Sentricare Limited

Sentricare Birmingham

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Sentricare Birmingham is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection the provider told us 76 people were using the service. The service was providing support to children, older and younger adults, people living with; dementia; learning disabilities; autism; mental health conditions; physical disabilities and sensory impairments.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support. There were several people being supported by the provider who had multiple needs including those with a learning disability and autism.

Right Support
We continued to be told people were not always supported to have maximum choice and control of their lives and they were not always involved in care reviews. Some people told us concerns they had raised these had not been addressed. Staff did not always support people in the least restrictive way possible and in their best interests.

We found guidance within some people's care plans for staff members to follow when supporting autistic people or people with a learning disability who may express distress or frustration, had improved. Care plans and risk assessments in how to respond to such expressions did provide staff with information on how to respond, how to de-escalate for some people but not others.

Staff training and record keeping needed to be improved in relation to the Mental Capacity Act 2005 (MCA).

Right Care
People's care, treatment and support plans continued to not always reflect their range of needs or promote their wellbeing and enjoyment of life.

People who were known to express anxiety did not have proactive behaviour strategies documented in their care records. This meant they lacked detail on the specific actions staff should take to ensure practices were least restrictive to the person and reflective of a person's best interests.

Right Culture
Care was not always person centred and people were not empowered to influence their care and support.

Governance systems remained inadequate and not ensure people were kept safe and received high quality care and support in line with their personal needs.

At the last inspection the provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks. At this inspection this continued.

Systems in place for managing complaints, safeguarding concerns, accidents, and incidents were not robust or effective. Not enough staff members were deployed by the provider to support people. The main complaint raised by people and their relatives continued to be the length and inconsistency of their care calls. Staff who attended people's homes remained inconsistent at times and for some staff their ability to communicate with people and their relatives was restricted due to language barriers.

People were supported by staff to take their medicines, however, guidance in place continued to not always be clear for staff to follow.

Staff did receive an induction when they started work but some people continued to tell us they felt staff members did not have appropriate skills and knowledge to support them how they wished.

Care plans and risk assessments continued to lack robust and clear guidance, with incorrect or conflicting information. Risk assessments continued to fail to direct staff on recognising symptoms of known health conditions.

People continued to tell us their care and support was not always planned in partnership with them, and persons close to them.

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 22 March 2023).
At this inspection we found the provider remained in breach of multiple regulations and they had either not implemented or maintained the improvements they said they had made.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

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

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

Enforcement
We have identified continued breaches in relation to; Regulation 9 - Person centred care, Regulation 10 – Dignity and respect, Regulation 11 - Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 – Safeguarding service users from abuse and improper treatment, Regulation 16 – Receiving and acting on complaints, Regulation 17 – Good governance, Regulation 18 – Staffing and Regulation 19 – Fit and proper persons employed, Regulation 20 – Duty of candour at this inspection.

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

Follow up
The overall rating for this service remains '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.

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

Sentricare Birmingham

Detailed findings

Background to this inspection

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

Inspection team
Three inspectors visited the provider's office location and 1 made telephone calls to staff to gather their feedback. Two Experts by Experience carried out telephone calls to people and relatives using the service and to staff to gain their feedback. 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
Sentricare Birmingham is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was announced. We gave the provider 24 hours' notice before attending the office location to ensure they were available to support us with the inspection. Inspection activity started on 01 August 2023 and ended on 16 August 2023. We visited the location's office on 01 and 02 August 2023.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and 24 people's relatives. We also spoke with 4 care staff, the registered manager who also is the provider and 3 members of the office staff team. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider, following the site visits. We also looked at peoples care record, medication records, staff recruitment records, audits and monitoring records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection we found the provider had not made the necessary improvements and the rating 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; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the safety of people and learn from these. This was a breach of Regulation 13 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 13 - Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of abuse and were not consistently protected from harm.
- Lessons had not been learned. At this inspection we continued to find, multiple safeguarding concerns had not been identified, reported, or actioned robustly. This included short and late care calls which resulted in people not receiving the correct level of support, such as taking their medication and being supported to have something to eat and drink which was unsafe.
- Some staff continued to incorrectly log into 2 care calls at the same time on the provider's system. This meant the provider could not demonstrate the calls had taken place for the length of time recorded or if they had taken place at all. This placed people at risk of harm.
- Incidents were not consistently recorded or acted on, this included when both staff members were not in attendance for a call which required two to attend to ensure safety or people. This meant people were at risk from potential further incidents happening, as concerns were not always identified, and appropriate actions had not always been taken.
- The continuation of poor systems meant the registered manager had not taken action to safeguard people. For example, where care calls were significantly late or too close together, robust actions had not been taken to prevent recurrence to keep people safe.

The registered person did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
At our last inspection the provider had failed to ensure medicines were managed safely ensuring people received them as prescribed. This was a breach of Regulation 12(1) 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 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection improvement was required to ensure people's care records identified the level of support they needed from staff with their medicines. At this inspection we found the same concerns. Care plans and risk assessments contained conflicting or inconsistent information to guide staff on the level of medication support people needed. This was unsafe and continued to place people at risk of not receiving their medicines, as prescribed.
● The provider had failed to make improvements to ensure people received their medication as prescribed. This was due to care calls taking place at much later than scheduled or had been scheduled too close together. Continued poor or inconsistent administration of medicines could have long term effects on people's health conditions.
● The information for staff members to follow, for 'as required' medicines, to ensure a consistent approach, continued not to always be clear. Without clear protocols in place this could lead to staff not knowing when to give these medicines, leading to the potential for too much or too little medication to be given.
● For people who were prescribed creams to treat skin conditions, we saw these medicines were still not consistently included on the Medication Administration Records (MAR). This meant people were at risk of their skin condition deteriorating and staff did not have the information they needed to provide safe care. Also, body maps were not consistently in place to provide staff with clear instructions on when, where, or how the creams should be applied. This was of particular concern for people who had skin conditions or were at risk of developing pressure sores and required their creams to be applied to prevent further deterioration of their skin.
● Relatives shared concerns about medicines management. One relative told us, "They [care staff] have an app and some medicines are on there that shouldn't be, and ones that should be on are not. I have spoken to [Name] in the office and told them it's not an accurate record. They [care staff] are recording to say they have administered medicines when they haven't." They went on to say staff had told them they did not have an option to record 'not required' medicines which indicated the provider's system was not fit for purpose.
● The provider's electronic records continued to have inconsistent recording. Staff had recorded they had 'administered' 1 person's medicines which conflicted with the record which also documented 'no one had opened the door'. This meant records were confusing and inaccurate. One relative told us, "Sometimes carers are giving meds without food. I have told them [Name] registered manager. It is because carers are early."

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

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health and safety of people. This was a breach of regulation 12(1) 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 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks associated with people's care and support continued not to be consistently and effectively managed. This was unsafe.
● Risk assessments were either not in place or were not sufficiently detailed to help staff provide safe care. For example, risks associated with health conditions, were not consistently in place or contained conflicting information. We also found the risk assessment had not always been reviewed and updated as per the providers policies which meant opportunities to keep people safe had been missed.

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

Preventing and controlling infection
At our last inspection the provider had failed to ensure staff followed safe Infection Prevention and Control (IPC) practices to keep people safe. This was a breach of Regulation 12 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 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found people and staff continued to be at risk as the provider could not be assured all staff were following safe practices and were adhering to the correct use and safe disposal of PPE.
●One person who had complex health needs told us, "My regular carers wear masks and gloves, the weekend ones don't. I have to chase them out if they come in and are coughing, I am very vulnerable." They also told us staff did not wear uniforms.

The provider did not have robust systems in place to ensure all staff met their responsibilities in relation to preventing and controlling infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us the PPE they needed to prevent and control the spread of infection was available to them.
● Most people and relatives we spoke with confirmed staff wore appropriate personal protective equipment (PPE).

Staffing and recruitment
At our last inspection the provider had failed to ensure the followed safe recruitment practices. This was a breach of Regulation 19 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 19 – Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider's recruitment systems remained inadequate. Safe recruitment practices were not always followed.
● People at risk of harm from receiving care and support from unsuitable staff. Suitable references had not been obtained for some staff members in line with requirements. For example, a community pharmacist had provided a reference for 1 staff member. Another staff members reference had been provided by their

co-worker instead of their previous employer.
● Another staff members file listed 2 home addresses, and their identification documentation contained both addresses. This meant it was unclear which address the provider had used when completing their safety checks.

The provider failed to ensure they had obtained all the information required ensuring the suitability of all staff employed. This meant people were placed at risk as the provider did not know if staff were suitable to support vulnerable people. This was a continued breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff members joining the service from overseas, had evidence of police checks from the country, they were moving from.
● At the last inspection records demonstrated at least 2 staff members did not have a DBS check completed prior to commencing employment. At this inspection we found this had improved.

At our last inspection the provider had failed to ensure they had sufficient numbers of suitable staff to meet people's needs. This was a breach of Regulation 18 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 18 – Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At this inspection some people continued to tell us they often did not receive their care calls on time and they regularly experienced short call. We looked at a range of call records and staff rotas which confirmed this had happened.
● Records showed some people's care calls continued to last for less than half of the required time. These records also demonstrated that some staff were recording they were in attendance of 2 calls at the same time, meaning these records were incorrect. For many people using the service we found they frequently received late calls or even early calls.
● At the last inspection staff told us, and records confirmed people who required 2 staff to support them safely often only 1 member of staff attended their call. At this inspection records indicated this poor practice still occurred as staff logged into care calls at different times, so were not in attendance together. This meant people were exposed to the risk of harm as the provider had not identified this was occurring.
● Staff continued to tell us their allocated rotas did not always include travel time between calls, or more than 1 care call was scheduled at the same time. Rota's, we looked at confirmed this. This meant calls would either be shortened or late, impacting on the standard of support people received. This had resulted in some missed calls.
● Travel time and the full allocation of time staff needed to provider care and support was not factored into their rotas. Some staff members continued to tell us they were concerned to raise issues about their rota's as they feared they would not be paid or would lose their jobs. For 1 staff member, the provider had unsafely scheduled 36 care calls between 05.50 and 23.00hrs. If all calls were completed for the correct amount of time this should have taken the carer 20.5 hours to complete. This did not include, any travel time, breaks and calls were scheduled to overlap. This meant people would receive short, late or missed calls to ensure all calls were undertaken.

The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. This was a continued breach of Regulation 18 (Staffing) 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 inadequate. The rating for this key question has remained 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 the provider had failed to ensure people received support to meet their needs and preferences. This was a breach of regulation 9 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 9 - Person centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not consistently receive care that met their needs and preferences.
- At the last inspection people and relatives told us they were not involved in their initial assessments completed by the provider before starting to use the service nor on-going care reviews. At this inspection some people and relatives told us they still had not in involved in a care review or in their care planning.

- Many people continued to tell us they did not receive their care calls at the times that they wanted or needed.
- People and relative's main concerns continued to be the short length of calls and inconsistent call times. This left people at risk of neglect as they were unable to access, the support they needed, when they needed it. When we asked 1person if staff turned up at the right time they said, "I am very confused about the times. I have spoken to [Name] registered manager but nothing has changed."
- The provider had failed to make improvements in reviewing people's care plans to ensure these continued to reflect people's needs. For example, 1 person's daily care records indicated staff were supporting them with medicines, however, this information was not recorded in their care plan or risk assessments. This meant people were at risk of not receiving effective care.
- One person and 1 relative told us they struggled to communicate effectively with their carer due to language barriers. The person told us, "I asked for a particular flavour of soup in my cup, but she [carer] did not know what it was." A relative told explained how their loved one struggled with communicating due to the carers accents and how the carers did not understand her. They told us, "[Name] is 'old English', they don't get her sense of humour. It affects communication all around and how she [relative] likes things."

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

● Despite our findings some people and relatives told us they had been recently asked recently for their feedback on care plans and risk assessments.
● Staff told us people's care plans were accessible on the provider's computerised system.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure all staff were competent, skilled and had up to date training in order to carry out their role and effectively support people.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18 - Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We continued to receive mixed feedback from people and relatives about the level of skill demonstrated by the staff, others felt there was a lack of training. A relative told us they did not feel the staff had appropriate experience or skills to support their loved one's support needs.
● People told us there were some issues with staff rushing them resulting in carers not being gentle enough. When asked if they felt the carers had adequate training and knowledge to meet their needs, 1 person told us, "Yes, they know what they are doing, except for the weekend staff." A relative told us, "There are issues, 1 care does it right [catheter] but the others don't. If they don't take care, it will cause [name] trauma and we will have to call the district nurse."
● The provider had failed to assess the effectiveness of their staff training. For example, competency checks of staff skills were not always completed. The providers records also demonstrated some staff competency had not been assessed this year.
● Feedback from staff continued to be mixed regarding their training which included on-line training and face to face training in the office. Some staff told us they had not received specific training. One staff member told us they found the monthly training 'repetitive' and 'not informative'.
● Some staff members understanding, and communication of English was limited their training, continued to be predominately on-line and presented in English. Alternative formats still had not been provided. Whist the provider told us care staff had received health specific training to meet people's needs some staff members, some could not tell us what they had learned, which meant some staff had failed to understand some important information.

The registered person did not ensure all staff were competent, skilled and had up to date training in order to carry out their role and effectively support people. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure people's consent was consistently gained prior to support being provided.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11 - Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● The provider was not compliant with the MCA. For people who were unable to make their own choices and decisions, the provider had still not obtained evidence, that those making decisions on their behalf had the necessary legal authority to do so. This meant the provider could not assure themselves people were being supported in the least restrictive way and decisions were not being made on their behalf inappropriately.
● We continued to have concerns in relation to the registered managers understanding and application of the MCA. We found the required principles of the MCA were not consistently applied and where mental capacity assessment had been completed these were not decision specific. For example, for 1 person, the registered manager had recorded, 'they do not have full capacity because they have slurred speech and struggles to make sensible statements'.
● Some people and relatives continued to tell us they had not been consulted or involved in developing their care plans. Some also told us they had not been given the opportunity to read and consent to the information made available to staff members.

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

● The majority of people and relatives who had regular carers gave positive feedback as to staff always seeking consent before providing care and support and had good interactions with staff.
● Most staff we spoke with were gave examples of how they gained consent before supporting people with their care.

Supporting people to eat and drink enough to maintain a balanced diet
● Not all people we spoke with required support with meal preparation or assistance to eat. Where this support was offered feedback continued to be mixed. Due to late care calls, people's hydration and nutritional needs continued to be at risk of not being met. For example, where people could not access their own food and drinks there were times, records demonstrated there could be very short gaps resulting in them not wanting the food at that time. At times there were very long gaps due to calls being short, very early or late.
● People's dietary needs were considered and assessed by the local authority. We found, information shared with staff members for a person who required specific fluids, was still unclear. However, staff we spoke with knew how to support people's specific nutritional needs.
● Records indicated most people had access to drinks and snacks before care workers left their home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records we reviewed and people we spoke with indicated the provider and staff worked in partnership with people, their relatives and health and social care professionals when additional support was required.
● Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency.

Inadequate

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls. Many people told us they did not feel well cared for.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure all staff treated people with dignity and respect.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 10 - Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not demonstrate a caring approach towards people. At our last inspection, we had bought to their failings to their attention for them to address. At this inspection they had failed to make improvements. We found on-going issues and some people were still experiencing late, short, and potentially missed care calls. This meant people were often uncertain or anxious about when they would get their care.
● Staff did not demonstrate a caring approach. One person told us, "She [carer] is abrupt and too quick. She gets more and more unfriendly and throws things about." A relative told us, "On 1 occasion when they [carers] were late she [relative] wanted go to sleep but she didn't in case they came and woke her up." Another relative also told us, "They make her feel she is an inconvenience."
● Other people and relatives continued to tell us they felt rushed by staff which meant they did not get their support in a dignified and respectful way. One person told us when asked if the staff stayed the full time, "I feel extremely distressed and anxious, it [the call] should be a 30 minute call and they are gone in 10 minutes. They do not give me a choice of anything. I tell them not to bang the door and they seem to bang it even louder when they leave." At the last inspection the registered manager assured us they would address these issues. That had not happened.
● Some people told us staff did not always respect their privacy and their dignity was not always promoted. Staff did not always ensure people and their personal living spaces were respected whilst supporting with their personal care. A relative told us, "I have told them [carers] they should cover [name] body up when they are not washing her. They don't close the doors or curtains either. I have told them."
● Feedback confirmed not all staff promoted people's independence. One relative told us, "The past couple of weeks I have had to remind the carer to show [name] how to do things themselves. Staff forget to do this." Another person became upset when asked about staff promoting their independence. They told us, "This is something they should be helping me with, they should be working with me and encouraging me to do

things. They only ever stay about 5 minutes."
● The provider employed staff from different cultural and religious backgrounds, but this did not always lead to positive outcomes for people or their relatives. For example, whilst it was the provider's intention to allocate staff members from the either the same culture or who had the ability to speak the same language as the person this did not always happen. At our last inspection, the provider told us improvements would be made, but people and their relatives told us they remained unable to always effectively communicate with staff due to language barriers.

The provider did not ensure all staff treated people with dignity and respect. This was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

● Despite our findings 1 relative did tell us their loved one was supported by staff who were able to speak in their preferred language which made a big difference to them.
● Most staff spoken with told us how they supported people to do as much for themselves as they were able, to help them maintain some independence.
● Some people provided positive feedback about the staff. One person told us, "The care workers go the extra mile, they support me physically and mentally, they are amazing. It's the office staff that need sorting, they never get back to you." A relative told us, "They [carers] are wonderful, very kind and caring."
● For many people we found information about their preferences and personal histories in their care plans, to help staff get to know them and how they liked to be supported had been improved. However, they lacked detail.

Supporting people to express their views and be involved in making decisions about their care
● Some people continued to tell us their care plans and care records were not easily accessible to them; these were held electronically. At the last inspection we had discussed this with the nominated individual who explained they were happy to provide a paper copy of the care plan should people require this. We found this had not always happened.
● Some people and their relatives continued to tell us care plans were not always developed with their involvement and their relatives had never been asked about their care needs and wishes. One relative told us, "[Name] the registered manager came back about a week ago to try to get us to sign paperwork. I sent him away a while ago as he was shoving the contract in my face."
● Other people and their relatives confirmed they had recently been consulted about their care needs and wishes. Whist some people said they had been asked to complete feedback others said they had never been asked.
● Records demonstrated the provider had gained feedback from some people and their relatives. This feedback contained both very positive and negative feedback which the provider told us they had actioned.

Inadequate

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant services were not planned or delivered in ways that met people's needs.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure people's complaints were listened to, acted on and responses provided.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 16 - Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Information the provider shared with us stated; 'We have a robust complaints procedure.' Whilst a complaints policy was in place, complaints were not consistently recorded and the actions that had been taken to prevent similar occurrences were not recorded. Some people and relatives who had raised complaints were unhappy with the investigation outcomes. This contradicted the providers records.
● People continued to tell us they were able to raise complaints, but they were not confident their concerns and complaints were listened to, acted on or led to any positive change in their care and support. This included short, missed and late care calls. One person told us, "They [office staff] never get back to you. They just don't ever sort out complaints."
● Other people and their relatives told us they continued to not receive a call back from the registered manager when raising complaints so felt there was no point calling anymore.

The provider continued to fail to ensure people's complaints were listened to, acted on and responses provided. 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

● People told us they were able to speak to someone out of hours if they needed to contact them and action was taken to address their concerns. At previous inspections people told us their calls, out of hours, went un-answered.
● Other people and their relatives told us they had experienced positive outcomes when raising complaints and felt the issues raised had been resolved.
● The registered manager provided us with evidence of complaint outcome letters, which they told us they sent to service users following their investigations into complaints.

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

● The provider had failed to make necessary improvements to ensure people's plans of care were personalised as per their current level of support or health needs. For example; care plans did not always include guidance for staff to follow in relation to supporting people with their mental health needs. In addition, they lacked information on recognising when there were changes in people's mental health and what action to take, to keep them safe.
● Some people continued to feel their care was not responsive to their needs and the inconsistency of their call times made them feel anxious. In addition, 1 person told us because their calls were rushed their independence was not promoted and they had lost their confidence.
● Whilst staff could tell us about people's needs and how they supported them, this was not always reflected in care plans. This posed risks people could receive inconsistent care as they were supported by different staff.
of their call times made them feel anxious.
● Our inspection evidence confirms concerns raised by people via quality assurance questionnaires had not been actioned. These included concerns such as; 'there are language barriers with new carers sometimes', 'not providing information of where to report experience of abuse', 'if a call has been cancelled or carers are not on time the communication to inform the client is not good', 'if my regular carer is not available please call me to let me know'. All these issues impacted negatively on people.
● Care records and conversations with staff continued to demonstrate staff recognised when a person was unwell and required additional support such as a GP or ambulance.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their 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.

● At the last inspection staff did not always have clear information about people's communication needs to ensure they were able to involve them in making decisions. Although there had been some improvement at this inspection, records lacked detail.
● For example, 1 person was unable to communicate verbally to indicate their needs, wishes and feelings. We found they now had a communication passport which informed staff how to recognise if the person was happy, sad or in pain. The passport referred to a book containing small pictures to help identify what the next task they would be doing. Feedback confirmed that although the book was available, it was not used to communicate with the person. This meant information in care plans and supporting documents was incorrect.
● At the last inspection, people and relatives told us they had not been offered their care plans in an alternative format. At this inspection for a person receiving support who was unable to read English, relatives told us alternative formats had still not been provided. However, the registered manager told us this was not accurate.

End of life care and support
● At the time of the inspection, no one supported by the service was receiving end of life care.
● The provider told us they had commenced work developing people's care plans to ensure people's preferences and choices for their end of life care were acted on and they had the support they needed. At the time of our inspection, we did not see evidence of this other than a reference to people having a funeral plan in place in the section titled 'last wishes'. This was a generic statement in all care plans we reviewed, even for children's care packages.

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 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

At our last inspection we found the provider had failed to operate an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 - Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The providers governance systems and oversight of the service provided remained inadequate.
- The system in place to undertake checks was ineffective as it failed to support the registered manager in identifying the on-going concerns, we found. For example, we continued to find; inaccurate, conflicting, and unclear information in people's care plans and risk management plans; call cramming and the working time directive not being applied by the provider to ensure all staff had suitable and adequate rest time. That meant opportunities to drive forward improvement to benefit people had been missed.
- The provider's auditing of people's care calls remained ineffective. People continued to experience late, short or potentially missed calls through the lack of provider oversight of the service. The provider's care call monitoring system remained ineffective. Staff continued to log into 2 calls at the same time. The provider had not taken action to ensure improvement was made.
- The provider's staff recruitment checks had failed to identify discrepancies in staff records which was unsafe.
- The providers systems to assess the effectiveness of staff training was not robust as some staff were unable to tell us what they had learnt from certain training. This lack of oversight meant the provider could not assure themselves their staff were skilled and had the necessary knowledge to undertake their job roles.
- At the last inspection the provider had failed to make the needed improvements in their safeguarding processes to ensure people were protected from the risks of abuse and where incidents happened that the correct actions were taken. At this inspection we found the same concerns and people remained at risk from abuse.
- Effective improvement had still not been made to the handling of complaints and the provider continued to fail to robustly use complaints as an opportunity to learn and improve.
- Audits of care plans and risk assessments had not identified the continued discrepancies and missing information we found. This meant people were placed at risk as the providers systems continued to fail to

provide staff members with robust information to keep people safe.

Continuous learning and improving care
At our last inspection we found the provider had failed to operate an effective system to enable them to use learning from incidents to improve and develop the care provided.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 - Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was receptive to our inspection feedback and told us they would take on board our findings to improve their documentation and systems. However, we lack confidence in the providers ability achieve this. This is due to the fact they have been rated inadequate for the last three inspection without making the required improvements to adequately improve the service.
● The provider told us they had recently engaged with a consultant to help them to identify shortfalls within their processes, implement improvements and to help them sustain such improvements in the future. The provider did not share with us, the action plan which the consultant had compiled for them following their initial assessment of the service.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17 (Good governance) 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 provider told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care. However, the failings we found during this and the previous inspection are not reflective of such responsibilities.
● The provider had failed to provide us with the full and correct details of all staff employed by them. This occurred at the previous inspection also.
● The provider continued to not fulfil this obligation with people using the service as they have not acted consistently on complaints and concerns raised.

The provider had not operated in an open and transparent way about the level of service they provide. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we were initially told the provider was only operating 1 care planner system at this location, when they were operating 2. At this inspection the provider assured us that only 1system was in use.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
● Following the last 2 inspections, we were aware of concerns people had about their care and support. At this inspection those concerns were on-going and had not been rectified.
● The evidence we gathered demonstrated service did not always promote a person-centred approach. People's individual needs continued to not always be considered or met. Such as; Accessible Information Standard, communication and the negative impact late and short care calls had on people's safety and

overall well-being.

● Although some people and relatives told us they had been involved in care reviews, some continued to tell us they had not been invited to attend care reviews to discuss the continuing care and support required.

● The providers records demonstrated staff competency checks, to confirm staff were working in line with their expectations had not routinely been completed for all staff. We saw some evidence monitoring calls were made to a random sample of people to obtain feedback on how well staff were meeting their needs. However, such monitoring calls had not been made to everyone.

● The provider was displaying their most recent inspection rating as they are required to by law.

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

● We saw evidence feedback from people had been sought via questionnaires. Some people were positive about the service they received, however, there was no evidence that negative feedback had been consistently acted on and rectified to ensure they were supported in a person centred way.

● People and relatives told us they understood how to contact the office to discuss concerns and had an on-call number they could use when this was closed.

● Some care staff told us the training they received was repetitive and not engaging. This meant staff members did not benefit or learn from such training required to support people and keep themselves safe.

● The culture at the service was not inclusive or supportive. Some staff spoken with told us they found the registered manager unapproachable, but others felt they were supportive. Some staff and people referred to the registered manager as a 'bully'. Some staff told us they were fearful of approaching the registered manager about their rota as they were threatened with having their hours reduced. Similar allegations of such behaviour have been raised by staff at previous inspections.

● People's equality characteristics were not always taken into account to ensure their needs could be met.

Working in partnership with others

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

● However, we continued to find failure by the provider to apply this practice in the best interests of people when making decisions about the support they required.

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure all staff treated people with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

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

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 12 HSCA RA Regulations 2014 Safe care and treatment 1. The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. 2. Medicines management was not robust enough to demonstrate that medicines were managed safely at all times. 3. The provider did not have processes and systems in place to ensure that all staff met their responsibilities in relation to preventing and controlling infection. This meant people were 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.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider continued to fail to ensure people's complaints were listened to, acted on and responses provided. 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 enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 1. The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. 2. The provider had continued to fail to operate an effective system to enable them to use learning from incidents to improve and develop the care provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure they had obtained all the information required ensuring the suitability of all staff employed. This meant people were placed at risk as the provider did not know if staff were suitable to support vulnerable people. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions have been imposed on the provider's registration.

Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not operated in an open and transparent way about the level of service they provided. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 1. The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. 2. The registered person did not ensure all staff were competent, skilled and had up to date training in order to carry out their role and effectively support people. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Conditions have been imposed on the provider's registration.
Imposed conditions support the provider to drive and sustain the required improvements.