Brisen Company Limited

Brisen Company Limited

Inspection report

194 Wricklemarsh Road
London
SE3 8DP

Tel: 02088565305
Website: www.brisen.co.uk

Date of inspection visit:
10 August 2022
16 August 2022

Date of publication:
04 May 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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: Brisen Company Limited is a domiciliary care agency. It provides personal care to people living in their own homes as well as reablement services; which meant that people are referred to the service from local authority representatives and health care professionals. The service provides short term care, normally up to six weeks, and therefore the numbers of people receiving support varies on a weekly basis. At the time of the inspection there were 146 people 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

The provider failed to ensure appropriate assessments of risks to people were completed, or risk assessments were not updated. Risk management plans were not always in place to manage these risks, which included, health conditions, moving and handling, falls, medicines, skin integrity and diabetes. People's medicines were not always safely managed.

Staff were not deployed to meet people's needs in a timely manner. People and relatives told us that staff were frequently late, this sometimes meant that at times a family member had to support as the second carer.

People and their relatives told us that people did not always feel safe. Appropriate recruitment checks were not carried out before staff joined the service.

Potential safeguarding concerns were not always reported to CQC. There was not a robust system in place to record accidents and incidents. These were not analysed and learning was not disseminated to staff.

People were not always protected from the risk of infection as not all staff wore Personal Protective Equipment (PPE). Staff were not always supported through regular supervisions.

Assessments were not always carried out prior to people joining the service to ensure that people's needs could be met and were not used to develop care plans. Staff did not always receive adequate training. People's privacy and dignity and their independence was not always promoted. People's end of life care wishes was not recorded in their care files. The complaint system to manage people concerns was not effective.

People and/or their relatives were not involved in planning their care and support, Care plans were not always reviewed and/or updated. People's consent to care and support was not always documented.

Feedback was not always sought from people about the service, where feedback had been sought, the provider did not always act upon and rectify shortfalls identified. Governance and audit systems were not effective at identifying and reducing risks to people's safety. There was a lack of effective leadership and oversight of the service.

Rating:
The last rating of the service was Good (published on 21 March 2021) when we carried out a comprehensive inspection.

Why we inspected:
We received concerns about late visits, staff recruitment, neglect and poor medicines management. As a result, we undertook a comprehensive inspection. We identified breaches in relation to lack of person-centred care, risks, care plans, medicines management, recruitment practice, and there were no robust systems in place to assess and monitor the quality of the service provided. There was a lack of effective leadership and oversight of the service.

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

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

Enforcement:
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 continue to monitor the service closely and discuss ongoing concerns with the local authority. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. This means we will keep the service under review. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below

Inadequate

Is the service effective?

The service was not effective

Details are in our effective findings below

Inadequate

Is the service 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

Brisen Company 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by one inspector on the first day of the inspection and three inspectors on the second day of inspection. Four Experts by Experience also supported this inspection. 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
Brisen Company Limited is a domiciliary care agency. It provides reablement and personal care to people living in their own homes.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection site visit took place on 10 August 2022 and 16 August 2922 and was announced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed information

we had received about the service since the last inspection, this included from external professionals. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people and 15 relatives to seek their views about the service. We spoke with three members of care staff, the lead care coordinator and the registered manager. We reviewed records, including the care records of 14 people using the service and recruitment files and training records 14 staff members. We also looked at records related to the management of the service such as quality audits, accident and incident, and policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
• People were not always safe and protected from known risks of harm. Risks to people such as Parkinson's disease, falls, diabetes, medicines, moving and handling, choking, seizures, pressure sores had either not been assessed or assessments were inadequate.
• Risk management plans were not in place to ensure that there was not up to date guidance for staff on what to do if people become ill.
• Some people used mobility aids, such as wheelchairs and hoists. However, their moving and handling risk assessments did not identify the potential risks of using these mobility aids and there was no guidance in place for staff on how to safely mobilise the person and how to minimise potential risks.
• Some people experienced anxiety or distress, could become agitated or display distressed behaviour. However, there were no risk assessment or risk management plans in place to guide staff on what they should do if this happened to ensure their safety.

• People who were receiving care initially through reablement packages and who had been receiving care for longer than six weeks, did not have care plans and risk assessments in place to ensure that their needs could be met adequately and safely.

We found no evidence that people had been harmed however, 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 breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were not always safely managed. People did not always receive their medicines as prescribed which meant they were at risk of harm.
• People's medicines were not recorded in their care plans and the provider failed to ensure staff had their competencies to administer medicines assessed regularly.
• Medication administration records (MAR) were not regularly audited. For example, we found a number of gaps on one person's MAR. The provider was not able to assure us that gaps we identified did not mean that the person had not received their medicines,
• When people were prescribed PRN medicines (this means they took medicines as and when required) there were no protocols in place to guide staff how and when people should take these medicines. There were no records describing what these medicines were prescribed for, dose instructions, signs or symptoms, or information about when to offer these medicines. Therefore, there was no guidance in place for staff to help them understand when to give these medicines. This meant people were at risk of not receiving their medicines as prescribed.

• Where people were prescribed topical creams, the application of these were not always appropriately recorded on their MAR and there were no body maps in place to guide staff where these topical creams needed to be applied.
• Some people or their relatives told us that they did not always receive their medicines on time. One person told us, "[Staff] have altered my [relative's] medication times with the GP to suit their [staff] needs...." One relative said, "[Staff] are supposed to do my [relative's] medication in the morning, but they leave the blister pack beside her. My [relative] can't take it alone wouldn't do it. So, medicines are often left until the lunch time call which isn't the correct time."
• Regular medicine audits were not carried out, but when they were, they failed to pick up the shortfalls we identified in relation to medicines during the inspection.

We found 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 breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• There were not enough staff deployed effectively to meet people's needs in a timely manner. The provider failed to ensure that they had an effective call monitoring system in place to monitor staff attendance and punctuality and ensure people received their care as planned. The lead coordinator told us that they relied on staff or people to inform them if calls were going to be late.

• People and their relatives told us their visits were often late and they were not informed if there were going to be any changes. One relative said, "It can get very stressful, when my [relative] doesn't know who is coming or not coming and when…This in turn makes my [relative] anxious and their condition flares up even more." One relative told us, "The timings go wrong when [management] struggle with staff if they are on holiday or worse of all unexpected time off due to illness".
• People and their relatives told us that they were not always informed if staff were going to be late and staff did not stay for the duration of the call. One relative told us that staff were frequently late, this sometimes meant that at times a family member had to support as the second carer. They said, "I am there all day on a Sunday and there is mostly only one carer, when there should be two. If one [member of staff] uses the hoist my [relative] is picked up too quickly and left swinging about. I have often stepped in. A second relative told us, "[Staff] have a few times not turned up for the lunch call. But this week they have not turned up at all, as car has broken down". A third relative told us, "No way do they stay as long as they should, often its 5 to 10 minutes…and then they're off."
• Staff we spoke with told us that they were not enough staff and they did not always have enough travel time between calls. Therefore, staff often changed people's call times because they planned calls in relation to the geography of clients' homes. One staff member said, "I don't have enough time between calls because of where clients live. So, I plan my calls around the geography of clients' homes."

The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were effectively deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider did not have safe recruitment practices at the service. The provider had not always ensured they had gathered enough information about staff prior to employing them. This meant there was a risk of staff working at the service without the appropriate skills and experience.
• We found that application forms were not completed in full. The provider had not explored the reasons for gaps in education and employment histories.
• We saw that the provider had failed to ensure that two adequate references were obtained in line with their

recruitment policy. For example, for one particular staff member, the provider had obtained one reference, however, the referee had the same surname as staff member.
• The provider had failed to ensure that they had conducted thorough checks to confirm the identity of staff they employed. For example, there was a photograph on a staff file that did not match the rest of their photographic documents. Therefore, we were unable to determine that the photograph belonged to the staff member or another person.

Recruitment practices were not safe. Although we found no evidence that people had been harmed this was a breach of regulation 19 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 always protected against the risk of abuse. Relatives told us that they did not always feel safe. One relative told us that they only felt their relative was safe, "Because someone is always in the house." Another relative said, "I don't think my [relative] is safe in their care really. Whenever they have had to go to A&E, there has been no sense of urgency, [staff] have to call the manager for permission to act and then take ages to do things."
• There was not a robust system to record, investigate and monitor accidents and incidents. There was no detailed information about accidents and incidents, which included what happened, what the outcome was and what follow up actions had been taken.
• We saw that the provider had failed to carry out analysis of any trends to identify areas in the service where lessons could be learnt and disseminated to staff, so there could be a positive impact in improving people's experience of the care they received.

Preventing and controlling infection
• Infection control was not always appropriately managed and required improvement to ensure people were safe from the risks of infection. We received mixed feedback from people their relatives about staff wearing PPE.
• Some people and relatives told us that staff sometimes wore PPE or not at all, while other people and their relatives said that staff always wore PPE.
• The registered manager told us that they dropped PPE off to each person's house to ensure it was available to staff on calls.

Inadequate

Is the service effective?

Our findings

Effective – this means 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 inspection this key question was rated as Good. At this inspection this key has deteriorated to Inadequate. This meant that people's outcomes were not consistently good.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not always fully assessed. The provider did not complete comprehensive assessments for people they supported. There was no overview of people's care needs in care plans which did not support staff to fully understand people's needs.
• Referral information from the local authority that commissioned the service were not always used to produce individual care plans so that staff had the appropriate information to meet people's individual needs effectively.
• People's care plans only consisted of a list of tasks staff were required to carry out. Therefore, people's needs were not always accurately assessed and documented in their care plans.

• Care plans failed to address people's emotional and behavioural needs in assessments and care plans. There was a lack of guidance and strategies in place for dealing with people's behaviours to ensure people were kept safe.

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

Staff support: induction, training, skills and experience
• Staff were not always sufficiently skilled or competent for their roles. The provider could not evidence that where it was needed, staff who worked independently and without supervision in the homes of vulnerable service users had received PEG (percutaneous endoscopic gastrostomy) training to meet service users' needs safely. This placed people at risk of unsafe care
• Staff were not supported through regular supervisions. Out of the 14 staff files we reviewed we saw that seven staff members did have any supervisions within the last year. Staff we spoke with told us that they did not have regular supervisions. Two of the staff members we spoke with told us, "I don't have supervisions." This meant, staff did not have a formal process between staff and managers where staff can review their workload, monitor and review performance, and identify any learning and development opportunities.

This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough with choice in a balanced diet
• People were not always supported to eat and drink a balanced diet. We saw care records failed to document any cultural food requirements people had to support staff to meet these needs.

• People and their relatives told us that they were not always supported with meals adequately.
One relative told us, "[Staff] should be preparing breakfast [for my relative] but they clearly aren't. No evidence is found even if it's been prepared and not eaten…. They can't force [my relative] to eat I understand that, but at least prepare it. If it's in front of [my relative] they might eat it".
• Another relative said, "[Staff] do breakfast and it's in the care plan that they do other meals as well. But a few weeks ago, when I mentioned my [relative's] lunch, the carer said, 'we only do breakfast'. I had to show them the care plan to remind them. Basically, I think they [staff] just wanted to rush off".

The failure to ensure people's nutritional and hydration needs were met is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were not always supported to live healthier lives as staff were did not have detailed information about people's specific health and medical needs. This required improvement.

• People's care plans were ineffective and failed to clearly document the support people required to maintain their health and wellbeing.

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 and saw the service was working within the principles of the MCA

• The manager and staff had an understanding of the MCA and when it should be applied. Staff completed training to help them understand the principles of the MCA. They understood the importance of gaining people's consent before providing care and support and promoting people's rights and choices.

• People were encouraged to make all decisions for themselves. The registered manager knew that if a person did not have the capacity to make a decision it could be made in the person's best interests by relatives, healthcare professionals and others involved in the person's care.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection the rating has deteriorated to requires improvement. This meant people were not well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity were not always respected. People and relatives told us that people's privacy and dignity was not always maintained and independence was not always encouraged. One person said, "My bed is dirty, they don't change it for me." A relative told us, "A new carer came with a regular carer, they showered my [relative], they left the door open. I asked them to shut the door." Another relative said, "There was a time my [relative] was on the floor and the carer didn't attempt to pick my [relative] up, just asked what are you doing on the floor. My [relative] was really upset." A third relative said, "[Staff] don't encourage my [relative] to do anything."
• Care records did not detail what people could and could not do for themselves or give staff specific guidance on how to support people to encourage or maintain their independence.

The failure to ensure people were always treated with compassion, dignity and respect was a breach of Regulation 10 of the HSCA 2008 dignity and respect.

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

• People and/or their relatives were not supported to be involved in decisions about their care.

• Care records did not capture any preferences about people's culture and religion.

• Care records did not always contain enough detail about people's daily care personal care preferences. For example, care records briefly stated, 'Support with personal care: Washing and dressing'.' So, there was not guidance for staff about whether people preferred to have a bath or shower or if they liked to choose their clothes for the day.

The above issues amount to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• People were not always well treated and respected. Some people and their relatives told us that they did not feel that staff were caring and kind and that they did not feel well supported because their care teams were inconsistent. One person told us they felt rushed by staff quite often, especially at the weekend. They said "[Staff] rush when they come in and they are in a rush until they go.' Another person said, "What [staff]

are doing for me is not what I need. If I say anything to the carers, things don't change." One relative told us, "My [relative] has complained to me that they are rough don't treat her well" One relative told us, "[Staff] aren't particularly nice to him; they just do his care. They don't try to stimulate him by chatting".
• Some people told us that individual staff showed people that they were kind and caring. Notwithstanding the positive feedback, we were concerned that staff shortages impacted on people being cared for with dignity and respect and receiving support in line with their needs.

• Issues with people's needs not being fully assessed prior to joining the service, the lack of risk assessments, and lack of supervision of staff along with lack of management oversight meant improvements were needed to ensure people were well cared for and received a good standard of care.
• People's cultural needs had not always been explored and documented in people's care plans, this included the food they liked and the language they were able to communicate in.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection the rating has deteriorated to requires improvement. This meant people did not feel well-supported, cared for or treated with dignity and respect.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences End of life care and support
• People did not always receive personalised care that met their needs and preferences

• People and their relatives told us that they were not involved in the planning of their care, nor was there any evidence of this documented in people's records
• One relative said, "We weren't involved in setting up [my relative's] care plan, the hospital did that" Another relative said, "We were trying to set up a new care plan, the manager was very abrupt and rude, they kept shouting us down. We took it to their boss and then that person resigned. There has been no progress since then.'.
• Care records were not regularly reviewed or updated if someone's needs changed. One person's records stated, 'Carers to moisturise' rather than accurately reflecting their current care needs putting people at risk of not getting the correct support.
• Care records contained either brief or no background information about people so care staff could know more about the person they were supporting.
• Care plans failed to document people's individual needs, personal histories, allergies, likes and dislikes. There was no guidance for staff on how to support people with their individual needs effectively.

• Care records did not contain advance decisions about people's choices about the end of their life. The registered manager told us that they had not explored this with people where appropriate.

The above issues amount to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (AIS). 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.

• People's communication needs had not been assessed. There were no individual communication plans detailing people's preferred method of communication or the support their required. This included the approach to use for different situations and depending on their cognitive ability.

• The provider failed to ensure there was an AIS policy in place, this meant people were at risk of not having their communication needs met.
• There was no information available in different formats should people need it to meet their personal needs. The registered manager was not aware of the AIS and told us that information was not available in different formats.

Improving care quality in response to complaints or concerns
• The provider did not have a robust system in place to handle complaints effectively. Not all complaints, including verbal, were logged and investigated in line with the provider's complaints procedure. This meant people did not always receive a response to their complaint within the timescale specified by the provider's policy.
• We asked relatives how complaints were dealt with. One relative said, "They are not. I have to communicate with the carers as management don't contact me." Another relative said, "If you complain, nothing changes." A third relative said, "I haven't seen any information about making complaints."

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means 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 inspection this key question was rated as Good. At this inspection the rating has deteriorated to Inadequate. This meant people did not feel well-supported, cared for or treated with dignity and respect.

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

• People did not receive a service that was well-led. The registered manager did not have an adequate understanding of their role, regulatory requirements and lacked oversight of the service. The provider had not effectively identified issues that we found at the inspection and people were exposed to unsafe care and treatment.
• The registered manager was unaware of the issues identified during the inspection, regarding the lack of risk assessments, ineffective care plans, poor recruitment processes and accident and incident records, inadequate staffing levels and absence of staff competency assessments.

• The registered manager lacked awareness of their statutory responsibilities in relation to safeguarding and legal requirements. Statutory notifications to inform CQC of certain changes, events and incidents that affected their service or people, had not been sent in line with regulatory requirements or in a timely way.

• Monitoring systems had not been put in place to ensure effective oversight of the service. This meant the provider had failed to ensure they operated effective systems to assess and improve the care provided.

• Risks relating to medicines, Parkinson's disease, diabetes, choking, falls, seizures, pressure sores and moving and handling were not being addressed safely and effectively by the provider.
• Accidents and incidents were logged, however the provider failed to carry out any analysis and disseminate any learning to staff on how to minimise these in the future.

• The provider had failed to carry out regular audits to identify issues. For example, since our last inspection in January 2019, there were no regular medicine audits carried out for all people using the service. The medicine audits we saw for one person for May to June 2022 and July to August 2022, did not identify the shortfalls we found with medicines at the inspection.
• There were no audits carried out in relation to care plan audits, staff files, daily notes and communication books, to identify shortfalls and drive improvements.
• We saw that out of the 14 staff files we reviewed, only two staff members had a spot check, on 22 June 2022 and 22 March 2022 respectively. This meant that the provider could not be assured that all staff were competent to carry out their remit.
• Although the staff files we reviewed recorded the mandatory training staff had received, the provider did not record dates for refresher training. Therefore, there was no oversight of when this training was due to

ensure that staff skills and knowledge was kept up to date to meet people's needs effectively.

The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider did not have systems in place that supported staff, people and relatives to be fully involved in people's care. The registered manager had held three staff meetings since our last inspection in January 2020. The provider could not provide records to show that all staff had attended or that all staff had read the minutes of meetings. The minutes of the meetings also did not show that learning had been disseminated to all staff. This meant staff were not supported through regular staff meetings and their feedback was not obtained to drive improvements.
• People and relatives, we spoke with told us that they had not been asked for feedback about the service they received. This meant people and their relatives did not have a regular opportunity to provide feedback about the service to help drive improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and understands and acts on duty of candour responsibility when things go wrong
• People did not always receive good outcomes. At the time of the inspection the service did not have an embedded culture that looked to achieve positive outcomes for people.

• The registered manager had failed to demonstrate clear and accurate records were maintained to provide staff with robust guidance to ensure positive outcomes.

• Care plans were not comprehensive and failed to detail people's needs and preferences to ensure person-centred care and support was provided.
• Relatives we spoke with told us that communication with the management team was poor and this needed improvement.
• People were supported by a service that did not have adequate understanding of the duty of candour. The registered manager was unable to identify the appropriate steps to follow when things went wrong. We have signposted the registered manager to the Care Quality Commission Regulations for further information.

Working in partnership with others.
• The service worked with the local authority, who had been supporting the service to drive improvements since June 2022, at the time of our inspection we saw that improvements had not been made.

The above issues meant that the provider's systems to assess, monitor and improve the service were not effective. The above issues were a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People's needs were not always assessed and care plans were not person-centred People or their relatives were not involved in planning their care needs

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People dignity and privacy was not always maintained

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have a robust complaints process in place