BBC Care Service Limited

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Inspection report

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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
BBC Care Service Limited is a domiciliary care agency in Chertsey providing support with personal care to people who live in their own houses and flats. At the time of the inspection the agency supported 12 people in different geographical areas of Surrey. Both older and younger adults living with physical support needs, some of whom also live with dementia, learning disabilities and/or autism were supported by the agency.

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 told us they did not always receive their care as planned, care visits were late or missed, or did not last as long as they should have. People felt overall safe with staff but did not feel they received personalised care, as not all staff knew their needs. Not all staff provided caring and compassionate support.

New staff pre-employment checks were not always carried out as per legal requirements. Not all staff who supported people with their medicines received appropriate training and competency checks.

People did not always feel their feedback and complaints were welcomed and listened to or acted upon. The registered manager failed to have a good oversight of the care people received and to action concerns raised effectively.

The governance systems and processes in the service were not implemented successfully to enable continuous improvement of the service. Hence, people's feedback was not always actioned putting people at risk of distress and harm.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: Model of care and setting maximises people's choice, control and Independence;
The level of care was determined by people's support needs and to compensate what was currently being provided by family and other professionals. However, the agreements on when people would receive care and for how long were not always adhered to by the agency.

Right care: Care is person-centred and promotes people's dignity, privacy and human rights;
People had individual care plans in place and some of their wishes and preferences were recorded and known to staff. However, people's care records were not always detailed enough and robust to ensure all their personal needs were considered by staff when supporting them. Due to that and the issues with staff attendance on the care visits, people did not always receive personalised care.

Right culture: Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives
People's experience of care was inconsistent, some told us they did not feel listened to by the registered manager when they raised concerns or suggestions. There was limited assurance on how the registered manager monitored the quality and safety of the care people received on a day to day basis.

We found no evidence that people were harmed but these shortfalls put them at increased risk. We discussed these concerns with the registered manager who was responsive to feedback and started making changes to how the care was monitored and organised to improve it for people.

Staff received basic training and felt supported by the manager but further training specific to people's individual needs was required as not all people felt staff were competent for their roles and knew their needs well.

People had care plans in place but those did not always consistently assess and address their specific needs, wishes and preferences.

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; the policies and systems in the service supported this practice.

People overall felt staff asked for their consent before providing care. However, we identified improvement needs in how the service implemented Mental Capacity Act 2005 guidance to protect people's rights.

Staff knew how to protect people from the spread of the infections. The service worked in partnership with other health and social care services.

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

Rating at last inspection
This service was registered with us on 11 March 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the timeliness and quality of the care visits provided by the agency and partly as the service had not been inspected since its registration. A decision was made for us to continue with the inspection as planned and to inspect and examine those risks.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, fit and proper persons employed, assessing risks to people and safe use of medicines, need for consent, person-centred care, receiving and acting on complaints and good governance at this inspection.

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

Follow up
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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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**

BBC Care Service 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 Health and Social Care Act 2008.

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

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and the registered manager is often working outside of the registered office. We wanted to make sure they were present in the registered office to support the inspection.

Inspection activity started on 15 March and ended on 22 March 2022. We visited the location's office on 15 and 18 March 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people and three relatives of the people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager, care coordinator and care staff.

We reviewed a range of records. This included four people's care plans, one person's medicines records and daily care records. We looked at recruitment checks and training records for two staff members. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed the action plan and further care and medicines records provided by the registered manager following the inspection.

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 of 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

● Staff were not deployed effectively to provide people with the care they needed. People's relatives told us they did not always receive their care as planned. One relative said, "[Person] has a big issue with [staff's] time keeping. They don't come on time and they don't keep to their word." They went on to explain this meant the person missed an important appointment, telling us, "They were told umpteen times to be here on time and they still couldn't manage it." Another relative said, "There have been a couple of incidents that I've had to phone the office for as nobody showed up on Saturday and nobody called us." A third relative said, "I get angry when they come whenever they feel like it."

● People's relatives told us people did not always receive care for as long as it was agreed or needed for them. One relative said, "There have been some missed calls. They've only called through once with their lateness." Relatives told us staff were rushing with care and wanted to, "Get out [person's house] as quickly as possible." People's relatives commented this increased people's anxiety and had a negative impact on them. This was also confirmed in the local authority feedback we received about the agency.

● The registered manager implemented a monitoring system following local authority's feedback but it was not fit for purpose and did not enable them to effectively monitor staff's attendance. For example, although staff had to now log on the electronic devices when on duty, the system used could not confirm staff were actually visiting people at that time, where they were and at what time. Staff were not always logging in for duty either due to connection or other IT issues. The registered manager was not always aware if staff visited and if any visits were late. This was confirmed in people's daily care records we reviewed.

The provider had failed to ensure there were always enough staff deployed to support people which put people at risk. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had systems in place to safely recruit new staff but did not follow them. For example, DBS checks and obtaining references for prospective employees were part of the pre-recruitment checks as per the provider's policy. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● However, the provider could not locate full evidence of pre-employment checks for staff whose records we reviewed. For example, one person's DBS was not verified online prior to them starting employment. There was no evidence of the registered manager checking staff's employment history and obtaining any references. They could not evidence how they mitigated any risks when staff could not provide suitable references. There were no records of staff interviews, induction training, or how the registered manager monitored their performance since they started working with people. This could impact on people as there

were insufficient pre-employment checks, as well as systems of monitoring staff's performance when staff were lone working most of the time.

Following the inspection, the registered manager advised us they had reviewed staff records to ensure all appropriate checks were completed. We will review this at the next inspection.

The provider had failed to effectively operate their recruitment procedures which put people at risk. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to people were not always consistently managed, recognised and addressed clearly in their care plans. It was not always clear how many staff were required to support people or what support was needed during the care visit to mitigate any identified risk. For example, one person was assessed to be at specific risk around their eating and medicines but there was no plan on how staff should address those or what they needed to escalate to others involved in their care. This person was at high risk and required hospital treatment at certain times.

● When people were diagnosed with specific health conditions, their care plans did not always explain those to staff and did not fully inform staff on how to provide safe and comfortable support. The provider also failed to consult timely around the management of individual risks when they were recognised by them. This led to one person being supported in a potentially unsafe way with their mobility.

● Staff confirmed they were aware of the care plans but could provide limited assurance on how they supported people around their individual risks. Staff told us they would mostly ask people what support they needed and could ask the office staff for support. One staff said, "We just have to be vigilant; no accident comes without warning." As the care plans provided limited guidance for staff and there was no evidence of staff completing any needs- specific training, this could pose risks to people if staff did not recognise changes in their needs timely.

● We received mixed feedback from people and their relatives on how staff supported them to keep safe. Some people told us staff knew how to recognise and how to help them when, for example, they were unwell. Others told us staff did not know the care plans and failed to support people safely and comfortably for them. The impact on people was minimised as the agency provided only parts of their care and most people were supported by their families to keep well overall.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who may be at risk which arise from the carrying on of the regulated activity. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff did not always support people safely with their medicines. At the time of the inspection, the agency supported only a small number of people with their medicines. It was not always clear from people's care plans what level of support they required around their medicines and what happened if they needed their medicines in between the care visits.

● Staff did not always keep accurate record of the support they provided with medicines. Although staff signed medicines administration records for some people, they were not always completed correctly and there was no information on what medicines people were supposed to take and any risks involved. The registered manager reviewed that following the inspection and added information on people's medicines into their care plans.

● Not all staff supporting people with their medicines received training to do so and were competency checked. One staff member told us they thought it was not required as the person they supported had their medicines in specific packaging. This was in contradiction to the provider's medicines management policy and the national best practice guidance on supporting people in the community with their medicines. People were at risk of not receiving their medicines as prescribed.

Following the inspection, the registered manager advised us that all staff would be undergoing training in the safe handling of medication, and that a process to audit and safely manage medicines would be implemented. We will review this at the next inspection.

The provider had failed to safely support people with their medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Opportunities to act on changing risks to people, any adverse events and feedback of concern could be missed. The registered manager told us there were no incidents, accidents or other concerns recorded since the agency re-started providing people with personal care support in January 2022. They also made us aware of some concerns they reported to the local authority, some feedback of concern they received from people's relatives and the local authority.

● Due to lack of robust records it was unclear how the registered manager analysed and investigated those events and concerns. They could explain to us some actions they took to minimise risks to people and learn from those incidents.

● For example, they identified the need to better monitor staff attendance on the care visits and took some action to address that by improving their monitoring systems and equipping staff with appropriate devices to enable real time monitoring. This action had not been successfully completed yet. The registered manager also told us how in some cases they had escalated concerns to other health and social care services and worked with them to review people's care to protect their health and wellbeing.

● We discussed our findings with the registered manager who told us they now worked closely with the local authority on completing investigations into the recent events. We have referred to this more in our key question of Well-led.

Systems and processes to safeguard people from the risk of abuse

● Although people told us they felt safe with staff, improvement was needed in how the registered manager acted on and recorded safeguarding concerns. One person told us, "I feel completely safe [with staff]."

● We saw evidence of the registered manager reporting concerns to social services or other external partners but they did not always follow the correct multiagency process and their own policy on reporting those to the local authority.

● Where the registered manager reported concerns to the local authority, there was limited assurance on action they took to mitigate risks to people and they did not always identify safeguarding concerns appropriately, for example when care visits were allegedly missed.

● We addressed this with the registered manager at the time of the inspection and they assured us they had been responsive to the local authority safeguarding team's feedback. They showed us they now worked closely with the local authority and planned to improve on their reporting and recording of safeguarding concerns in line with their policy.

● Staff received recent safeguarding training and knew how to recognise abuse. Staff told us they would report any concerns to the registered manager and they were confident the manager would took action and share the information externally when needed to protect people.

Preventing and controlling infection

- People overall told us staff wore personal protective equipment (PPE) when visiting them. One person told us, "Everyone [staff] wears the right PPE".
- Staff received recent training in infection prevention and control and told us they felt supported by the registered manager around access to PPE and COVID-19 testing.
- The provider had appropriate plans and risk assessment in place around 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 particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● Although some people told us staff asked for consent before providing care, MCA Code of practice was not followed by the provider. The registered manager had limited knowledge around MCA and this impacted their assessments which were not always in line with the MCA 2005 Code of practice. Records around people's consent and mental capacity were either not kept or not consistent with the MCA Code of practice.
● For example, people's care plans stated they might have lacked capacity to consent for their care but there was no capacity assessments or best interests' decisions recorded in their individual cases.
● Where people were said to have legal representation, the provider failed to complete appropriate checks around who represented them. Most of the consent records were not signed by people or annotated on how they provided their consent for care.
● Some people told us staff asked for their consent before providing care. One person said, "[Staff] always ask consent and ask what I want to do or if there is anything else they can do". Staff confirmed they would ask for consent and be led by people around what they needed support with.
● Due to the lack of appropriate systems to ensure people's consent was sought and capacity assessed when needed, people were at increased risk of their rights not being protected effectively.

Following the inspection, the registered manager advised us they completed additional training in Mental Capacity Act 2005 and reviewed people's care records. We will review this at the next inspection.

The provider had failed to act in line with the Mental Capacity Act 2005 and the related code of practice. 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

● The registered manager did not always consider all relevant information about people's needs, wishes and preferences when assessing their care. The registered manager completed initial visits to people's homes to discuss what care they would wish to have and completed appropriate risk assessments of their individual needs and home environment. One relative confirmed this, "Somebody came around in the beginning to talk about the care plan."

●Those assessments were not always consistent and fully informed by people's social care plans. The registered manager failed to gather all information required to complete robust review of people's needs despite some initial information received from social services suggesting people had complex needs.

● For example, some people lived with specific health conditions which could affect their physical and emotional wellbeing. The registered manager failed to enquire around these conditions to ensure staff were competent to provide safe support and knew how the person and their support could be affected. Where people might have lived with learning disabilities and/or autism, the registered manager failed to consider the Right support, right care, right culture statutory guidance.

● We fed this back to the registered manager who said us they would make further enquires with people, their supporters and social services to address those gaps.

The provider had failed to ensure the care provided to people was always appropriate and 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.

Staff support: induction, training, skills and experience

● Staff completed basic training preparing them for their roles, although they did not receive any specific training around people's needs and their training records at the point of induction were not maintained. Staff did not receive any specific training around supporting people living with learning disabilities and/or autism or supporting people living with dementia although they provided care to people with those needs. Their competencies in respect of moving and handling or medicines administration were not checked at the point of the inspection. Some staff received training in their previous roles in social care.

● Although the registered manager and staff told us they received support and training within their induction, there were no records confirming that. There was no evidence of staff completing the Care Certificate where required. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● We received mixed feedback from people and their relatives around the competence of staff. One person said, "They seemed to be well trained, everyone knows what they're doing." Others raised concerns around some staff's practice and understanding of the care standards, for example, around helping people with personal care.

● The registered manager took some action to ensure staff were competent for their roles. For example, they provided staff with basic training refresher course shortly before the inspection and planned further face to face training including competency assessments for the following week.

The provider had failed to ensure there were always enough suitably qualified, competent, skilled and experienced staff deployed to support people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Most people required only minimal support around their meals and drinks. Where needed, those needs were included in their care plans and staff provided support.

● People's preferences around their drinks and meals were included in their care plans.

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

● Staff knew when to escalate concerns around people's health and how to do that. People told us in general they felt staff would know when and how to help them to contact health services, for example their GP or an ambulance.

● The management team completed referrals to other health services when needed and worked with other professionals involved in people's care, for example, community nurses, hospice or social 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

- Staff were not consistently caring and understanding towards people. We received mixed feedback from people and their relatives around the attitudes of staff and their practice. One relative told us, "I don't think they treat [person] with dignity" and went on to explain this was due to how the care call was managed by staff and what effect it had on person's wellbeing. They added however that some carers knew the person well and were kind and caring.
- Another relative said, "I'm not happy with some of the carers" and went on to explain what care was required by their loved one. They commented, "But [staff] are trying to get out (as quickly as possible). There is usually someone outside waiting in the car, beeping and revving the engine and flashing lights. It's such a nuisance to the neighbours". A third relative told us, "I'm having to shadow some of the staff. I don't think they treat him with dignity."
- Some people who were supported by more consistent staff were happy with how they were treated. One person said, "I'm not the chattiest, but I find them to be nice and friendly and we will talk if I'm feeling up to it. The ones who see me regularly treat me with respect." A relative said, "Some [staff] do well to encourage [person's] independence."
- We discussed this feedback with the registered manager who said they increased monitoring calls to people to better act on their feedback and monitor staff's practice to ensure people received kind and compassionate care.

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

- People did not always feel involved in the care they were receiving. Some people told us they took part in creating and reviewing their care plans and felt listened to. One person said, "I've seen the care package. I haven't made any changes". A relative of a person receiving care commented, "We've got a big book, and I check that it is filled out".
- Not all people had the same positive experience. One relative told us, "We've never been involved with the decision making. They just crack on and do it."
- Following the inspection, we received assurances from the registered manager on how they increased monitoring of people's care and how they would involve them more effectively.

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 requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People's care was not consistently personalised, although their care plans included information about some of their preferences and wishes. One relative said, "We've told them what [person] likes and dislikes, they don't always listen" and added, "So much needs improving. [Staff] need to turn up, read the care plan and know [person's] needs." The relative also said, "We've asked for the same carers to come around – so they know to [care for the person in a specific way]. With some of the new [staff], [person] has to tell them to slow down."
- Another relative told us how inconsistent care visits not adhering to the agreed times impacted on the personalisation of the care received by their loved one. For example, they felt the person was treated like a child as support to get ready for the night was provided too early. We were made aware prior to the inspection other people terminated their care with the agency due to lack of personalised care provided in a timely way as agreed in individual care plans.

Following the inspection, the registered manager advised us they sought people's feedback on their care to review and personalise their care plans. They also planned regular reviews of people's care in the future. We will review this at the next inspection.

The provider had failed to ensure the care provided was always appropriate and reflected people's preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager discussed some of people's preferences with them. For example, people care plans included information around their life story, people important to them, their preferred items of clothing, food and drink.
- The service was not currently providing any end of life care to anyone.

Improving care quality in response to complaints or concerns

- People told us they did not always feel their complaints were listened to or their feedback welcomed and actioned by the registered manager. One relative told us they felt threatened by the registered manager's response to their concerns and they were not offered any solution to their concern. The local authority shared with us information on other complaints which were not resolved by the agency.
- The provider had a complaints policy which was robust and clear. However, they failed to follow that policy and there were no records of complaints or action taken following concerns raised by people or relatives. The registered manager told us there were no complaints raised to them which was contradictory

to people's and their relative's feedback we received.
● Following the inspection, the registered manager provided us with their action plan on how they would encourage people to share feedback and act on complaints. They also worked with the local authority to respond to one of the complaints and implemented a complaint investigation record.

The provider had failed to operate an effective system to identify, receive, record, handle and respond to complaints. This was a breach of regulation 16 (Receiving and acting on complaints) 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. 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.

● Staff knew how to communicate with people although there was limited information on people's individual communication needs in their care plans. For example, one staff member explained to us how they gave time to a person who needed it to express themselves and how they would simplify the language they used and slowed down their communication to enable the person to understand better.
● People told us they were overall happy with how staff communicated with them. One person said, "I'm happy with the communication." The registered manager explained to us how they worked with another person's relative to enable better communication during the care visits.
● The registered manager was not fully aware of the Accessible Information Standard but confirmed people would be supported with different ways of communication if needed and they would ensure appropriate language and format of information was available for people.

Following the inspection, the registered manager advised us they included AIS in how they responded to complaints. We will review this at the next inspection.

We recommend the registered manager reviews their responsibilities under the Accessible Information Standard requirements.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Staff did not provide any specific support to people around their interests, hobbies or relationships as this was not a part of their care plan. Care plans included information on things people enjoyed doing and people important to them.
● Staff knew who was in people's support network and what relationships were important to them and commented they would offer support to people to contact their loved ones or to do what they wanted should that be required. Staff also knew when to communicate with other health and social care professionals should people require more support in this area of their lives.

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

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

- The registered manager did not use the governance systems and processes they assured CQC of at the point of their registration effectively. For example, although they told us on the inspection, they carried out spot checks of people's care and staff practice, there was no record of this and how this was monitored or what action was taken to address any shortfalls identified. People told us this impacted on their care, causing distress for some and posing a risk of harm if not for the support they received from their relatives and other services.
- The registered manager had systems and policies in place around management of incidents and accidents, safeguarding, medicines administration and complaints. However, they failed to implement those policies effectively. For example, no incidents and accidents, safeguarding concerns or complaints were recorded and there was no evidence of investigation or action taken to improve people's care. Hence, some people continued to complain around the care they received, and others changed their care provider.
- There were no audits or checks recorded in other areas of the quality and safety of the service such as staff recruitment or training. Some records could not be easily located by the registered manager at the time of the inspection. This included people's care plans, staff pre-employment checks and service policies.
- The registered manager did not maintain a good oversight of the day to day care provision. People's daily records we reviewed showed inconsistencies in the times of the visits and lack of record for some visits as planned which were not spotted by the registered manager as no auditing took place since people started using the service. People were at risk of not receiving their care as required which could pose a risk of harm.
- In response to the local authority feedback the registered manager implemented a care visit monitoring system. However, this was ineffective in monitoring staff attendance on care visits at the time of the inspection and no contingency actions were implemented prior to our feedback.
- There was no continuous improvement action plan for the service at the point of inspection and there were significant gaps in the business contingency plan around how risks to people's care provision would be managed.

Following the inspection, we were advised by the registered manager about action they took to monitor people's care going forward. For example, they advised us they implemented telephone and in person spot checks and contacted people to seek their feedback and to make necessary improvements. They also advised they had reviewed their governance systems, contingency plans and recording systems to make necessary improvements.

The provider had failed to establish and operate effective governance systems which impacted on people's care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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;

- People told us, although some of them knew the registered manager, communication was not always easy and they did not feel the service was well-managed. One relative said, "I've only got one number, and I can't understand what they're saying to a degree". Another relative said, "I don't think the service is well-managed at all. I haven't got a clue who the manager is, the communication is very poor".
- The culture of the service did not always promote person-centred care for people. One relative said, "I'm very unhappy. [Person] is lucky I'm fighting their corner. What about the other poor people? What way are they treating them?". Another person said, "They [staff] don't do anything outstanding, but they don't do anything bad".
- People's care was affected by inconsistent timing of the care visits, inconsistent practice from staff and lack of good management oversight. Hence, people's outcomes differed and not all were happy with the care they received. Feedback form the local authority also suggested several people chose to leave and seek another care provision since they were supported by the agency.
- We identified concerns around how the registered manager used their governance systems to receive and act on people's feedback. One relative commented how their complaint was received, "The manager gets aggressive if I call and recently said that she was going to refuse our care".
- People told us they were not asked about their feedback on care and had limited opportunities to provide it. One relative said, "I have never filled in a survey."; and commented on things they would like to improve but were not able to or asked to share with the provider. There were no records of how people's feedback was gathered, acted upon and used to improve the care they received and the overall service.

The provider had failed to establish and operate effective governance systems which impacted on people's care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The provider worked in partnership with local social services, hospitals and health services where needed.
- When people received support from community nursing teams or other care services, the registered manager was aware of that and communicated with them around people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care provided was always appropriate and reflected people's preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in line with the Mental Capacity Act 2005 and the related code of practice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to safely support people with their medicines.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to operate an effective system to identify, receive, record, handle and respond to complaints.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to effectively operate their recruitment procedures which put people at risk.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate effective governance systems which impacted on people's care. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were always enough staff deployed to support people which put people at risk.

The enforcement action we took:

Warning Notice