G P Homecare Limited

Radis Community Care (Brunel Court)

Inspection report

Brunel Court
Nutfield Place
Portsmouth
PO1 4JB

Website: www.radis.co.uk

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18 April 2023
20 April 2023
26 April 2023
02 May 2023

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

Summary of findings

Overall summary

About the service
Radis Community Care (Brunel Court) provides personal care services for people living in 55 self-contained flats in an extra care housing scheme. Not everyone who lived in 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.

Brunel Court is one of four extra care housing schemes in the city which Radis Community Care manage along with an agency providing personal care in people's homes. The service provides support including for people living with dementia, physical disability, and older and younger adults. At the time of our inspection there were 33 people using the service.

People's experience of using this service and what we found
Service users were not protected from abuse and improper treatment. Risks to people using the service were not consistently assessed or mitigated. Medicines were not managed safely. People were not consistently cared for by staff who were safely recruited. Staff files did not consistently include all necessary information to ensure safe recruitment practices were followed to keep people safe.

Where people had specific health conditions, there was not always an associated management plan for staff to follow. This meant staff did not have access to information to safely care for people.

Safeguarding concerns were not consistently identified, investigated, and reported. Themes and trends were not consistently identified and learnt from. This placed people at risk of harm.

Staff did not complete training or receive competency assessments, supervision or spot checks on a proactive basis. This meant appropriate action had not been taken to ensure fit and proper persons were employed to care for people.

Quality monitoring and oversight of the service was not effective. For example, audits in place had not identified concerns found during inspection which meant lessons could not be learned and embedded across the service.

People were not consistently involved in their care and their feedback was not consistently sought by the provider. As part of the inspection, people who used the service gave feedback which indicated inconsistency in staffing ability, knowledge, and professionalism. This had not been identified by the provider.

Analysis and learning from accidents and incidents was limited. This meant the provider was not continually striving to improve standards of care people received.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the provider's 'Mental Capacity Act and Decision Making' policy was not up to date to support this in practice.

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 service registered with us on 12 August 2021 and this is the first inspection.
The last rating for the service under the previous provider was Good, published on 10 January 2019.

Why we inspected
The inspection was prompted in part due to concerns received about neglect of a person using the service and poor medicines management. A decision was made for us to inspect and examine those risks.

We have found evidence the provider needs to make improvements. The overall rating for the service is inadequate based on the findings of this report.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding, staffing, fit and proper persons employed, consent 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
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, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Radis Community Care (Brunel Court)

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 undertaken by 1 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 provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support.

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 were 2 registered managers in post.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 18 April 2023 and ended on 19 May 2023. We visited the service on 18 April, 20 April, 26 April and 2 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who use the service or their family members, 6 members of staff, including the 2 registered managers. We also received feedback from 3 external professionals.

We reviewed a range of records. This included care records and associated documents of 13 people. We reviewed 5 staff files in relation to recruitment and supervision. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

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.

Assessing risk, safety monitoring and management

- Risks to people using the service were not consistently assessed, mitigated, or reviewed to support staff to manage risks safely. For example, 1 person had a history of falls, however there was not a robust risk assessment in place to guide staff how to mitigate the risk of falling. In addition, when a fall occurred for this person, their care plan and risk assessment had not been reviewed in response. This meant people were at potential risk of harm as the provider had not always identified, mitigated, or safely managed risks to people.
- Another person had a history of falls. This risk was not suitably assessed and managed to reduce future risk of falls. This person went on to have 2 falls, one of which resulted in injury, but their care plan and risk assessment were not reviewed to help prevent further occurrences. We raised this with the registered manager during the inspection who said they would take action to review the relevant care records.
- Risks associated with specific health conditions were not assessed safely, including, but not limited to diabetes, epilepsy, and continence care. For example, 3 people who had diabetes and 1 person who had epilepsy did not have a care plan or risk assessment detailing how to manage the risks associated with these conditions, how to identify medical emergencies associated with these conditions or when to seek medical advice. This put them at risk of avoidable harm from unsafe care.
- Known risks to people's skin integrity, were not consistently risk assessed and managed effectively to reduce risks to people. For example, one person's care plan said they had a history of poor skin integrity and required repositioning regularly, however there were no management plans or effective risk assessment in place to guide staff how to reduce the risk to this person. This meant people were at risk of harm as staff did not have suitable guidance to support safe delivery of care.
- We received mixed feedback from people about how they were supported with risks to them. One person said, "If I buzz, it's an emergency. They're there in seconds," however another person with a history of falls told us, "I'm told to sit back in the chair more and lean less forward. They [care staff] are busy, it can take an hour before they come [response to call for assistance]." This meant we could not be assured people's risks were effectively managed consistently and robustly to reduce the risk of harm to people.
- Staff we spoke to during the inspection had a mixed level of knowledge about the management of risks to the people they supported. One staff member told us how they supported someone with diabetes and said they had completed online training; however, they were not aware of any guidance in any care records for staff to follow. This meant there was a risk staff would not know how to safely support people.

The failure to assess the risks to the health and safety of service users and to do all that is reasonably practicable to mitigate any such risks was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental risks were assessed regularly, and assessments contained information for staff to follow to mitigate and manage any risks to people and staff. A recent compliance audit had identified risk assessments were not in place for staff to lone work, the registered manager had responded and had completed the necessary risk assessments.

Using medicines safely

● Medicines were not consistently managed safely. Systems and processes in place were not effective or robust in identifying and acting on concerns. Monthly audits were completed of people's medication administration records (MARs) but did not consistently recognise errors or the concerns we found during inspection. This put people at risk of harm.

● People we spoke to gave mixed feedback about the medicines support received. Comments included, "They [care staff] bring me the pills I'm supposed to have." However, another person told us, "They [care staff] give me things like 'as required' medicines when they shouldn't. They [care staff] mark on a chart what [medicines] I haven't had." Another person told us their MAR chart had not been updated to reflect current prescribed medicines in a timely manner. This meant we could not be assured people were supported safely with their medicines.

● Competency assessments and spot checks were not carried out consistently with all staff and not all staff had completed medicines training. We asked the registered manager for dates staff had received competency assessments and spot checks over the last 12 months and these records were not available. Some staff had received competency assessments in response to an error or concern, however this did not mitigate the risk to people from untrained staff supporting them.

● Risks around medicines were not consistently recognised and managed safely. For example, we reviewed people's medicines records and identified 2 people were prescribed flammable creams, and no fire risk assessment or management plan had been completed. We saw 2 people were prescribed anticoagulants, which had not been risk assessed to identify an increased risk of bleeding. When raised with the registered manager, they were not aware of the need to complete risk assessments for this and agreed they would review people's records and complete risk assessments where necessary.

● Systems in place for monitoring and ordering people's medicines were not always effective in ensuring an adequate supply. The process described in the provider's medicines policy stated a repeat prescription log should be in use when care staff support people with ordering their medicines. We asked the registered manager for the repeat prescription logs and were told these were not completed and no service users had this record in place. Records reviewed during inspection showed 3 people had run out of medicines putting them at risk of harm.

● Systems in place were not robust to ensure changes in people's medicines were managed safely. For example, 1 person's diabetic medicine had been moved to a different time of day when a care call was not provided. This was not identified by the existing system which meant the person missed this medicine for 3 days until reported by care staff, at which time senior care staff took appropriate action. We raised this with the registered manager who told us the system in place relied on staff reporting changes to people's prescribed medicines. This put people at significant risk of harm.

● When medicines were delivered out of hours, there was not a robust system for checking them in. Care staff on shift had hand written entries on MAR charts, however these were inaccurate, or did not contain necessary information to ensure medicines were supported safely. There were no systems to check hand written entries. In one example, a person was prescribed a new medicine which contained codeine which was already prescribed. This had not been identified as a risk, had been added to the MAR chart by care staff without suitable guidance and the amount staff should administer was incorrectly recorded. This put the person at risk of harm, of an overdose. We raised this with the registered manager who was not aware of the concern but provided records to show the MAR charts and guidance had been updated.

● There was a lack of robust protocols for medicines prescribed 'as required' (PRN). We reviewed 3 peoples

medicines records, who were prescribed a PRN for constipation. These records did not contain an effective protocol for staff to follow around when and why to support the person to take this medicine or how to support their bowel care.

Systems had not been established to ensure medicines were managed safely. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us they were working with partners to ensure systems were in place to effectively manage people's medicines safely.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider failed to consistently identify, investigate and report safeguarding concerns to the local authority. When the service was made aware of a safeguarding concern, they acted and investigated, however internal systems and processes had not identified all the concerns found during inspection.
● The provider did not have effective systems and processes to protect people from the risk of abuse or for learning and continuous improvement. For example, one person was supported with regular repositioning to prevent pressure injury. Records reviewed during inspection showed this person had, on one occasion, only been supported to reposition three times in 24 hours and on 7 occasions they went 8-9 hours between being assisted. This had not been identified which put the person at risk of harm.
● Records showed entries from care staff regarding potential safeguarding concerns which had been received by senior team. However, actions taken in response to these concerns were not always appropriate and relevant information was not always recorded. These concerns included, but were not limited to, risks people posed to themselves or staff, call bells not answered or not available for people to use and poor personal care provision. This meant people were at risk of harm from neglect or abuse.
● An accident log was in place but was not used effectively. Records reviewed showed 2 people had falls, which were not recorded on the accident log. The information on the log did not allow effective lessons to be learnt and no evidence was seen of patterns or trends being identified and acted upon to reduce the risk of further incidents.
● Themes and trends were not consistently identified and learnt from. For example, when medicines errors were identified, the provider did not investigate themes so that learning could be shared across the service, to improve quality of care provided to people. More information can be found in the well-led section of this report.
● When safeguarding concerns were investigated, policies and procedures were followed, however records of these investigations were only available for the 4 months prior to inspection as previous records had been archived. The records of investigations were requested for the previous 12 months, but they were not provided during the inspection. We received a copy of the safeguarding tracker, however there were no entries since February 2022. This meant we were not assured the provider had recognised and acted on all safeguarding concerns in a timely and appropriate way nor made all necessary referrals to the local authority.
● Training records showed out of 31 staff, 19 were not up to date with annual safeguarding training, as required by the provider. Staff we spoke with had mixed levels of knowledge around safeguarding concerns. All staff we spoke to said they would report a safeguarding concern to management, however not all staff were able to describe what a safeguarding concern was. This had not been identified by the registered manager prior to inspection. This meant people were cared for by untrained staff which put them at risk of harm. We raised this with the registered manager who took action and 16 care staff completed safeguarding training by the end of the inspection.

Systems to ensure people were protected from the risk of neglect and abuse were not robust. This placed people at risk of harm. This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked people who use the service and their relatives if they felt safe. Comments included, "I feel safe most of the time," "Yes, they [care staff] keep them [relative] safe," and "I definitely feel safe."

Staffing and recruitment

● People did not consistently receive care calls for the agreed duration stated in the care plan. For example, we reviewed the records of 3 people who received care, over a 2–4-week period. During the period reviewed, these people consistently received less than the agreed duration of the call. This had not been identified by the provider and no action had been taken to investigate whether staffing levels contributed to this, putting people at risk of not receiving appropriate care and treatment.

● People had reported long waits for buzzers to be answered, of up to 1 hour. This had not been consistently investigated by the registered manager and there was not an effective system in place to monitor the number of calls and response times by care staff. There was no system to analyse whether delays were due to staffing levels. We raised this with the registered manager who told us they would gain this information from people during care reviews; however, we were not assured these were completed on a regular basis or obtained the relevant feedback around staffing levels. This meant people were at risk of harm from support not being available when required and whether staffing levels contributed to this risk.

● Records reviewed during inspection indicated 7 care calls to people had been missed in the previous 6 months and had not been investigated or reported appropriately. We raised this with the registered manager who was not aware of the missed visits and had not taken appropriate action to rule out if staffing levels had contributed.

● The provider allocated care calls in 'rounds' so staffing levels were based on how many rounds there were to complete, and no staffing dependency tool was in use to evaluate the needs of people and how this impacts the staffing required to support them. If the service was short staffed, the registered manager told us that office staff helped with the care calls, however some concerns found during inspection indicated this arrangement was not effective.

● People's feedback was mixed and included positive and negative comments about staffing levels, staff training and professionalism. This was raised with the registered manager who said they would review the information.

● After the inspection the provider told us they were working with stakeholders to address this issue.

Systems to ensure sufficient numbers of suitable staff were not effective or robust. This placed people at risk of harm. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relevant information and checks were not consistently recorded in staff recruitment files. This included evidence of conduct in previous employment, explanations for gaps in employment history and recent photos and proof of identity checks. This meant the provider had not made appropriate checks in line with legislation to ensure fit and proper persons were employed. This meant people were at risk of harm due to staff not being recruited safely.

● Staff recruitment procedures were in place; however, staff were not consistently recruited safely. The provider had not consistently completed DBS checks prior to staff commencing employment. 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. When requested, these DBS records had been completed, but not filed in staff's recruitment files.

The failure to ensure recruitment procedures were established and operated effectively placed people at risk of harm. This was a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was managing risks to ensure infection outbreaks were prevented or managed. On one occasion records showed 6 people and 2 staff had diarrhoea and vomiting. This had not been identified by the registered manager as a potential infection control risk and no evidence was seen of any action taken to reduce cross contamination between people or identify areas of learning.

● We requested the provider's infection prevention and control policy. The registered manager sent an out-of-date document which was no longer appropriate. Following the inspection, the provider sent an up to date infection prevention and control policy which was in place, which included relevant COVID-19 guidance. We were not assured the provider's policy had been implemented effectively as staff were not consistently applying safe infection control practices and systems and processes had failed to ensure infection control was managed safely.

● Training records showed not all staff had received yearly Infection Control training. This was raised with the registered manager who was not aware. Action was taken and 14 care staff completed training during the inspection.

● Staff we spoke to were able to describe when and how to wear personal protective equipment (PPE) appropriately. The registered manager and staff confirmed PPE was available for staff to use when providing care to people. However, one person who received care told us staff did not always follow guidance with PPE and did not always change gloves between personal and domestic care tasks.

● Another person told us their care plan included staff to check expiry dates on food items. The person said this was not always followed by care staff and out of date items were found in the fridge. This meant people were at risk of not being protected by the prevention and control of infection.

The failure to ensure infection control measures were managed safely was a breach of Regulation 12 (1) 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.

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 people's care, support and outcomes.

Staff support: induction, training, skills and experience

- We received mixed feedback from people who received care about the training staff received. One person told us, "Some care staff are not trained, [care staff] just look and stand around. You can't expect a person to tell a new carer everything they are meant to do." Another person said, "Some are new staff and don't seem to be trained." Other comments included, "I haven't had an occasion to question their training," and "The ones [care staff] who have been there a long time are good."
- Not all staff new to care had completed the Care Certificate. 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. This had not been identified by the registered manager, however when raised, the registered manager said they would review this.
- Staff deployed to care for people had not all received relevant training to allow them to care for people safely. For example, staff had not completed training for specific medical conditions, including, but not limited to, catheter care, stoma care, epilepsy and diabetes, even though people receiving care lived with these conditions.
- In addition, the provider's training matrix showed considerable shortfalls in training. At the time of inspection, the training matrix recorded 21 staff were not up to date with the provider's mandatory training. This included moving and handling, safeguarding, infection control and medicines management. The registered manager took action when we raised this and after the inspection only 3 staff were still to complete mandatory training.
- Gaps in training had been identified in January 2023, but minimal action had been taken prior to inspection. This meant people were being supported by staff who had not completed the relevant induction and training to check they had the competence, skills and knowledge to support people effectively and safely. This meant we were not assured effective systems were in place for induction or ongoing training of staff.
- Supervisions, competency assessments and spot checks of staff performance were not regularly completed across all staff. This had been identified during the quality and compliance audit in January 2023, however an effective system for oversight and prompting of these reviews was not embedded across the service at the time of inspection.

Systems were not operated effectively to ensure people were supported by suitably trained and knowledgeable staff. This placed people at risk of harm. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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
● The service was not always working within the principles of the MCA. Assessments of people's capacity to make certain decisions had not been completed where they had conditions of the mind or brain which may affect their ability to understand, retain, weigh up and communicate decisions about their care.
● Although some people had signed consent recorded in their care records, this was not consistently obtained from the appropriate person. For example, one person's records said they had capacity to make their own decisions, however their care plan and consent form for sharing information had been signed by a relative with no explanation of why the person had not signed themselves.
● One person had refused care visits, however a wellbeing check had been instructed by management without alerting the person to the fact they were being observed. When a person using a service does not give consent or withdraws it, all people providing care should respect this. This impacted on the privacy of the person and was potentially an infringement of the persons human rights. This demonstrated a lack of understanding of consent on the part of the provider.
● The service had a policy in place; however, this had not been reviewed since 2018 and was not being followed by the registered manager regarding MCA assessments. Staff had received MCA training and had access to the providers policy, however, staff lacked detailed knowledge and understanding of the MCA when we spoke to them. Due to staff knowledge being limited, we were not assured the training was effective and this gap in knowledge had not been identified by the registered manager.
● The registered manager was not able to demonstrate a clear understanding of the MCA and how to apply it to the people supported by the service. The registered manager told us they would outsource to another professional if an MCA was required, however this is not in line with the services own policy or the MCA code of practice. We discussed this with the registered manager and area manager who said they would take immediate action to learn about MCA.

The failure to obtain consent from appropriate persons or undertake capacity assessments in line with the principles of the MCA is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were able to describe how and when they gained people's consent during delivery of personal care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed prior to commencing their care package. People and their relatives, where appropriate, were involved in the development of their care plans. However, we received mixed feedback about people's involvement with their care plans being reviewed. We asked people and their relatives if they were involved in regular care plan reviews, one person told us, "Not really, I don't know

if it needs updating," another said, "They [person] are involved, once a year [office staff] come to talk to them."

● Care plans were not consistently reviewed and updated regularly and there was no effective system in place to ensure these were completed in a timely manner. Care plans reviewed during inspection had not been updated in a timely way or in response to people's changing needs. This meant staff did not consistently have access to accurate, up to date information about people's needs, putting people at risk of harm.

● People's care records, including risk assessments and medical condition management plans were not person-centred and contained mainly standard statements. This meant staff did not have access to information about the individual before providing care, however the risk was somewhat mitigated as staff were able to describe the individual needs of the people they supported.

● Best practice guidance was not effectively used. For example, nationally recognised tools such as the multi universal screening tool (MUST) was not in use to assess people's nutritional risk. In addition, the medication policy referred to best practice guidance from the National Institute for Health and Care Excellence (NICE) which was not being followed by the provider. This meant staff did not always have information about people to enable care to be delivered in line with best practice guidance.

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

● Where concerns were raised about people's fluid intake, the service implemented fluid intake monitoring. However, these records were not effective in monitoring fluid intake as did not record the amount of fluid consumed and there was no way to establish how much fluid a person had taken within a 24-hour period to ensure this was enough to prevent dehydration.

● These records were not regularly reviewed in a timely way to identify areas of concern and relied on staff recognising and reporting concerns. After inspection, amounts of fluids consumed had started to be recorded and the registered manager said they would monitor this in future.

● People's nutritional and hydration needs were assessed and planned for. Where people were supported by care staff to meet this need, records reflected people's choices and preferences.

● Where the service provided support to people with their meals, people told us they were given choices and were happy with the food provided and the options and choices given to them by care staff.

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

● People were supported, where required, to access a range of health and social care services when they needed them. One person said, "Most experienced carers are more alert if you're not well," another said, "The last time they [care staff] dialled 999 for me, they [care staff] packed a bag and waited with me for the ambulance." One person's relative said, "They [care staff] didn't like the way they [person] was breathing so they [care staff] called an ambulance."

● The registered manager told us how and when they would access support from other professionals, for example occupational therapists, community nurses and social workers. The service also employed a nurse who was available to provide additional guidance with wound care and end of life care if needed.

● Feedback was requested from external professionals who worked with the service. We received feedback which reflected some of the concerns found during the inspection along with positive feedback of the service responding and investigating concerns when raised.

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

- People we spoke to did not always feel well treated and supported. We asked people who use the service this question and comments included, "They [care staff] are fairly professional, some are better than others," and "Some new carers just have a job rather than be caring."
- One person we spoke to told us care staff had refused to support them with an aspect of their medical condition relating to skin integrity and had told them, "I'm not cleaning that." This meant we were not assured people were always cared for in a kind and caring way by all staff.
- The registered manager spoke of the culture they wanted to promote, of caring for each individual and their own specific needs, tailoring care to these needs and ensuring people are treated well and supported. They told us, "My aim is to make sure we are going the extra mile for the residents, to ensure they are happy with the care and service provided to them." However, a lack of monitoring, including regular spot checks, competency assessments, training and feedback, potentially impacted their ability to do this.
- Staff had received training in dignity, equality, diversity and inclusion and care staff we spoke to described a commitment to providing a service which was non-discriminatory.

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

- People did not always feel involved in decisions about their care. We received mixed feedback from people which included, "They [care staff] listen in the office and try to accommodate each person," "They're fine in the office, they do listen," and "They [relative] are involved, once a year they come and talk to them." Negative comments included, "Not really, I don't know if [my care plan] needs updating," and "On occasion we fill in a form, that hasn't happened for ages." This meant we were not assured people and their relatives are involved in making decisions about their care.
- Care plans were not consistently reviewed regularly and there was no oversight or effective system in place to identify and prompt a review when due. Please refer to the effective and well led section of the report for more information.

Respecting and promoting people's privacy, dignity and independence

- People we spoke to did not always feel their privacy and dignity was respected by care staff. We received mixed feedback about people's privacy and dignity needs being met. One person told us, "A lot of [care staff] have respect, some don't. They wheel me into the shower and pull the curtain, but if another carer wants something, they will just pull the curtain back. It's about keeping your dignity at all times," another said, "They [care staff] are discreet."
- Care plans included information on how to support individuals to be as independent as possible and staff

we spoke to were able to describe how they maintained people's privacy and dignity during personal care tasks.

● Staff ensured people's confidentiality was maintained. People's personal information was stored securely and only accessed by authorised staff. Information was protected in line with General Data Protection Regulations (GDPR).

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

- People's care was not always well planned in a person-centred way to mitigate and manage their risks and did not always involve them in these plans, and information was not always up to date or accurate. Please refer to the safe section of the report for more information.
- When a risk was identified, person-centred information was not contained in risk assessments or management plans, such as managing the risk of falling. This was raised with the registered manager during the inspection who submitted an updated falls risk assessment. This did not contain information on how to mitigate or manage the risk for that person, only general statements.
- People's care plans did not consistently contain person-centred information around medical conditions. People's care plans contained general statements about the condition only. This meant people would be at risk of not receiving safe, appropriate, person-centred care. This meant people were at risk of receiving care by staff who did not know their individual needs.
- People had records in their home which described care tasks to be completed which were person-centred and included people's choices and preferences. One person's relative told us, "There is a holistic and person-centred approach to my relative's care."
- Care plans related to care tasks, such as food people liked or their preferred daily routine and included guidance for staff to follow which was person-centred and described people's choices and preferences.

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 had a Policy in place which outlined how the provider was meeting the Accessible Information Standards. When we discussed this with the registered manager, they were unaware of the provider's policy.
- People's care plans contained some information to support staff in how to communicate with them according to their individual needs.
- Care records were in place in people's homes to share information with other visiting professionals, for examples GPs or paramedics, around people's individual communication needs.

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

● The provider supported people to access activities within communal areas inside the building. This included bingo, board games and access to a hairdresser. Other activities provided included, holiday celebrations, movie afternoons and weekly fish and chips, which people told us they enjoyed.

● The registered manager told us of plans to introduce more activities over the summer, including an ice cream van to visit and day trips.

Improving care quality in response to complaints or concerns

● People and their relatives knew how to complain, and the service had a policy which was available in peoples care plans.

● When complaints were received, appropriate investigations were conducted, and processes followed which included competency assessments and spot-checks on staff involved. However, the provider did not have an effective system in place to identify and learn from patterns and trends throughout the service. Please refer to the safe section of this report for more information.

● People told us when they made a complaint, they were satisfied with the outcome.

End of life care and support

● The service did not give people the opportunity to discuss their plans, preferences and choices related to their end of life care ahead of time. We raised this with the registered manager who said they would include this in assessments and reviews.

● The service was not supporting any people with end of life care needs at the time of inspection. The registered manager was able to describe how people would be supported at this time and said they would be guided by other medical professionals to safely support people.

● Staff were able to describe how they had provided end of life care to people and were knowledgeable about the changes with people's care needs at the end of life.

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

- Quality monitoring systems and audits in place were not robust and had not been effective in identifying all the concerns found during inspection. For example, audits completed for MARs, repositioning and fluid charts and accidents or incidents, had not identified the concerns found during inspection and daily team leader reports were not being completed as the service required.
- Information about risks and safeguarding incidents were not always reviewed and updated so relevant management plans were not available to staff. Please refer to the safe section of this report for more detail.
- A compliance audit carried out by the service did not identify all of the issues found on inspection, and no action plan was provided to us on request to evidence the issues identified in the compliance audit had been or would be addressed in a timely way. For example, the compliance audit in January 2023 had identified staff did not have photographs or ID documents in their recruitment files, however this was not reflected in an action plan, and had not been addressed prior to the inspection. The audit had identified supervision and spot-check monitoring records were not up to date, this had also not been addressed prior to the inspection. The audits did not identify shortfalls in people's risk assessments, and no plan was in place to address this.
- Following the inspection, we were sent a 'service quality development plan' which identified improvements required following concerns raised by the Local Authority. This action plan reflected concerns identified by an external agency, and not by internal audits. Issues identified in the compliance audit had not been identified on this action plan.
- We were not assured that the service had robust measures in place to identify and address quality and safety issues. For example, missed calls had been identified as an issue by the local authority, however the service had not identified that care calls were not meeting the assessed time allocated. The improvement plan identified medicines errors needed to be addressed, however, on inspection we identified medicines errors were not consistently or adequately reported internally, investigated and actions taken in response.
- Records were not retained and stored appropriately. Records were archived when a replacement record was created, for example, when a care plan review had been completed, the original was sent to head office to be archived. These records were also not available to be reviewed electronically when requested of the registered manager, only the current care plan in place was available for review. Also, all safeguarding records were archived at the end of year. This had not been identified as limiting the ability of the registered manager to analyse incidents and learn from them.
- Care plans were not consistently signed and dated by people or staff to demonstrate when they had been written or updated and did not always state when a review was due.

● Care plans were not reviewed regularly and were not consistently reflective of the person's current needs. For example, care plans were planned to be reviewed every 6 months or in response to any change of needs, however this had not always happened. One person's health needs had changed but their records had not been amended to reflect this. Also, no effective oversight was in place to ensure care records were not outdated or inaccurate.
● Learning from the wider organisation was shared in the monthly manager's meetings and office meetings, however this learning was not embedded into practice. For example, during February's office meeting, lessons learnt were shared, however all required actions had still not been completed at the time of inspection.
● Records kept were not consistently contemporaneous and did not contain all up-to-date information to allow staff to provide care. Daily records did not always include complete, legible, contemporaneous records of tasks completed as per the care plan. The registered manager had identified the concern with daily logs and was working with staff to improve the quality of records.
● The systems in place for oversight of staff training, competency assessments and care plan reviews were not being used correctly and did not contain necessary information. This meant there was a risk of harm from people receiving care from untrained staff.
● We were not assured the provider ensured policies in place were appropriate, up to date, disseminated to all staff and fully understood and implemented by the registered manager and others responsible for the running of the service. For example, the Mental Capacity and Decision-making policy was not being followed, as described in the effective part of this report. In addition, when asked for the accessible information policy (AIS) and infection control policy (IPC), the registered manager told us there was no AIS policy and provided an out-of-date IPC policy.
● Although, following the inspection, the provider demonstrated there was an up-to-date infection control policy and an accessible information policy, we were not assured all staff understood which policies were in place or were following them.

The failure to ensure risks to people, the quality and safety of the services is appropriately assessed, monitored and improved, and the failure to maintain accurate, complete and contemporaneous records in respect of each service user placed them at risk of harm. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service was not consistent or effective with gaining people's feedback about the service they received. The quality and compliance team contacted people who use the service as part of the yearly audit, out of 55 questionnaires sent out, 3 people who used the service responded. There was no evidence of action taken in response to comments received.
● We asked the registered manager how feedback is sought, they responded this was obtained during care plan reviews, but these were not completed regularly. For example, 2 care plans reviewed during inspection had not been reviewed for 15 and 16 months. This meant people were not actively engaged in the service they received.
● There was limited evidence to show people were actively involved in care and the running of the service. No evidence was seen of resident's meetings being arranged by the provider.
● When the provider did investigate complaints, lessons were not effectively learned and systems were not in place to effectively identify patterns and trends.
● Existing systems had not identified the processes which were ineffective. For example, the communication book contained entries between care staff and management and was used to hand over information between shifts. There was no evidence staff were reading these messages, reporting incidents recorded in

this book, or taking action to keep people safe, and there was insufficient oversight from management to identify or address this.
● We received mixed feedback from professionals working with the service. One social care professional said, "I do feel that residents are safe and their care needs are appropriately met," however another social care professional told us they had raised concerns with the service about not having a robust investigation process and they were not assured by the providers response.

Failure to seek and act upon feedback from people to improve the quality of the service was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Meetings were held regularly for staff. These consisted of managers, office staff and care staff meetings. Relevant information was shared during these meetings and staff had the opportunity to raise any concerns. Staff told us these meetings were beneficial.
● The registered manager had worked with an outside organisation to start a regular games morning which people who use the service spoke positively about.
● The registered manager told us they worked in collaboration with all relevant agencies, including health and social care professionals to help ensure there was joined-up care provision.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture within the service was not always person-centred, did not promote inclusion through treating people with dignity and respect and good outcomes for people were not always achieved. For example, some entries within a communication book used by staff were not respectful when talking about the people being supported.
● Mixed feedback was received from people who used the service about the culture and knowledge of care staff. One person told us, "The good carers are upset and want to leave. Tasks in the care plan are not always followed," another said, "They [office staff] don't know how the person is or what the diagnosis is. They [office staff] don't come and see me." One person said, "Some [care staff] are very kind, others get it done as quickly as possible." This meant people were not cared for in a consistently person-centred, open, inclusive, and empowering way.
● We received mixed feedback from staff about the culture within the service. Some staff told us they were happy and felt well supported by management, however we also received anonymous feedback describing care staff not following people's care plans and a poor culture among staff within the service.
● The registered manager told us they had an open-door policy and staff confirmed they felt able to approach the manager and felt supported by them and the office team. The registered manager also recognised there had been some difficulties with the staff team when they began with the service, however, the team had worked hard to make improvements, though recognised additional work was needed to ensure a cohesive, supportive team which would allow care staff to provide best care to people they support.

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 registered manager was able to describe their responsibilities under the duty of candour regulations in line with the services policy.
● When the registered manager was aware of an incident or complaint these had been investigated, the manager had responded appropriately and met duty of candour requirements.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to obtain consent from appropriate persons or undertake capacity assessments in line with the principles of the MCA.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure recruitment procedures were established and operated effectively which placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to have robust or effective systems in place to ensure sufficient numbers of suitable staff employed. The provider failed to ensure systems were operated effectively to ensure people were supported by suitably trained and knowledgeable staff.

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 The provider failed to assess the risks to the health and safety of service users and to do all that is reasonably practicable to mitigate any such risks. The provider failed to establish systems to ensure medicines were managed safely placing people at risk of harm. The provider failed to ensure infection control measures were managed safely.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure robust systems were in place to ensure people were protected from the risk of neglect and abuse which placed people at risk of harm.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure risks to people, the quality and safety of the services is appropriately assessed, monitored and improved, and the failure to maintain accurate, complete and contemporaneous records in respect of each service user placed them at risk of harm. The provider failed to seek and act upon feedback from people to improve the quality of the service.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.