. A PRN protocol was sent to us after the inspection. However, this only provided basic information and was required to be reviewed monthly. The protocol was dated April 2022 and there had been no reviews since that time. The absence of PRN protocols meant that staff did not know when to give PRN medicines to people and left people at risk of harm if medicines were not given as prescribed.

The provider failed to ensure medicines were managed safely. These issues are a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Not all accidents and incidents had been recorded. An accident and incident policy was in place. One incident had been recorded in the past 12 months. Although the detail of this incident was recorded there was nothing to indicate what steps had been taken to try to minimise the risk of a similar events occurring again.

● We were made aware of a number of incidents including , medicines errors, staffing issues and safeguarding incidents that should have been recorded but had not been. A professional said, "We do hope that when we have these SARs (safeguarding) come through that lessons are learnt but it doesn't seem that way." (See our well led section for more about accidents and incidents.)

Staffing and recruitment

● There were sufficient numbers of staff to support people. We were shown a two week rota which showed every care call being covered by staff. Daily notes showed that care calls had been attended. Staff told us they had enough time to support people and enough time between care calls. If running unexpectedly late staff told us how this would be managed, "Call the company and inform family." Another said, "It's not a problem. Inform managers and call client." Most people told us carers were on time, one said, "They come every day for an hour and are usually on time." Another said, "Regular? Not all of the time, it's a mixture." (see our responsive section for more about care calls.)

● Staff had a password protected application on their mobile phones which they used to record all care and support activities carried out. The information entered was then immediately accessible to the manager and support office staff, to monitor the staffing provision.

● Most of the staff had been recruited from abroad. The manager told us that they ran a cultural induction for new staff followed by an induction for the carers role. We were shown driving documents and work permits which were correctly dated.

● Staff had been recruited safely. We looked at eight staff files which contained documents that confirmed staff were safely recruited. We saw photographic identification documents, application forms, references and Disclosure and Barring Service (DBS) documents. 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.

Preventing and controlling infection

● Policies and procedures were in place and were followed to ensure effective infection prevention and control. Staff had received training in working during a pandemic and the use of personal protective equipment (PPE). There were plentiful supplies of PPE available to staff.

● The manager had responded to any changes in government guidelines throughout the recent pandemic and had kept staff informed of changes to procedure using the service mobile phone contact group. Staff confirmed that they had received these messages and updates.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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. Staff support: induction, training, skills and experience

- Staff did not always have the training and skills required to support people's needs. The manager carried out pre-assessment checks and we saw some paperwork within care plans to support this. The manager or a senior member of staff would then carry out a home visit. However, the manager had agreed to support some people who lived with specific care needs, without having the staff trained in these areas to support people. For example, a person had a PEG feed through which medicines were administered. No staff at that time had received training in this area. A PEG feed is a feeding tube placed through the skin directly into the stomach. Similarly, some people had urinary catheters but staff had not received appropriate training to manage these. The absence of staff training in these areas place people at risk.
- People's care and support needs had not been reviewed regularly. There were no updates on people's health needs and the views of people, and their relatives varied. A person told us, "Yes I have a copy of the care plan. It doesn't bear much resemblance to what actually happens." A relative said, "The care plan has been fine tuned." Another relative said, "They only contacted me in the early days, not recently."
- There was no good practice guidance available to staff relating to some health needs for example, dementia care, skin care and how to support people using PEG feeds. This placed people at risk of not receiving the full support they needed.
- Staff told us about their induction. Comments included, "First three days," "Did training in diabetes and medicines" and "We did training and then shadowed."
- We were told by the manager that staff had supervision meetings monthly. Staff comments about the frequency of supervision meetings varied, however. Comments from staff included, "A couple of times since April," "Every three months," "At least twice a month" and "I'm not sure but we have staff meetings." We were shown some documents where meetings had been recorded but these were inconsistent and were not recorded for all staff.
- We were shown a training matrix that showed that the only training staff had completed, including the two staff members with over 12 months service, was during their induction. The exception was that every member of staff was shown as having completed mental capacity assessment, deprivations of liberty safeguards and risk assessment training on the same day in August 2022. We asked the manager how this training was achieved without compromising care calls and they responded saying that staff popped in at various times during the day for the training. The manager was not able to assure us that the training in these areas was comprehensive having been covered in such a short period of time.

● A professional told us, "There seem to be training issues. Carers knowledge and training is poor."
● No member of staff had started working towards their Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

The provider had failed to ensure staff had the appropriate training and skills to support people safely. Ongoing staff support using supervision meetings was inconsistent. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us the manager carried out spot checks, unannounced checks on staff competencies when with people. These checks were recorded in staff files.

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

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

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

We checked whether the service was working within the principles of the MCA.

● Some people lived with dementia and needed help with making decisions. There was no reference in care plans about choice or detail about people's capacity to decisions.
● There were no mental capacity assessments (MCA) in place for people needing help with making decisions. There was no documentation to demonstrate that decisions made on people's behalf was done so in their best interests. The service had a generic MCA policy which described the steps to be taken if a person was unable to make decisions themselves. This policy had not been applied to people and this meant people were at risk of decisions being made on their behalf that they would not have agreed with.
● The training matrix showed that all staff had received some MCA training. In all cases the training had been completed several weeks after staff had started to support people living with dementia who needed support with decisions.
● In the care plans we saw there were no consent forms that would indicate that people and their representative had agreed for people to receive personal care.

The provider had failed to deliver MCA training before staff started supporting people. Decisions had not been made following best practice guidance and assessments of people's capacity to make decisions had not been assessed appropriately . This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they supported people with decisions. A member of staff told us, "I stay calm and take time with people."

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

● People's health and support needs were sometimes at risk of not being met. Gaps in staff training meant there was a risk of staff missing changes in people's health for example, identifying changes in blood sugar levels and identifying urinary tract infections from the use of catheters.

● In most cases people were either supported by family or loved ones to make and to attend health and social care appointments. The manager told us that with enough notice the service could support people with appointments if needed.

● The manager worked with several health and social care professionals some of whom were able to provide positive comments about the service. For example, "I have not had any negative feedback about them from the team or from relatives" and "I visited in June 2022. I found the manager to be open, transparent and very keen to build a working relationship." The service worked well with professionals to provide the care and support people needed.

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

● People's nutrition and hydration needs were met. Most people could either prepare their own food or lived with family members who supported them with food and drink. Some however did require support from staff, either to make food and drinks or to prompt and encourage people. Staff recorded details of support provided and food and drink consumed in their care notes. A member of staff said, "I ask them what you would like, we would always ask people."

● Some people lived with diet controlled diabetes. Some staff were aware of this and knew which food and drinks could be safely provided to people.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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

- Care plans did not promote people's cultural needs. Care plans had a section called, 'About me.' However, these sections were blank in the care plans we looked at. There were no details of people's cultural or spiritual needs recorded. Some people told us that they had religious needs and that they enjoyed attending places of worship on certain days. These details were not recorded in people's care plans. Staff were unable to tell us about people's cultural needs or preferred routines.
- The manager told us that they tried to support people with the same small group of staff but that it was not always possible to do this. People told us they preferred to have the same carers support them each day but that this did not happen all of the time. People's comments varied, "Some are regular," "We get different ones" and "Regular? Not all of the time it's a mixture."

These were areas that required improvement.

- People and relatives told us that staff were kind. A person said, "They are very caring and friendly." Another added, "Yes everything is alright. They are very easy to get on with." A relative told us, "They are kind, compassionate and informative."

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

- People were not always able to make their views known. Some relatives told us that communication with staff was sometimes difficult. Comments included, "They are very respectful and although they don't speak very fluently, she is comfortable with them now," "Their English is not amazing but they are comfortable with them now" and "Their English is not very good and (loved one) is pretty deaf and slow, so there is a communication barrier on both sides." This was acknowledged by the manager who had arranged for some English language courses for some staff to attend.
- Staff spent time with people and provided people with some choices about their care and support. For example, people could choose what clothes they would like to wear each day and staff told us that people they supported with food, where given a choice of what they would like. People and their loved ones confirmed this.
- Staff understood the importance of taking time with people, to make sure that they understood the nature of the support that was being provided. A member of staff said, "I take time with people. Sometimes I wait and come back to a job and sometimes I may not do it. It's their choice."

Respecting and promoting people's privacy, dignity and independence

● Care plans were not person centred. Each section began with a sentence, 'What I can do.' However, the notes written after every section listed support needs and did not highlight what people were able to achieve themselves.

● Care plans did not always reflect what people could do for themselves. However, staff acknowledged the importance of people's independence and they told us they supported people safely to do some tasks themselves. A staff member said, "I get to know what they can do themselves."

● People and relatives told us that their privacy and dignity were respected. A person said, "They are mostly respectful." Relatives told us, "Yes they respect the home and their dignity." Another relative said, "They give them a blanket bath, which I think is a wash with a flannel and they do their best to keep their dignity."

● People's personal information was kept on password protected computers with any printed documents kept in locked cupboards.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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. End of life care and support

- Staff did not always stay for the full time of a care call, as had been contractually agreed with people. People told us that the length of their care calls varied. Comments included, "I have one half hour visit, they are here for 20 minutes" and "We get four visits of 45 minutes a time, they can be 20 minutes max." Another person told us, "I'm being billed for 45 minutes and I get 20 minutes."
- Some people told us the timings of care calls often varied and they were not always informed if a call was going to be late. A person said, "No, they don't inform me if running late, I have no idea." A family member said, "We don't always know what time they are turning up; they do ring if they are going to be significantly late."
- People's preferences were not always supported. In most cases people were happy to have either male or female carers. However, some people specified whether they wanted male or female and this was not consistently provided. A person told us, "I've said time and time again I am not comfortable with male carers. Even the carer's themselves say, 'I'm really sorry.'"
- Not everyone knew how to raise issues or make a complaint. A person told us, "No I don't know who to contact. That's why I'm writing to the council." Some people were more confident, one telling us, "I'd ring the number on my daily care book." Another added, "(name of manager), she's busy but approachable when you get through."
- There were no end of life care plans in place for people.
- All staff we spoke with told us they supported people who were towards the end of their lives. Staff had completed some end of life training as part of their induction process and the manager told us that further training was being planned with the local authority. We asked staff about the important aspects of supporting people towards the end of their lives and responses varied. For example, "Treat them no different," "Make sure meds are given at the right time" and "Family are important, remind people to take their meds."

The provider had failed to ensure that people consistently received their care in a personalised way that met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns.

- Not everyone knew how to raise issues or make a complaint. A person told us, "No I don't know who to contact. That's why I'm writing to the council." Some people were more confident, one telling us, "I'd ring

the number on my daily care book." Another added, "(name of manager), she's busy but approachable when you get through."
● A folder contained copies of complaints made against the service. There were only four complaints recorded and all four related to late care calls. These complaints had been addressed by the manager.
● A complaints policy was in place and the manager told us that a copy was available to people.

Ensuring people knew the process of how to make a complaint was an area that required improvement.

Meeting people's communication needs. 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

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

● Most people were able to communicate verbally, and the manager told us there were no current need for any specific support apart from people needing more time to understand and process information. Staff told us they took their time with people living with dementia and spoke clearly and slowly, explaining the care they wanted to help them with and only providing support when people understood. However, some people and relatives told us that communicating with staff whose first language was not English was not always easy.
● Most people were supported by their relatives or loved ones in social and cultural activities. Some people attended religious services and the manager told us that care calls would be scheduled to fit around these activities where possible.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. Auditing of MAR and daily notes had not been completed each month and some errors had not been identified. There was no guidance for staff about supporting people living with catheters and no quality assurance processes were in place. These issues had not been addressed. The rating for this key question has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not have effective auditing processes. We were shown some historical auditing documents relating to care plans but these only showed that documents had been checked. There was no analysis of patterns, trends or details of any action taken when things were missed.
- Not all accidents and incidents had not been recorded. There was no effective system in place for capturing information about accidents and incidents which resulted in having no meaningful information to analyse, to understand trends and patterns which would help to minimise future accidents and incidents.
- The manager had not considered the protection of people's personal information when creating the staff WhatsApp group. There were no safeguards or risk assessments in place to guarantee that staff could not access data relating to people that they did not support. The WhatsApp group was not password protected and we were not assured that people from outside of the service may be able to view people's personal information.
- The service was in the process of transferring from written records to a computerised system. The computer system enabled managers and office staff to monitor the actions taken by staff that they record on their mobile phone applications. The system also enables auditing processes to be carried out. However, this system was not yet embedded.
- Systems and processes for capturing feedback from people and relatives were ineffective. We were shown some generic, blank feedback forms and some that had been completed but were one word responses with no detail or commentary. It was not clear who had completed these forms. People and relatives told us that they had not been asked to provide feedback about the service.
- Feedback from staff was not sought and acted upon. We were shown meeting minutes but these just contained agendas with no record of any comments made by staff or any action points. The absence of feedback meant that no views were captured about the positive or negative aspects of the service which meant there was no measure from which improvements could be implemented.
- No reference had been made to equality characteristics within care plans.

There were no auditing processes in place and there was no effective way of capturing feedback from

people, relatives or staff. Some records were absent. These failings were a breach of Regulation 17 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.
● The manager had not complied with the duty of candour. Managers are legally obliged to inform CQC about significant events that affect their service. The manager told us that they were aware of their responsibilities under the duty of candour. However, we have received no notifications from the service during the past two years.
● The manager told us that there had been no safeguarding issues raised by or about the service. However, the local authority have informed us of four safeguarding incidents that the provider had not notified us about. A professional told us, "I am a case manager and have been involved with several safeguarding's involving this service."
● Professionals told us that the manager had not engaged with the safeguarding process when issues had been raised.

The provider had failed to notify CQC of significant events affecting the service. This was a breach of Regulation 18 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
● There was not a positive culture at the service. The service had had four registered managers in the last 18 months, all of whom had left. At the time of the inspection the service was being overseen by an interim manager and the nominated individual.
● Most people and relatives told us they knew who the manager was and that they had communicated with them and found them helpful. A person said, "Very helpful, I have no complaints." A relative said, "I think she would sort problems; I've spoken to her and have her direct number of my phone." Another relative added, "I've spoken to her on many occasions and she sorts out problems."
● Similarly, staff told us they felt supported by the manager. Comments from staff included, "Manager has helped me, sorted out many issues," "Good, would listen and sort out problems" and "Any issues can call the managers. Listen and try to help us."
● An out of hours on call system was in place so staff could contact the manager or a member of office support staff if they needed advice or support at any time.

Continuous learning and improving care. Working in partnership with others
● We were shown some contingency documents relating to how the service managed during the recent pandemic. The manager was keen to improve the service and to provide more support to more people when the time was right. The manager had kept up to date with bulletins and advice from the local authority, CQC and the UK Health Security Agency, with key messages being cascaded to staff using a group WhatsApp tool.
● Despite some professionals telling us that the manager had not engaged with them, some were able to provide positive feedback. A professional said, "I find (manager) very responsive and good to deal with." Another added, "The manager is very polite and helpful."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of significant events that affected their service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that care was delivered to meet people's needs. The provider had not ensured that people received care in a person centred way and had not responded to people's requests. The provider had not ensured care plans were in place for people in receipt of end of life care and no end of life training had been provided to staff.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that people were supported in making decision about their safe care and treatment. Decisions were made for people without considering their best interests.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The provider failed to provide safe care and treatment to people, including failing to assess and mitigate risks for people living with certain health issues..

The provider had not appropriately assessed the risk of diabetes, skin damage, Parkinson's disease and for people living with catheters. The provider had failed to ensure environmental risks had been recorded at the initial assessment in people's homes.

The provider had not ensured the safe management of medicines. MAR charts were not accurate and there were no medicine risk assessments to advise staff of the side affects of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure staff could identify and act upon safeguarding incidents and to ensure safeguarding incidents had been reported.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient training of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

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 How the regulation was not being met: The provider had failed to maintain oversight of the service.

The enforcement action we took:

text