Orchard Homecare Services Limited

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Inspection report

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Tel: 01913890072

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Orchard Home Care Services Limited is a domiciliary care agency providing personal care to people living in their own homes in the community. It provides a service to children, young adults and older adults. At the time of inspection, 215 people were using the service.

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
Risks to people were not always identified or monitored safely. Medicines were not safely managed. We were not assured people were receiving their medicines as prescribed. People did not always receive visits at a consistent time or for the right length of time.

Staff were recruited safely. However, staff did not always have sufficient or up to date training to support people safely. New carers were not always introduced formally to people. Most people told us they felt safe and spoke positively about the carers themselves.

People's needs were not consistently assessed and there was a lack of guidance for staff to help them support people safely. People's preferences, such as whether they would prefer a female or male carer, were not always met. Care plans were not always up to date and did not always have key information about a person.

We received mixed feedback about the management team. People, staff and relatives said the office was not well-led. Audits were ineffective and did not identify the issues we found on inspection. The service did not always comply with regulatory requirements. The provider had failed to make improvements following the last two inspections.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, care plans did not record whether people had capacity to consent to different decisions or document the impact of certain medical conditions on a person's capacity, such as dementia and mental health needs.

Communication plans were in place to support staff to communicate with people effectively. Communication aids were used where appropriate. People and staff were asked for their opinions through surveys.

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 requires improvement (published 5 February 2020) and there were two breaches of regulation. The provider completed an action plan after that inspection to show what they would do and by when to improve.

We returned and carried out a targeted inspection, looking at the breaches only, on 27 October 2020 (report published 18 November 2020). At that inspection we found enough improvement had not been made and the provider was still in breach of regulations. The overall rating for the service remained requires improvement. The provider completed a further action plan after that inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the breaches of regulation and other concerns identified at the last two inspections had been addressed.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about.

We initially undertook a targeted inspection and found not enough improvement had been made and there were still concerns around safe care and treatment and good governance. We therefore widened the scope of the inspection to become a focused inspection of the key questions safe and well-led. This meant that we looked at those entire key questions.

We undertook a targeted inspection of the key questions effective, caring and responsive. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. The ratings from the previous comprehensive inspection for those three key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and treatment and good governance at this inspection. We have also identified a new breach in relation to staffing.

We have identified a breach in relation to the service's regulatory requirement to notify CQC of important

incidents. This will be dealt with outside the inspection process.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Orchard Home Care Services Limited

Detailed findings

Background to this inspection

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

Inspection team
This 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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 the registered manager would be in the office to support the inspection.

Inspection activity started on 10 May 2021 and ended on 19 May 2021. We visited the office location on 10 May 2021.

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 was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and 13 relatives about their experience of the care provided. We spoke with 12 members of staff including the nominated individual, the director, the registered manager, the compliance officer and eight care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and procedures, and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found that risk assessments needed more guidance to support staff on how to reduce risk. 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.

- Risks to people were not always identified. Risk assessments were not in place for people who required percutaneous endoscopic gastrostomy (PEG) care, and for key medical conditions such as asthma, chronic obstructive pulmonary disease, diabetes and heart conditions. This lack of information and guidance for staff placed people at risk of significant harm.
- Where risks had been identified, the severity of the risk for the person was not correctly calculated and there was insufficient information to guide staff on how they should ensure those risks were safely managed. For example, some risk calculations had been incorrectly assessed for the level of people's risk for choking and when suctioning support was needed.
- There was limited information recorded for how people's individual risks impacted upon their daily life. For example, where people were living with a dementia type illness, there was no information for staff around how this affected the person's memory or understanding. This information was needed to ensure staff could support people appropriately.

Risk was not effectively managed. 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.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not safely managed in line with national guidance. Staff did not follow the provider's medication policy. We could not be assured people were receiving their medicines as prescribed.
- There were unexplained gaps in people's medication records. Where people's medicines were prescribed to be administered by a PEG, this was not consistently recorded on the medication records. Medication

doses and frequencies were not consistently documented. Key information, such as people's dates of birth and the name of their doctor, was not always recorded on the records. The provider had identified the need for further staff training and we were told this would be arranged.
● Guidance for staff around medication administration was not always clear. For example, we found conflicting information in one person's care plan around whether this person required prompting to take their medicines or whether they required full support to take their medicines safely.

Systems were either not in place or robust enough to demonstrate medicines were safely managed. 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.

Learning lessons when things go wrong

At our last inspection we found systems needed to be improved for the monitoring of late and missed calls. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Systems were still not in place to effectively manage timekeeping and rotas. The systems which were in place were not robust enough. One relative told us, "Weekends are usually a bit hit and miss. [Person's] visits are made around their timings for their PEG feed. If the office changes the call times to fit another call in, this can have an impact. If they move the call to after [person's] feed [person] will be sick. The office doesn't make any effort to let us know."
● At our previous inspection, the director had said they would start to add travel time to the rotas. This had been implemented in one area, one week before this inspection.The director told us they planned to implement travel time in all areas in due course.
● Staff confirmed they still do not always get any travel time between calls. One staff member told us, "We get pulled here, there and everywhere. There is no time between calls, and it can be three to six miles between clients. We are running permanently late or pinching time from clients."
● People, staff and relatives told us visits did not always last the allocated time. The provider informed us they had experienced difficulties during the pandemic. The provider informed us there had been a significant number of absences when staff were required to self-isolate and this had impacted the rotas.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staffing and recruitment
● Staff did not have sufficient time to provide care and support in a way which was not rushed. Staff told us, "Calls get squeezed in. I feel rushed to get to the next one. If I have a break in my rota a call will be stuck in." The provider informed us they had been faced with several constraints during the pandemic which had made it difficult to always manage effectively the rotas. These constraints included: staff absence; a depleted workforce; difficulties in hiring and training staff during the pandemic; and the prioritisation of service users.
● People and their relatives said they were often not informed about staff changes and who would be visiting. One person told us, "It would be nice to have a list or an idea of who is coming every week and a rough idea of the time." One relative told us, "We don't know who is coming, they might say 'see you tonight' and then their rota will be changed. It would be better for us if we did know." The provider informed us that,

during the pandemic, this was not always realistically possible. Absences due to care workers being required to isolate was a daily occurrence and the provider's priority was ensuring service users received their calls
● Staff did not always have sufficient or up to date training to support people safely. Training was deficient in areas such as moving and handling, falls prevention, substance misuse, learning disabilities, autism, diabetes awareness and mental health needs. The provider informed us they had employed a compliance officer and one of their roles would be to undertake staff training.

This failure to provide staff with sufficient time and training to perform their tasks safely placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Staff were recruited safely. Appropriate pre-employment checks were carried out.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding processes and procedures were not robust enough to provide us with assurance that people were being protected from avoidable harm and abuse. Allegations of neglect were not thoroughly investigated. We were not notified of two allegations of neglect which was in breach of regulatory requirements.
● Sometimes new staff arrived to care for people without any formal introduction and without knowledge of their needs. One relative said, "It doesn't happen very often (new carers), but when it does, they are just thrown in at the deep end as they just turn up on the doorstep." The provider informed us that, due to the constraints of the pandemic, it had not always been possible to introduce all new carers to service users.

This failure to have appropriate systems in place to manage allegations of neglect and safeguard people from abuse placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Most people told us they felt safe with the carers. One person told us, "I feel 100% safe, [the carers] do a good job." Another person told us, "I feel very safe, they're very honest. I consider myself so fortunate, you hear such things about carers. They are great."
● Carers had received training in safeguarding and understood their responsibilities. Carers told us they were confident to raise any concerns with their co-ordinator or manager.

Preventing and controlling infection
● The provider's infection prevention and control policy was up to date and staff had received COVID-19 specific training. Visitors to the office were appropriately screened for COVID-19.
● Staff had completed food hygiene and food safety training.

Inspected but not rated

Is the service effective?

Our findings

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

At the last comprehensive inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the breaches of regulations identified at the last comprehensive inspection had been addressed. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last comprehensive inspection we found records needed to be improved for people's needs and care delivery. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Assessments to identify people's needs continued to be unsuitable. There was a lack of information for staff around people's key medical conditions and the impact on each individual person.
● Care plans did not always provide enough information and clear guidance for staff to help them support people safely. For example, we found staff were supporting two people with stretches and exercises. There was no information in either care plan to guide staff with these tasks.

This failure to adequately assess people's needs and provide clear guidance for staff was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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

At our last comprehensive inspection we found care plans did not always support people's health and wellbeing. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Care plans and risk assessments did not consistently contain key information provided by the local authority. This did not support consistent and effective care.
● Care plans were not always kept up to date or reviewed regularly. One staff member told us, "Care plans are out of date. They don't cover everything we need and need renewing. If people develop another illness, it's not incorporated into the care plans." Another staff member told us, "Care plans will say a person can

walk to the bathroom but it turns out they're bed bound."

This failure to transfer key information and keep care plans up to date was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

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

At our last comprehensive inspection we found care plans did not record people's ability to consent to different aspects of their care and treatment. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Care plans continued to not record whether people had capacity to consent to specific decisions. For example, the service supported people with mental health needs and people who were living with a dementia type illness. There was no information around whether these people had the mental capacity to make their own decisions about their care or if they needed support with this.
● There was nothing specific recorded in people's care plans around their ability to make decisions. Management told us they would make enquiries when each care package was created. However, there were no records to show people's mental capacity had been assessed or reviewed as time progressed.

This failure to record people's capacity and ability to consent was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last comprehensive inspection we found records needed to be improved for people's nutritional needs and their likes and dislikes. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and the provider was no longer in breach of this part of the regulation.

● Care plans provided guidance for staff on how they could safely support people who required assistance with eating, drinking and any specialist dietary requirements such as lactose intolerance.
● People's eating and drinking likes and dislikes were recorded in the care plans.

Inspected but not rated

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 the last comprehensive inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the breaches of regulations identified at the last comprehensive inspection had been addressed. We will assess all of the key question at the next comprehensive inspection of the service.

Ensuring people are well treated and supported; respecting equality and diversity

At our last comprehensive inspection we found systems were not always in place to ensure people received reliable, consistent and person-centred care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● We were not assured people were appropriately and adequately supported.
● Care plans continued to be out of date and not reviewed. Sufficient improvements had not been made to the quality of records since the last comprehensive inspection.

This failure to keep timely and relevant care plans was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Overall, people and their relatives were happy with the care provided by the care workers. One relative told us, "The carers are really dedicated and in the job for the right reasons." One person told us, "The carers are great. I've no qualms about the carers. The office is the problem."

Respecting and promoting people's privacy, dignity and independence

At our last comprehensive inspection we found systems were not always in place to promote people's privacy, dignity and independence. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Systems were not always in place to promote people's privacy, dignity and independence.
● People were asked whether they would prefer a female or male carer to support them. However, people's choices continued to not be met. One relative told us, "[Person] told the service [person] didn't want a male carer, but nearly every day a male carer attends and [person] is very uncomfortable with it. If [person] needs

the bed pan, [person] won't use it." The provider informed us they accommodated people's preferences wherever they could. However, this was not always possible, particularly due to the ongoing constraints of the pandemic.

This failure to have systems in place to promote and meet people's needs was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last comprehensive inspection we found care plans did not record people's communication needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and the provider was no longer in breach of this part of the regulation.

- People were supported to communicate in a way which was suitable for them.
- Communication care plans had been put in place for people. Guidance was provided for staff to help them communicate effectively with service users. For example, one communication care plan told staff, "I like carers to be in front of me when speaking as it can confuse me if people talk to me from the side or back."

Inspected but not rated

Is the service responsive?

Our findings

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

At the last comprehensive inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the breaches of regulations identified at the last comprehensive inspection had been addressed. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last comprehensive inspection we found people did not always receive person-centred care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● People continued to not receive personalised care consistent with their individual needs. Care plans failed to provide staff with suitable and up to date information about people's specific needs to ensure staff provided the level of support people required.

Systems were not always in place to ensure people received personalised care. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

At our last comprehensive inspection we found the complaints procedure was not robust enough. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The complaints procedure was still not effective.
● Relatives told us they would not hear back from the office if they had cause to complain. One relative told us, "Office staff didn't come back to us about a complaint, I had to phone up and ask what was happening." People told us, "Nobody in the office listens to you" and "It goes in one ear and out the other."
● The quality of care found at this inspection had not improved following concerns raised at the previous two inspections.

Care quality had not improved in response to complaints and concerns. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last comprehensive inspection we found systems were not always in place to meet people's communication needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and the provider was no longer in breach of this part of the regulation.

● In the new template care plans, the provider had implemented communication plans for people. These plans informed staff about any communication impairment and how best to communicate with people in a way which they would understand.
● The service used communication aids where appropriate, such as using signs and symbols to encourage people to develop their communication skills.

End of life care and support

At our last comprehensive inspection we found information was not available about people's religious and cultural preferences. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and the provider was no longer in breach of this part of the regulation.

● In the new template care plans, the provider documented people's religious and cultural preferences, and bereavement wishes, where applicable. Staff had received training in end of life care.

Inadequate

Is the service well-led?

Our findings

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

At the last comprehensive inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found there was not enough information in care records to ensure people were provided with person-centred care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The management team failed to provide staff with accurate and person-centred information to ensure they could provide safe care to people. Key risks continued to have not been assessed and therefore staff did not have clear guidance on how they could minimise those risks for people.
● We received mixed feedback from staff about the management of the service. One staff member told us, "Staff morale can be okay." However, another staff member told us, "Everyone is fed up with the hours and the travelling and the pressure. There is no incentive to want to do more. People ring in sick all the time or don't want to work weekends and nothing happens."
● Staff, people and relatives told us that the service was not well-led. One staff member told us, "The office staff are in above their heads. They are always too busy to report anything. You feel like you are a nuisance if you ring up." One relative said, "I've only spoken to one person in the office and they don't sound terribly in control. They sounded harassed and rushed. It seems in a state off chaos." One person told us, "I don't think it's well organised at all, sometimes they are not very obliging."

This failure to ensure systems were in place to provide person-centred care and promote a positive culture was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did not receive any negative feedback from professionals. In February 2021 the provider requested a reference from the local authority and this reference was positive and raised no concerns.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; continuous learning and improving care

At our last inspection we found quality audits were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Quality assurance measures were ineffective and auditing systems did not support improvements. Audits had failed to identify that care plans continued to be insufficiently detailed and staff had not had appropriate training to support people safely.
● The provider had failed to effectively evaluate and improve the service. Breaches were first identified in December 2019 and again in October 2020. The provider had submitted two action plans, however, sufficient improvements had not been made. The provider had failed to maintain and deliver a good safe service.
● The service did not always comply with regulatory requirements. Services that provide health and social care are required to inform CQC of important events which happen in the service by submitting a 'notification'. During inspection we found the service had not informed us of two significant events.

The governance and quality monitoring of the service was not effective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to notify CQC of two important incidents is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

● The provider told us that some actions had been delayed due to the restrictions which were in place during the pandemic. The provider informed us that certain actions suffered, such as updating care plans within people's homes and face to face training. The provider confirmed, however, that this was mitigated by their interactive electronic system, which gave up-to-date information to carers' phones in real time.
● The provider had updated and improved a number of policies following our previous inspection, including the medication policy.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others
● Surveys were used to gather feedback from staff and service users. The results were analysed, however, actions were not always taken in response. For example, the results of the previous staff survey showed that 49% of staff did not think there was enough time allocated by the local authority to carry out the calls. There was no evidence of any action taken in response to this feedback. 71% staff said they were never or only sometimes informed in advance if usual call times were changed. Again, there was no evidence that any action was taken in relation to this feedback.
● A reward scheme was in place to recognise staff achievements.

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 HSCA RA Regulations 2014 Staffing 18(1) and (2) (a). Staff did not have sufficient training or support.

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 12(1) and (2)(a), (b), (c) and (g). Risks were not safely managed. Medicines were not safely managed. Staff were not always deployed effectively. Staff did not have sufficient and up to date training.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) and (2)(a), (b), (c) and (f). Systems and processes to support good governance were not robust.

The enforcement action we took:

Warning notice