Be Caring Ltd

Be Caring Manchester

Inspection report

294 Portway
Wythenshawe
Manchester
M22 1TG

Tel: 01619629786
Website: www.becaring.org.uk

Date of inspection visit:
05 October 2021

Date of publication:
09 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Be Caring Manchester is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 219 people at the time of the inspection, including older people, those living with dementia, people with a physical disability and younger adults.

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
People were not safe. Staffing levels and rota systems were unsafe. People's calls were significantly late, early, short or missed. People and their relatives told us staff were often late or missed calls completely. One person commented, "They [care workers] are supposed to come to give me a shower at 10am, they are late every time, sometimes they arrive at 12 or 12:30pm." Care workers rotas were unclear and inconsistent, which meant staff were not able to stay at people's homes long enough to safely meet their needs. More than half of people's planned care time had not been delivered.

People were not always safeguarded from the risk of abuse, particularly neglect, due to late, early, short and missed calls. People and their relatives were unable to rely on the service to provide essential care. One person commented, "I have three calls a day. Last week no-one came all day and the next day a carer came for one call."

Medicines were not managed safely. There was a lack of oversight of medicine administration and medicine records were not always complete. We were not assured people always received their medicines as prescribed.

Risks to people's health and wellbeing had not always been assessed, monitored or mitigated effectively. People were at risk of harm because staff did not always have the information, they needed to support people safely.

People's care and support was not person centred and frequently provided at times not to their preference. Care teams were not consistent, so people were supported by multiple care staff they did not know. People's support plans did not always contain detailed or accurate information to help staff support people safely.

People's complaints were not dealt with appropriately, so people had lost confidence in sharing their concerns or feedback with the service. People did not feel involved in their care and support.

People were not always supported to have maximum choice and control of their lives and staff did not

support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider had not established an effective system to ensure people were protected from the risk of abuse. Accidents and incidents were not appropriately reported, and actions were not always taken to ensure the safety of people.

The provider's systems to assess, monitor and improve the quality and safety of service being provided were inadequate. Senior staff and governance systems had not recognised or responded to the significant and widespread issues in a timely manner. A poor culture had developed at the service. Shortcomings in care, poor practice and a failure to meet people's needs were not always challenged but accepted. CQC had not been notified of all significant events which had occurred, in line with the registered provider's legal obligations.

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

Why we inspected
This was a five key question responsive inspection based on CQC receiving concerns and complaints. Prior to the inspection CQC received concerns about late and missed calls, lack of leadership and safeguarding concerns. The information shared with CQC indicated potential concerns about how people were being supported and risks being managed.

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 breaches in relation to people receiving safe care and treatment, management oversight of the service, need for consent, person centred care, keeping people protected from abuse, staffing and the suitability of people working in the service.

Follow up
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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Be Caring Manchester

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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by four inspectors, a medicines inspector and two 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 did not have a manager registered with the Care Quality Commission in line with the requirements of the provider's registration. The previous registered manager left the role shortly before we inspected. Until a manager was appointed the nominated individual and director were managing the service to ensure senior management was available.

Notice of inspection
This inspection was announced. We gave 24 hours' notice of the inspection as we needed to make sure the right people were available to answer our questions.

Inspection activity started on 5 October 2021 and ended on 21 October 2021.

What we did before inspection
We used information we had received through our ongoing monitoring of the service and feedback we received from the local authority and the community infection control team. 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.

During the inspection
We spoke with 21 people who used the service and 17 relatives about their experience of the care provided. We spoke with 22 members of staff including the provider and head of quality. We looked at 20 people's care records and multiple medication records. We looked at multiple staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training data and medicines audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also referred safeguarding concerns to the local authority safeguarding team for them to consider and review.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● Staffing levels and rota systems were unsafe. The provider's electronic call data demonstrated clear and widespread evidence of significantly late, early, short and missed calls.

● There was systemic and widespread evidence of unsafe practice. Staff were scheduled to be at multiple calls at the same time or back-to-back calls without any time for travel. One fifth of calls were either scheduled with no travel time or at the same time as other calls. This meant it was inevitable people's calls would be late or missed and staff stayed for less time than scheduled. Across the service, more than half of people's planned care time was not delivered.

● We saw multiple examples of rotas which were impossible for staff to follow which severely impacted on people's planned care. For example, one care worker was scheduled 27 calls in a day, but 19 of these either had no travel time or overlapped with other calls.

● People and their relatives told us staff were often late or would often rush calls. One person commented, "My morning call can be an hour and a half late if it's not my regular carer and my bedtime call was three hours late recently. Timing is important because I need my medicines on time with my breakfast in the morning and my stoma care at night needs sorting at the right time." A family member told us "They've been going in, checking on [my family member] and leaving. They are so rushed that they don't have time to do anything. As a whole I think they're absolutely shocking."

The provider had failed to deploy sufficient numbers of staff to make sure they could meet people's care and treatment needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were in place. For example, a Disclosure and Barring Service (DBS) check, and previous employer references were obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

Using medicines safely

● Medicines were not managed safely. Electronic medication administration records (eMARs) were written by the service, however the information recorded was not sufficient to ensure possible risks with administration were mitigated.

● There was a failure to complete the eMARs following the administration of medicines on a regular basis. This meant the provider was unable to evidence medicines were being administered by staff accurately and in accordance with the prescriber's instructions.

● Due to poor care planning and record keeping we were unable to establish whether medicines to manage

people's pain were being administered at the correct time intervals to ensure the maximum pain relief was achieved and the risk of side effects was minimal.
● Supporting information such as medication risk assessments and the visit schedules did not describe in any detail the support people needed with their medicines.
● Staff administering medicines had completed safe management of medicines training, however 17 members of staff had not completed the refresher training, outlined in the providers policy, within the 12-monthly period.
●The provider had a system for assessing the competency of staff to administer medicines safely, however we found the competency assessments for many staff were not up to date.
● We were not assured people had received their medication in line with their prescriptions. Some of the people's and their relatives' comments included, "My morning call can be an hour and a half late, if it's not my regular carer and my bedtime call was three hours late recently. Timing is important because I need my meds on time with my breakfast in the morning" and "There have been too many misses with medication."
● The medicines management policy did not reflect current national guidance and best practice set out in the NICE guidance for managing medicines in the community.

The provider had failed to ensure the safe and proper management of medicines. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Shortly after the inspection the provider indicated they implemented a number of positive changes connected to the medicines systems. This included coaching and training their assessors to ensure they are completing care plans and risk assessments correctly. We will review the progress of these changes at our next inspection.

Assessing risk, safety monitoring and management
● Risks to people's health and wellbeing were not always assessed and staff did not have the necessary information to support people safely.
● We identified there were no care plans or risk assessments in place for people with diabetes, pressure sores, continence support and people living with dementia. This meant staff may not identity or know how to respond to symptoms associated with these healthcare conditions to keep people safe. This placed people at increased risk of harm.
● When people sometimes displayed behaviours which challenged the service, concerns raised by staff were not listened to and acted upon. This placed staff at risk of harm.
● COVID-19 risk assessments were completed for people, but they did not always include information about people who had underlying health conditions which would place them in the "high risk" group or how staff were to minimise the risk for these people.

There was a failure to provide safe care and treatment by not managing known risks to people which put them at an increased level of risk. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
●People were not safeguarded from the risk of abuse, particularly neglect due to late, early, short and missed calls.
● People and their relatives were unable to rely on the service to provide the essential care and support they needed when they needed it. One person commented, "Yesterday I didn't get a morning call at all. This is a real problem because I'm diabetic. I didn't get to see a carer or have a drink or my breakfast until 12.30pm. It

hasn't happened before, but I'm worried in case it happens again. They seem really short staffed sometimes."

● From analysis of the accident and incident data we found a number of incidences that should have been safeguarded.

● During the inspection we made five safeguarding referrals as a result of concerns received during our calls to people and their representatives. Allegations consisted of poor recording keeping, medicines not being administered, not following people's care plans, late and short calls and poor care being delivered. These matters were currently being reviewed by the safeguarding authority.

●There were insufficient systems in place to ensure incidents were thoroughly investigated, reported, reviewed and monitored to prevent further occurrences. The service did not ensure lessons were learned when things went wrong and did not have systems in place to ensure reported safety concerns were addressed.

● Opportunities for lessons learnt were missed. One person's medicines had not been ordered in a timely manner, which meant they went without their prescribed medicines for three days. No follow up from the management team was undertaken.

Failure to provide safe care and treatment by not managing known risks to people put them at an increased level of risk. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People told us that staff wore personal protective equipment (PPE) whilst supporting them.

● Staff had received training about preventing transmission of infections and the increased precautions during the COVID-19 pandemic.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were not supported in line with the principles of the MCA. People's decision-making abilities were not clearly recorded in care plans. This meant staff did not have clear information on what decisions a person could make.
- The provider did not carry out mental capacity assessments when they were required to do so. Where there were doubts about people's decision-making capacity, mental capacity assessments were not always in place to determine people's level of capacity to make decisions. This meant people may not be supported to make decisions in an effective way.
- Best interests processes were not followed. It was not always clear how decisions around people's care had been made and/or agreed, as this information was not captured or included in people's care records. We also found consent forms had been signed by family members on people's behalf, despite them having no legal authority to do so.

We were not assured that the provider had sought appropriate consent from people, nor that they clearly recorded how to best support people to make decisions. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

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

- People's care needs were assessed before their care package commenced. However, the level of

information recorded did not always safely address people's assessed needs. This meant staff did not always have accurate information about how people's needs could be met.
● People's care plans did not always detail specific information about how their diagnosed conditions affected them as individuals. There was a risk staff would not always understand people's medical conditions and how they presented.
● People's needs in relation to their protected characteristics was not always included on their assessments or care plans. The protected characteristics in the Equality Act 2010 are: age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
● Best practice guidance was not always utilised which meant practice was not always consistent. For example, nationally recognised tools to assess people's diabetes such as the NICE impact diabetes guidance, published September 2018 was not considered or used to assess people's needs who lived with diabetes.

Failure to provide safe care and treatment by not managing known risks to people put them at an increased level of risk. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The majority of staff we spoke to told us they had received the training they needed to provide them with the skills to support people. However, we identified a number of training subjects staff required refresher training on. Assurances during the inspection confirmed a plan was in place to ensure this training would soon be completed.
● New staff received an induction when they started working at the service and spent time with more experienced staff members to understand how to support people.
● There was system in place for regular supervision. We received positive feedback from the staff team in respect to the recent changes in the management team at the service. Comments included, "Never had training that was so good. I got a lot of knowledge from it" and "Completed the training before started. This is my first job in care, and I found the training was really good. The trainer was always helpful and provided good support."

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people to eat and drink enough to maintain a balanced diet, where this was part of their package of support.
● Care records reflected whether people were supported to eat and drink. These were not always personalised to reflect people's food and drink preferences and we did find a number of incidences when records had not been completed to confirm people has received support with their meals

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People had access to health professionals as required. If staff were concerned about a person's health and wellbeing, they relayed these concerns to the previous registered manager for escalation and action.
● However, we identified incidences from the service's incident tracker where professionals such as social workers had raised concerns to the service on behalf of their clients. Concerns tended to be around late calls, calls being shortened and the poor performance of certain care workers.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● We found the care staff team to be well intentioned towards people. People gave us numerous examples of where the staff team demonstrated a caring nature towards them. One commented, "I do love my usual carers, I listen out for them at the right time and get them to shout up the stairs, so I know it's them coming up the stairs."

● However, the approach to care delivery was not always dignified. We found instances where care had not been provided at the correct allocated times, which at times impacted people's dignity. For example, one relative told us that due to late visits their loved ones had been incontinent, which impacted on their dignity.

● People's diverse needs had not been explored in documentation. We found a number of inconsistencies in the way care plans were devised, which meant sufficient details about people's health, personal care, emotional, social, cultural, religious and spiritual needs was not recorded.

The failure to support people in a person-centred way was a breach of regulation 9 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

● As detailed in the Effective section of the report, people were not always appropriately supported to consent to all aspects of their care.

● People did not always feel well-supported in a way they preferred. For example, one person told us, "The carers only use the hoist safely because I know what I'm doing, and I tell them what to do. Some carers are okay, but some just don't know what to do. I wouldn't want them to be lifting me if I didn't have capacity to direct them" and "About once a fortnight I get a carer I don't know, and this is a big problem for me because I'm disabled and need personal, intimate care. I need continuity of care to build up trust. Also, I don't like having to explain everything over and over again to new carers."

● People's preferences had not always been considered. People were not always able to choose what times during the day they received their care call or who supported them. For example, one person told us, "I have complained about timing, like today, I am waiting to go out and they (staff) still have not arrived at 10.30am. I have to put my life on hold for them." Some people felt they did not always have a choice about who supported them. One person told us, "There is just no continuity, and they are always changing [staff] so a bond can't be formed."

●The provider had processes for seeking people's views through meetings and surveys. However, this had

not always been implemented and consistently acted on to demonstrate how people's views had been listened to. No surveys were provided for people when we requested these for the last 12 months.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs

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

- People did not always receive personalised care that was responsive to their needs . Not all care plans contained personal information, such as capturing people's social history. One person's local authority assessment made reference to their diet needing to be monitored due to living with diabetes and storing out of date food. This person's care plan was limited, and we would not be assured the service was safely meeting this person's health needs.
- Another person's care plan made reference to the person living with autism and their routines were extremely important to them. However, we identified occasions when this person's routines had not been met due to late or rushed calls, which impacted on the person's mental health.
- Care reviews were irregular and not person-centred. We did not find any evidence people's care reviews had involved the person being supported. Comments from people and their relatives included, "My husband has a care plan which is not up to date, it was last reviewed about 6 months ago" and "We have the original paper care plan which has not been updated. It is now electronic, but I have not been told how to access it."
- The provider agreed further work was needed to improve people's care plans and clarified that care plan reviews take place every 12 months and not six months.

People did not consistently receive personalised care that met their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Care plans contained a section about people's communication needs; however, information was not always sufficient to ensure staff knew the best way to communicate with people. One person's care plan made reference to them not being able to speak English. We found no personalised communication plan had been devised. This meant people may not be supported in the most effective way with to meet their communication needs.
- Another person's care plan made reference to a person having a learning disability. The care plan had not been adapted in anyway and it had not been explored by the service whether the person could understand their care plan.

Improving care quality in response to complaints or concerns

● Complaints were recorded on a spreadsheet. However, a number of these lacked information on what action was taken when a complaint had been received. This meant people could not be assured their complaints would be resolved within a timely manner.
● During the inspection we received negative responses about the way people and their representatives concerns and complaints had been handled. Comments included, "I've had a man carer when I've always asked for a woman. I've complained but the office just says there's nobody else available. It's a problem because I have personal care and I don't want a man to do that" and "When I complained about the carers turning up two hours late and [person's name] being wet through and me having to wash all his clothes and bed clothes, they just didn't seem bothered. I don't think we're a priority for them."
● The provider accepted further work was needed to ensure complaints responses were accurately recorded and additional complaints monitoring had been introduced.

End of life care and support
● The service was not providing support to anyone at the end of their lives.
● People's end of life care wishes were not pro-actively gathered before they received an end of life prognosis. By not proactively having these plans in place, people could become too unwell to have these discussions and risk not having their end-of-life needs met.
● Multiple concerns have been highlighted at this inspection, including missed, late and short visits, record keeping, medicines management, safe care and treatment and ineffective governance systems. As a result, we could not be assured people being supported at the end of their life were receiving person-centred end of life support.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

- The service had fallen below the minimum regulatory standards required to ensure the vulnerable people in the provider's care received their care and support safely. We identified systemic and widespread failings.
- Quality assurance processes and audits had not been completed for a number of months prior to our inspection. Considering the widespread issues at the service the lack of oversight meant a poor culture had developed at the service.
- The provider's call-cramming approach towards staff rotas and call scheduling meant it was inevitable people's care needs would not be safely and effectively met or not met at all.
- The provider's electronic call data demonstrated clear and widespread evidence of significantly late, early, short and missed calls. However, the provider failed to take timely action to recognise the seriousness of the situation.
- Record keeping in relation to people's daily care was not always being recorded and where they were, they lacked detail and completeness.
- Where audits were in place, these did not identify the concerns we did during our inspection or drive the necessary improvement. For example, medicine audits had been carried out for some people, but they either did not identify the concerns that we did and if they had, action had not been taken to make improvement
- Incidents and complaints did not prompt learning to improve care. We identified a number of incidences of a safeguarding nature that had not been reported to CQC. Services providing health and social care to people are required to inform the CQC of important events happening in the service.

The provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous registered manager left the service shortly before we inspected. The director and nominated individual based themselves at the service to ensure the necessary improvements would be made. A new manager was appointed shortly after we inspected.

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

- The provider had failed to develop a positive, person centred culture.
- The organisation of the staff rotas demonstrated a disregard for people's needs and resulted in a culture

that accepted late and rushed visits as the norm.
● Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.
● Improvements were needed to ensure people consistently received empowering, high-quality care and good outcomes. These have been reported throughout the domains of the report.
● People and relatives provided us with a mixed view regarding how well-led the service was. For example, comments included, "The management make excuses about why the staff are late", "The managers are just a joke, they are not organised. They never ring me, only to tell me they are cancelling a visit because they have not got enough carers. It's like talking to a brick wall" and "Good carers are leaving; they tell me it is because the management is chaotic", "We're happy enough with the service - it's mainly reliable. I think all care companies are struggling at the moment" and "The service works well for us. I keep in touch with the office so it works ok."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others
● People in leadership roles did not always promote the delivery of high-quality person-centred care.
● People and relatives did not always feel the service involved them or engaged with them effectively. In the main this related to a lack of communication with office staff. Comments included, "When you ring the office after 5pm you get through to a call system where you have to listen to recorded messages directing you to 111 or emergency services, then you have to press 1 for this and 2 for that… it's very time consuming and not very helpful. Eventually you'll get through to someone working from home, I think. But I think some people will have given up by then!" and "I wish the office people would listen to me when I tell them what I need. I need to know when carers are coming because I live on my own and I get panicky when they don't arrive on time, but they don't listen. I don't think I'm important to them."
● Staff we spoke with told us that overall, they felt supported by the management team that recently replaced the previous registered and deputy managers.
● Surveys were carried out in February 2021 with people, relatives and staff to gather their views about the service.

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 was aware of their responsibilities under the duty of candour to be open and honest when things went wrong. However, as noted within this report we identified a number of notifiable incidents that the previous manager had not submitted. Assurances were provided these matters would be reviewed.
● The provider was open and honest in their communication with local authorities and CQC about the struggles to safely and effectively deliver its commissioned calls. This led to regular meetings with the local authority and a service improvement plan was created.