Sentricare Limited

Sentricare Birmingham

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

About the service
Sentricare is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection the provider initially told us there were 12 people using the service. However, due to information being shared with us by a whistle-blower, we later established we had been provided with incorrect information by the provider. Based on additional information shared with us by the provider, they provided a list of 88 people using the service. Again, during the inspection, we found this number was incorrect and had increased to at least 92 people using the service. We are still seeking clarification from the provider to establish the accurate number of people using the service. The service was providing support to children, older and younger adults, people living with; dementia; learning disabilities; autism; mental health conditions; physical disabilities and sensory impairments.

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

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support. Initially the provider told us they did not support any people who lacked capacity, had a learning disability or autism or expressed emotional distress. However, we identified that there were several people being supported by the provider who had multiple needs including those with a learning disability.

Right Support
People were not always supported to have maximum choice and control of their lives as they told us they were not routinely involved in care reviews and when they had raised concerns these had not been addressed. Staff did not always support them in the least restrictive way possible and in their best interests.

We found guidance within peoples care plans for staff members to follow when supporting autistic people or people with a learning disability who may express distress or frustration, was inadequate. Care plans and risk assessments did not provide staff with information on how to respond to such expressions of distress, how to de-escalate or how to provide positive re-enforcement.

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

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

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

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

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

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

There were systems in place for managing complaints, safeguarding concerns, accidents and incidents. However, these were only carried out for the 12 people we were initially told the provider supported. These did not include the monitoring for the additional 80 people, who received support. The main complaint raised by people and their family members continued to be in regard to lateness, shortness of calls and missed care calls. Staff attending people's homes remained inconsistent at times and their ability to communicate with people and their relatives was poor.

Based on our findings around the continual short, late and missed care calls, there continued not to be enough staff members deployed by the provider to support people. People were supported by staff to take their medicines, however, guidance in place was not clear for staff to follow. Records demonstrated that medicines were not always given as prescribed.

The provider had continued to fail to ensure appropriate pre-employment checks were in place to make sure newly recruited staff were suitable to carry out their role. Some people continued to tell us they felt staff members did not have appropriate skills and knowledge to support them how they wished.

Care plans and risk assessments continued to lack robust and clear guidance, with incorrect or conflicting information. Risks to people were not thoroughly assessed. Risk assessments continued to fail to direct staff on the action they should take in the event of a person becoming unwell or experiencing symptoms of known health conditions.

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

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

Rating at last inspection and update

The last rating for this service was inadequate (published 16 September 2022).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations and they had either not implemented or maintained the improvements they said they had made.

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

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

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

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

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

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

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Sentricare Birmingham

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors made a visit to the provider's office location and two inspectors made phone calls to people and relatives using the service and to staff to gain their feedback.

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

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

Notice of inspection
This inspection was announced. We gave the provider 48 hours' notice before attending the office location to ensure they were available to support us with the inspection.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also contacted commissioners of care services for their feedback. We

used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 7 relatives. We also spoke with 12 care staff, the care co-ordinator and the registered manager who is the provider. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider, following the site visits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection we found the provider had not made the necessary improvements and the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
At our last inspection the provider had failed to robustly assess the risks relating to the safety of people and learn from these. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13 - Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of abuse and neglect and were not consistently protected.
- At this inspection we continued to find, multiple examples of safeguarding concerns which had not been either identified, reported or actioned robustly. This included the impact of people being exposed to missed calls resulting in not receiving the correct level of support, short call, missed or late medication and missed meals or drinks and poor manual handling practices.
- Incidents were not consistently audited, recorded or acted on. This meant people using the service were placed at risk from potential further incidents, as concerns were not always identified and appropriate actions had not always been taken.
- Some staff continued not to always recognise abusive practice. This and poor systems meant staff and the registered manager had not taken action to safeguard people. For example; where calls were significantly late, close together or missed or when medicines had been given at incorrect times, no actions had been taken to ensure this did not occur again and reduce the potential harm to people.

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

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● At the last inspection some improvement was required to ensure people's care records identify the level of support they needed from staff with their medicines. At this inspection we found care plans and risk assessments remained inconsistent. These contained conflicting or inconsistent information to guide staff on the level of support people needed. This continued to place people at risk of not receiving their medicines, as prescribed.
● The provider had failed to make improvement to ensure people received their medication as prescribed. This was due to calls taking place at much later times than scheduled or staff simply not giving them or giving at the wrong time. This included medicine for the control of epilepsy, diabetes, heart conditions and Parkinson's Disease which should be administered at specific times. This continued poor administration of medicines could have long term effects on people's health conditions.
● The information for staff members to follow, for 'as required' medicines, to ensure a consistent approach, continued to not always be clear. Without clear protocols in place this could lead to staff not knowing when to give these medicines, leading to the potential for too much or too little medication to be given.
● For people who were prescribed creams, we saw these were still not consistently included on the Medication Administration Records (MAR). This meant people were at risk of their skin condition deteriorating. We also found that body maps were not consistently in place to provide staff with clear instructions on when, where or how the creams should be applied. This was of particular concern for one person who had a known skin condition and required creams to be applied to prevent further deterioration of their skin.
● Some people who staff supported with their prescribed medicines were happy with how this was managed. However, one relative told us, "Last year the carer was on holiday and arranged for her friend to do the call. She [the carer] had left [Name] medication in the bin outside to give to my relative." They told us their relative would not take the medication because they did not know the person.
● We found that electronic records often had 'No outcome' for medicines as staff had not completed the records. This meant is was not possible to corroborate if medication had been given by staff members from MAR records. One relative told us, "We had issues with medicines not been given, they were left in the blister pack. I tried to complain but they just made excuses. I asked them how they knew the medicines had been given and they said from the records completed. I told them they needed to go and check the blister packs."

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

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risks continued to not be effectively managed, this was also identified at the previous inspection.
● Risk assessments were either not in place or were not sufficiently detailed. For example, where risks to people was known due to their diagnosed health conditions, risk assessments and care plans were not consistently in place to guide staff on how to support people safely. We also found that when these should

have been reviewed and updated following changes to people's needs, this had not always happened and meant that people were not safe from the risk of harm.

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

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that people and staff continued to be placed at risk as the provider could not be assured staff were following safe practices adhering to the correct use and disposal of PPE. The provider had not carried out spot checks for all of their staff as part of their auditing processes and some people told us staff did not always wear PPE.

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

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

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19 – Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider's systems continued to be inadequate and were not robust enough to demonstrate recruitment was effectively managed. Safe recruitment practices were not always followed. Records demonstrated that at least two staff did not have a Disclosure and Barring Service (DBS) check prior to commencing employment. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Suitable references had not always been obtained for multiple staff members, full employment history had not been sought and gaps in employment had not been explored. This placed people at risk of harm from poorly managed recruitment systems and processes.

The provider failed to ensure they had obtained all the information required ensuring the suitability of all

staff employed. This meant people were placed at risk as the provider did not know if staff were suitable to support vulnerable people. This was a continued breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

● At this inspection people continued to tell us that often they did not receive their calls on time and regularly experienced short calls. We looked at a range of call records and staff rotas which confirmed these failings were taking place.
● Records showed that some people's care calls still continued to last for less than half of the required time. These records also demonstrated that some staff were recording they were in attendance of two calls at the same time, meaning these records were incorrect. For most people using the service we found the majority, frequently received late calls.
● Staff told us, and records confirmed that people who required two staff to support them often only one member of staff attended their call. Records demonstrated for one person this occurred on multiple occasions where only one carer attended a two person call. This meant that people were exposed to the risk of harm as the provider was not monitoring staff attendance for these people.
● Staff told us their allocated rotas continued to not always have travel time between calls or more than one call was scheduled at the same time. Rota's, we looked at confirmed this. This meant calls would either be shortened or late, impacting on the standard of support people received. In some cases, this resulted in missed calls.
● Some staff members continued to tell us they felt they could not raise concerns to the provider, about not managing to attend the calls as scheduled. They told us they feared they would lose their job. One staff member told us 'how they were not listened to' when they raised concerns about the number of calls, they were allocated in one day. One staff member had over fourteen hours' worth of calls allocated to attend to between the period of 08.00hrs – 21.00hrs. This occurred on multiple occasions. This demonstrated travel time and the full allocation of time is not factored into the rotas.
● One person told us, "They [care staff] have missed the call completely." This meant they had struggle to do their own food, drinks and medication, which care staff normally support with. They went on to tell us they were so unhappy with the service that they had given notice but had been told they could not leave the service without paying for the notice period and carers would still be sent. This was discussed with the provider who stated the person had not been told this by them.

The registered person did not ensure there were sufficient numbers of staff deployed effectively to meet people's care and treatment needs. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection the provider had failed to ensure people received support to meet their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9 - Person centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not consistently receive care that met their needs and preferences.
- At the last inspection people and relatives told us they were not involved in their initial assessments completed by the provider before starting to use the service nor on-going care reviews.
- At this inspection people and relatives continued to tell us they had not had care reviews or been involved in their care planning. However, when we returned to the office to continue with the inspection a couple of weeks later to follow up on concerns we had been told about, one relative told us, " I had a call from [Name] care co-ordinator who asked if they could book to come to do a review. A man turned up at [Name] relatives house, let themselves in and asked [Name] to sign papers – she didn't. We don't know who this man was."
- Most people continued to tell us that they did not receive their care at the times that they wanted or needed.
- People and relative's main concerns continued to be the missed calls, short length of calls and inconsistent call times. This left people at risk of neglect as they were unable to access food or medication. When we asked one person if staff turned up at the right time they said, "What is the right time, we don't know what the actual time is, it has been as late as 11.30hrs. This means mom won't have a drink until then and it is too long."
- The provider had failed to make improvements in reviewing people's care plans to ensure these continued to reflect people's needs. For example; one person's daily care records indicated staff were supporting the person using a hoist, however, this information was not recorded in their care plan or risk assessments. This meant people were at risk of not receiving care in the way they needed it.
- Some people and relatives told us that some staff members spoke in their own language and did not communicate with them. A relative told us they had complained about this and eventually they sent another staff member.

The provider did not ensure people's care was appropriate and met their needs. This was a continued

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

● Staff told us the care plans were accessible on the provider's computerised system.

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

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

● We continued to receive mixed feedback from people and relatives we spoke with. Whilst some were satisfied with the level of skill demonstrated by the staff, others felt there was a lack of training. A relative told us they did not feel the staff had appropriate experience or skills to support a person with their loved one's known support needs.
● People told us there were some issues with staff rushing resulting in support with transferring and mobility being rough at times.
● The provider had failed to assess the effectiveness of the training given to staff. For example, spot checks on staff skills were not always completed. People told us some staff rushed when supporting them with transfers or helping them with mobility. Whilst the provider's training records recorded all staff had completed practical moving and handling training, some staff told us they had never completed this.
● Feedback from staff continued to be mixed in regard to their training. Some staff told us when they first started working at the service, they received an induction. This included shadowing other staff members, on-line training and face to face training in the office. However, other staff members told us they had not received training only that which they had from previous employers.
● Staff did not always receive the support they needed for their job role. Whilst some staff told us they had one to one support meetings, others said they did not. Staff feedback about the quality of training and support was mixed. Some staff told us they were fearful of raising concerns to the provider about support needs for fear of being penalised or losing their jobs.
● Although some staff members understanding and communication in English was limited the training provided was predominately on-line which was presented in English and alternative formats still had not been provided. This meant some staff had not understood some important information.

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

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure people's consent was consistently gained prior to support being provided.
Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11 - Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

possible.

● People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.
● Following the initial inspection, the provider had commissioned the service of two, independent social workers to carryout needs assessments of people and sign documentation they had put in place. The purpose of this was to improve the providers understanding of people's support needs. However, we found these staff members had completed ReSPECT forms for some people using the service. ReSPECT forms (Recommended Summary Plan for Emergency Care and Treatment) are part of a process which helps create a personalised recommendation for people's clinical care in emergency situations where they are not able to make decisions or express their wishes. These staff members were not working in the capacity of which gave them the authority to complete such forms. They had not worked in partnership with people, their families or other health professionals.
● We found for people who were unable to make their own choices and decisions for themselves, the provider had still not explored or obtained evidence, that those making decisions on their behalf had the necessary legal authority to do so. This meant we could not be assured people were being supported in the least restrictive way and decisions were not being made on their behalf inappropriately.
● People and relatives consistently told us they had not been consulted or involved in developing their care plans. They also told us they had not been given the opportunity to read and consent to the information made available to staff members.
● People and relatives gave mixed feedback as to staff always seeking consent before providing care and support. Some people and relatives continued to tell us that at times, staff did not engage in communication with them at all. People told us this was either because of language barriers or lack of a caring approach. However, some people who had regular staff members gave more positive feedback and had good interactions with staff.

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

● Most staff we spoke with were able to give us examples of how they gained consent before supporting people with their care.

Supporting people to eat and drink enough to maintain a balanced diet
● Not all people we spoke with required support with meal preparation or assistance to eat. Where this support was offered feedback continued to be mixed. Due to late care calls, people's hydration and nutritional needs were not met. For example, where one person could not access their own drinks there were times, they went 16 hours between their last food and drink being offered to them.
● People's dietary needs were considered and assessed by the local authority however, information shared with staff members via care plans for some people, was still unclear for staff to follow. However, staff we spoke with knew how to support people with specific nutritional needs.
● Staff records indicated people had access to drinks and snacks before they left.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider and staff continued to be inconsistent in their approach in working in partnership with

people, their relatives and health and social care professionals.
● Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency.

Inadequate

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
At our last inspection the provider had failed to ensure all staff treated people with dignity and respect.

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

● The provider did not demonstrate a caring approach toward people using the service. At our last inspection, failings had been identified to them, but improvement had not been made. There were significant, on-going issues some people experienced around late, short and missed care calls. This meant people were often uncertain or anxious about when they would get their care.
● One relative said, "We didn't like the first carer and had a real battle to get them changed. She spoke on her phone in another language the entire time and mom was getting distressed." Another relative told us, "[Name] really likes this carer, he is challenging but she has the right approach. The last carer was so very rude. I made a complaint and was told her approach was due to her culture. I don't accept that, she was rude and did not care."
● Other people and relatives continued to tell us how they felt rushed by staff which meant they did not get the support they wanted in a dignified and respectful way. One person told us when asked if the staff stayed the full time, "No, never ever. The longest they (staff) stay is ten minutes, most only last seven minutes (call should last thirty minutes) All they do is make a drink put the meal in the microwave and go." At the last inspection this was bought to the attention of the nominated individual, who assured us they would remind all staff and re-visit dignity and respect training with staff members. We found these issues still continued.
● People's care plans included some information about their preferences and personal histories to help staff get to know them and how they liked to be supported. However, we found these still required improvements to give staff more detailed information, particularly for those people who have dementia and limited communication abilities.
● Whilst the provider positively employed staff from different cultural and religious backgrounds, this did not always lead to positive outcomes for people or their relatives. For example, whilst it was the provider's intention to allocate staff members from the either the same culture or ability to speak the same language as the person receiving the care and support, this did not always happen. At our last inspection, the provider told us improvement would be made, but people and their relatives told us they continued to have staff

members they could not effectively communicate with due to language barriers.
● Some people told us that staff did not always respect their privacy and dignity was not always promoted. Staff did not always ensure people and their personal living spaces were respected whilst supporting with their personal care. For example, another relative told us the staff member was continually on their telephone during the support they provided, speaking in their own language and not engaging with the person at all.

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

● Most staff we spoke with understood peoples' support needs and told us how they supported people to do as much for themselves as they were able to help them maintain some independence.

Supporting people to express their views and be involved in making decisions about their care
● People continued to tell us that care plans and care records were not easily accessible to them, these were held electronically. At the last inspection we discussed this with the nominated individual who explained they were happy to provide a paper copy of the care plan should people require this. We found at this inspection care plans still had not been made accessible to people by the provider.
● Many people continued to tell us at this inspection that care plans were not always developed with the involvement of people and their relatives and they had never been asked about their care needs and wishes. One relative told us, "[Name] had a man come (to the house) this week for a care review. The trouble is the man got her to sign lots of papers and she doesn't know what they were. I need to ring them to ask. We are worried about what she has signed. I don't know why they are asking her to sign forms after being here for 18 months." Another relative told us, "I have never been asked for feedback or asked to fill in a survey."

Inadequate

Is the service responsive?

Our findings

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

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

Improving care quality in response to complaints or concerns
At our last inspection the provider had failed to ensure people's complaints were listened to, acted on and responses provided.

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

● Information shared with us, from the provider, stated; 'We have a robust complaints procedure' Whilst a complaints policy was in place, complaints people and relatives told us they had raised had not been recorded, investigated or acted on. People and their relatives had not received any outcome from complaints they had made to the provider.
● People continued to tell us they were not confident that their concerns and complaints were listened to, acted on or led to any positive change in their care and support.
● People and relatives told us they were able to raise complaints with the service but not everyone was confident the issues would be dealt with. For example; people and relatives told us they had complained about short, missed and late calls and had not seen improvements in this area. For one person who raised concerns about calls taking place at the wrong times or being shorter than they should, this matter had not been addressed and calls continued to be short.
● Some people and relatives felt there was no point in making a complaint because action was not taken to resolve issues. One relative told us they had given up making complaints as no-one called them back and in the past nothing had changed.

The provider continued to fail to ensure people's complaints were listened to, acted on and responses provided. This was a continued breach of Regulation 16 (Receiving and acting on complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At the last inspection people told us the on-call systems were poor as when they needed to raise concerns, often they had no response out of office hours. At this inspection people told us they were able to speak to someone out of hours, if they needed to contact them and action was taken to address their concerns.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● The provider had failed to make necessary improvements to ensure people's plans of care were

personalised and reviewed as needs changed. People continued to feel that care was not responsive to their needs. For example; one person who had developed a pressure sore, their care plans and risk assessments did not reflect this change or details the support required.
● Whilst staff could tell us about people's needs and how they supported them, this was not reflected in the information in the care plan. This posed risks to people as they were not always supported by the same staff.

● People continued to feel the care and support was not responsive to their needs. They told us calls continued to take place at times to suit the service rather than when the person wanted or expected the call to take place.
● Staff told us, and we saw from care records they recognised when a person was unwell and required additional support such as a GP or ambulance. However, we found that when one person's skin condition deteriorated the provider told us he was not made aware of this. This meant not all staff identified concerns that needed to be acted on.

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.
● The provider's information return (PIR) stated. 'Our service always starts new care packages with a care needs and risk assessment. Part of the reason for this is to identify protected and other characteristics under the Equality Act which makes it necessary to remove barriers.'
● We found staff did not always have clear information about people's communication needs in order to ensure they were able to involve them in decisions.
● One person who was unable to communicate verbally to indicate their needs, wishes and feelings, we found they did not have a care plan in place to guide staff on what they should look for to identify if the person was happy, sad or in pain or how to respond to expressions of distress. This meant staff did not have enough information to support people in a person centred way.
● At the last inspection, people and relatives told us they had not been offered their care plans in an alternative format. For example, for people receiving support who are unable to read English, alternative formats had not been provided. At the last inspection we were told people would be made aware of alternative formats to meet their needs. At this inspection there were no examples of accessible information available.

End of life care and support
● At the time of the inspection, no one supported by the service was receiving end of life care.
● The provider told us they had commenced work developing people's care plans to ensure people's preferences and choices for their end of life care were acted on and they had the support they needed. However, these records demonstrated the provider had failed to act legally and ensure relevant health professionals and relatives, where appropriate, were involved in developing end of life care plans, in people's best interests. This is further reported on in our effective section of this report.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found the provider had failed to operate an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

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

● Since the last inspection, there had continued to be a failure by the provider to have adequate oversight of the service. The provider had previously told us they were also responsible for another location but could be contacted by telephone if needed. At this inspection we found there was insufficient managerial presence or oversight by the provider at this location. By their own admission, the provider told us they had not had good oversight of the service as they had delegated this task to a manager who had recently resigned. This had led to continued failings.
● Whilst a system was in place to undertake checks, this only covered the 12 people the provider initially told us they provided support to. It did not cover the other people, that is up to 88 people, that the service actually provided support to. However, this system was ineffective in the 12 people it covered.
● The provider's system of checks failed to identify the issues we found. For example, inaccurate and unclear information in people's care plans and insufficient detail in risk management plans.
● The provider's auditing of care calls taking place was ineffective. People had continued to experience late, short or missed calls through the lack of provider oversight of the service. The care call monitoring system was ineffective in that it enabled staff to log in and out of care calls when they were not in fact on the care call, but elsewhere. The provider had not acted on this to ensure improvement was made which meant records were inaccurate.
● The provider's staff recruitment quality checks had failed to identify poor practices that posed potential risks to people.
● The provider had failed to undertake an assessment of the effectiveness of staff training and had not always checked on staff's skills through spot checks. This lack of oversight had led to staff not always having the skills needed for their job role.
● The provider had failed to make the needed improvements in their safeguarding processes to ensure people were protected from the risks of abuse and where incidents happened that the correct actions were taken. We spoke with the provider about this but he told us he had delegated this task of auditing to the

manager who had recently resigned and he confirmed he had not had oversight of this.
● Improvement had not been made to the handling of complaints and the provider failed to use complaints as an opportunity to learn from and improve.
● We found that no audits were completed on care plans or risk assessments for the majority of people using the service. This meant people were placed at risk as the provider had no oversight and took no action when people's needs changed. Staff members did not have robust information to keep people safe.

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

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

● The provider was receptive to our feedback from the inspection however, they told us they had placed their trust in the manager of the service, although they were the registered manager, they had not had any oversight themselves. Following our inspection, we held a provider meeting, they shared further details of actions being taken to address these concerns, including people's late care calls.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care. However, the failings we found during this inspection are not reflective of such responsibilities.
● We found that the provider had failed to provide us with the full and correct details of all people using the service when we commenced the inspection.
● We were initially told the provider was only operating one care planner system at this location, when they were in fact operating two. The second system contained the names and details of the additional people we were not initially made aware of. The provider initially told us they could not access this second system, however, on the second day of our inspection they told us they did in fact have access.
● The provider continued to not fulfil this obligation with people using the service as they have not acted consistently on complaints and concerns raised

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Following the last inspection we were aware of concerns people had about the care and support they received. At this inspection those concerns we found to be on-going and had not been rectified.
● We continued to find from documentation and speaking to people, that the service did not always promote a person-centred approach. People's individual needs still continued to not always be considered

or met. Such as; Accessible Information Standard, communication and the impact of late, short or missed calls had on people's overall well-being.

● People and relatives continued to tell us they had not been invited to attend care reviews to discuss the continuing care and support required. Although following the start of this inspection the provider appointed two independent social workers to conduct assessments, the provider had not analysed this information. This meant the provider could still not be assured the care plans and risk assessments reflected people's current needs and wishes.

● Some staff we spoke with told us that they did not often see or speak with the registered manager and did not always feel supported by the management team. Some staff told us they were not approachable but other said they felt they were supportive.

● Spot checks to confirm staff were working in line with the provider's expectations had not routinely been completed for all staff. We saw some evidence that monitoring calls were made to a random sample of the 12 people to obtain direct feedback on how well staff were meeting their needs. However, such monitoring calls had not been made to any of the additional 80 people using the service.

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

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

● Quality surveys were not consistently sent to people and their relatives to invite their feedback on the service. We found that feedback had been sought from 12 of the 92 people using the service via telephone consultations. However, the provider had failed to gain feedback and analysis the responses, to improve the service for the additional people using the service.

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

● Care staff continued to not be consistently involved in meetings. This meant staff were not provided with important updates and involved in decisions about changes to ways of working.

● Some staff continued to tell us they did not always feel able to raise any concerns or worries they may have about the care provided. They told us they were fearful of losing their jobs as threats had been made by the provider when they had raised concerns about their rota's.

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

Working in partnership with others

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

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

This section is primarily information for the provider

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not operated in an open and transparent way about the level of service they

provided. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 1. The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. 2. Medicines management was not robust enough to demonstrate that medicines were managed safely at all times. 3. The provider did not have processes and systems in place to ensure that all staff met their responsibilities in relation to preventing and controlling infection. This meant people were placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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

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

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider continued to fail to ensure people's complaints were listened to, acted on and responses provided. This was a breach of regulation 16 (Receiving and acting on complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

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

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

The enforcement action we took:

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

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

The enforcement action we took:

Conditions have been imposed on the provider's registration.

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

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

The enforcement action we took:

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