Elizabeth Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Elizabeth Homecare Limited provides care and support to people who live in their own homes in Goole and surrounding areas. This service is a domiciliary care agency. The service is registered to provide the regulated activity of personal care to children 13-18 years, people with dementia, people with learning disabilities or autistic spectrum disorder, people with mental health, older people, people with a physical impairment, people with a physical disability, people with sensory impairment and young adults. At the time of our inspection 89 people were receiving a service from this provider.

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 failed to ensure that all staff employed at the service were tested for COVID-19 on a regular basis throughout the pandemic in line with government guidance. We found that no COVID-19 risk assessments had been completed for service users and staff. Masks were not worn by office staff when we visited the office.

The provider failed to ensure appropriate assessments and risk assessments were completed for service users who had risks associated with their care needs. Risk management plans were not in place for people who required support with moving and handling needs and specific health conditions including Diabetes and Epilepsy.

People's medicines were not managed safely. There was no guidance for staff to follow on when to administer 'as required' medicines.

People and staff told us there were not enough staff to meet people's needs. This meant that at times a family member had to support as the second carer. People told us they did not always feel safe with these arrangements which included using moving and handling equipment.

There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service. Shortfalls across the service such as poor risk management, lack of oversight of accidents and incidents and limited oversight of safeguarding had not been identified prior to our inspection. These failings resulted in multiple breaches of regulation.

The provider had failed to notify the Care Quality Commission of certain events as required by law.

There was no policies or procedures in place for a number of aspects of the service provision. For example,

to ensure the safe recruitment of staff.

Staff did not receive regular supervision or have an appraisal and there was no information available to show that checks of staff's competency had taken place.

Staff had little understanding of the Mental Capacity Act 2005. There was no system within care records to evidence that assessments of people's mental capacity had been completed. There were no records to show that where decisions had been made in people's best interests this was done in line with the principles of the MCA 2005.

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 policies and systems in the service did not support this practice.

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

This service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Care was not always person centred to promote independence. There was no evidence that consent had been sought in a way that meets a person's communication needs and the knowledge of staff did not support providing care to people with a learning disability or autism.

People's care plans were not person centred and lacked details about their preferences and goals they wanted to achieve.

We have made a recommendation about duty of candour.

People's privacy and dignity was respected, and staff knew how to promote independence. People spoke positively about staff.

We found multiple breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns during inspection is added to reports after any representations and appeals have been concluded.

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

Rating at last inspection
The last rating for this service was Good (published 22 December 2017)

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

We have found evidence that the provider needs to make improvements. Please see the key questions

sections of this full report.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to consent, safeguarding, management of medicines, staffing, infection prevention and control, record keeping, complaints, notification of other incidents and governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Elizabeth Homecare Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by two inspectors on day one and one inspector and an inspector manager on day two. An Expert by Experience made calls to people and their families. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Inspection activity started on 24 November 2021 and ended on 30 November 2021. We visited the office location on 25 November 2021 and 29 November 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a Provider Information Return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they make. We took this into account when we inspected the service and made the judgments in the report.

We used all of this information to plan our inspection.

During the inspection
We spoke with five family members and four people who used the service about their experience of the care provided. We spoke with 10 members of staff including the nominated individual, registered manager and eight care workers. We reviewed a range of care records. This included thirteen care records and medication records. We looked at four staff files in relation to recruitment and staff supervision and records relating to the management of the service.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted one professional who was involved with the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.
Preventing and controlling infection
● Risks associated with COVID-19 were not managed in line with government guidance. The provider had failed to ensure a COVID-19 testing regime for staff was in place. This meant the provider could not be assured that staff were working safely and not transmitting COVID-19 to service users.
● Staff confirmed they did not register COVID-19 test kits which were given to them by the provider. Two staff could not recall the last time they had taken a COVID-19 test.
● The provider had not completed any COVID-19 risk assessments for people or staff who may be at increased risk of complications from contracting COVID-19.
● The provider did not have a COVID-19 policy in place to provide guidance on how to meet government guidance during the pandemic and provide guidance to staff.
● Staff who were office based, including the registered manager and the provider, were not working in accordance with social distancing measures.
● Staff received training in donning and doffing personal protective equipment (PPE). However, the provider had not sought to observe or record this process or good hand hygiene practices.

Whilst we found no evidence that people had been harmed, we judged that infection control was not effectively managed by the provider. This placed people at increased risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulations 2014)

● Following the inspection, COVID-19 testing and risk assessments for staff commenced at the service. The provider told us a COVID 19 policy had been put in place.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of harm or abuse. The provider did not have a safeguarding policy and did not have a robust system to monitor and record safeguarding incidents.
● The provider did not record, report or investigate safeguarding concerns.
● Staff told us they did not know what action to take if they witnessed signs of abuse. They were not aware of how to report concerns to the local authority safeguarding team. This demonstrated there was a risk that safeguarding incidents may not be reported to or responded to appropriately.

Systems and processes were not in place to prevent and protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us they had taken action and implemented a

safeguarding policy.

Assessing risk, safety monitoring and management
● Risks associated with people's care needs were not robustly assessed or managed safely. The provider failed to complete robust individual risk assessments for people. This included risk assessments for moving and handling, falls, and other health conditions including Diabetes and Epilepsy. This meant staff did not know how to manage or mitigate risks to people.
●Two people were supported with Aerosol Generating Procedure (AGP). We found that risk assessments were not in place to guide staff how to do this safely during the pandemic.
● The provider failed to keep records in relation to servicing of equipment which was used by staff, to support people with moving and handling. The provider could not be assured that equipment in people's homes was safe to use or fit for purpose. This placed people at risk of harm.
● Information in care records was found to be out of date and did not reflect people's current needs. One member of staff told us people's records did not always get updated when needs changed; but they were supposed to be updated every six months. Another told us, "The records don't always have the right information, it can be very frustrating."

Risks were not identified, assessed or monitored within the service. This put 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)

Staffing and recruitment
● Staffing levels did not ensure people's safety. The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's needs. This meant that for some people only one member of staff attended to provide their care rather than two. Staff were concerned about their ability to safely meet the needs of people. One member of staff told us family members were requested to act as the second carer to support staff in moving and handling. This included using equipment. One family member said, "It is not always possible to get the right amount of help, sometimes they only send one carer, sometimes they send none." One person told us "Sometimes they just send one carer and expect my partner to help."

Sufficient numbers of suitable staff were not deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Robust recruitment processes were not in place.
● The provider did not have a recruitment policy to ensure safe recruitment practices were followed.
● Staff records showed relevant checks had not always been completed before staff worked independently. For example, references were not always followed through and historical Disclosure and Barring Service (DBS) checks had not been updated or reviewed. The DBS is a national agency that holds information about criminal records.

We recommend the provider implements a recruitment policy and procedures to support the safe recruitment of staff.

Using medicines safely.
● Medicines were not managed safely. The provider did not have robust systems in place to ensure the safe management of medicines. They did not have oversight of records relating to people they supported with medicines.
● One person experienced regular medication errors including missed doses. This had not been reported by

staff or identified by the registered manager or provider via any monitoring of medicines via audits. No action had been taken by the provider to address this and prevent reoccurrence.
● Protocols for people who were prescribed PRN (as and when required) medicines was not in place and staff lacked knowledge and understanding of what these were.
● Eight staff had not completed medicines refresher training and continued to administer medicines. Not all staff had checks carried out to assess their competency to administer medicines.

Medicines were not been effectively managed, and this placed people at increased 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.

● Following the inspection a medication policy was put in place

Learning lessons when things go wrong
● Accidents and incidents were not managed safely. The provider did not have an accident or incident policy. There were no systems in place for reporting or recording incidents.
● Staff told us they would ring the office to report accidents and incidents. They said they did not know how these were recorded. Staff also told us they did not receive any feedback in relation to what they had reported, nor did they know what if any action had been taken in response.
● People's daily care records contained information which showed accidents and incidents which had occurred. For example, staff had recorded where people had fallen. These incidents were not logged appropriately or responded to by the registered manager or the provider.
●There was no information to say how many incidents had occurred at the service over the last 12 months. This meant there was no learning from incidents, or analysis to identify themes and trends and actions taken to prevent reoccurrence.

We found no evidence that people had been harmed however, the systems in place were not effective to monitor accidents and incidents. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Staff support: induction, training, skills and experience

- Staff did not receive support from the provider. The provider did not have a supervision or appraisal policy. The registered manager told us they had no formal guidance on timeframes for when staff should receive supervision and appraisal of their work. In 2021. Fifteen staff were recruited to Elizabeth Homecare and only one had received observed supervision at the time of our inspection.
- Records showed staff did not have appraisals to support their development and they did not receive regular supervision to enable them to carry out their duties. There were no formal competency checks in place to ensure staff were competent in all aspects of their role.
- Staff spoken with told us they had received an induction. However, staff raised concerns that some staff were inexperienced in care.
- Some staff had an appropriate qualification in caring. However, we found staff lacked knowledge in areas of care delivery. For example, fire safety, safeguarding and the Mental Capacity Act 2005.

The provider did not ensure that staff received the appropriate training, support, supervision and appraisal as necessary to enable them to carry out their duties. This is a breach of regulation 18 (Staffing) 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- The Principles of the MCA 2005 were not followed by the provider. Care plans and risk assessments did not take into consideration people's capacity to consent to their care.
- The provider failed to assess or record people's capacity. Where a person was deemed to lack capacity, this was not recorded in their care plans. There was no recording of best interest meetings to support the

care needs of people who lacked capacity.
● Staff knowledge of MCA was poor. Staff said they did not assess capacity and they could not describe what action they would take if a person lacked capacity to consent to care.

The provider did not have suitable arrangements for obtaining and acting in accordance with people's consent. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health needs were not always well managed or responded to in a consistent manner. There was no record of collaborative working with other agencies to guide effective care. For example, liaising with the falls team where a person was identified to be at risk of falls.
● Staff told us that if people required assistance and support from healthcare professional's they reported this to the office. However, they could not be confident that this was always acted on, nor did they receive feedback about any actions taken.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
●People's needs were not always fully assessed. The provider did not complete comprehensive assessments and develop care plans for people. We found a limited overview of people on one-page documents which did not support staff to understand people's needs.
● Where people were supported with food and drink, their care plans contained little information about their personal preferences.
● People told us they were involved in their care planning. However, staff told us people's care plans did not always contain up to date information about their care needs. One member of staff told us, "I only know what the person needs because I attend calls regularly; the records don't have the information I need to know."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care:
- People were not always involved in their care. Care plans did not always show involvement from people and their families. There was limited information to show people were involved in making decisions about their care.
- The provider failed to seek and act on feedback from all people and their families for the purposes of improving care.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always well supported. The provider and staff showed a lack of regard for people's safety and wellbeing. They had failed to comply with government guidance about staff testing to ensure the safety of people from the transmission of COVID-19.
- Care records showed limited information about people's cultural needs.
- There was an equality and diversity policy in place and staff told us they could obtain it in the staff manual.
- People were complimentary about staff who supported them. One person said, "Staff are very kind, respectful and caring." Another person said, "The carers are all fantastic, there is a regular group that comes to me."

Respecting and promoting people's privacy, dignity and independence
- People told us their privacy and dignity was respected by staff. One person told us, "They [staff] get me dressed on the bed and always keep me discreetly covered."
- Staff knew how to promote people's privacy, dignity and independence. One member of staff said, "I would always protect their dignity by making sure the blinds/curtains were closed and door was locked. I encourage them to be independent and do as much as they could manage."
- Staff told us they would not disclose people's confidential information outside of the service.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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 did not receive personalised care. The provider had failed to ensure that people's care records contained personalised, up to date information about their care needs.
- Staff had limited information provided to them in care records about the preferences and wishes of people they supported. This meant they had little chance of delivering care in a personalised and person-centred way.
- Staff did not have clear guidance in care records to ensure they were meeting people's needs. This mostly related to the management of risks, but we also found information regarding people's preference around gender of staff they would like to support them was also not considered or included.
- There was no recording of advocacy involvement to support people to make choices about their care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were not fully met. The provider had failed to ensure that assessments of people's communication needs were fully completed. This meant where people had difficulties in communicating these needs were supported appropriately in line with guidance.
- Information was not always provided in an accessible way. There was no easy read information or guidance available to people and their relatives.
- Staff were not knowledgeable about how to support people with communication difficulties.

Improving care quality in response to complaints or concerns

- Complaints were not well managed or responded to. The provider did not have a complaints policy.
- The provider and registered manager had no knowledge of the number of complaints received in the last 12 months.
- Complaints were not managed and recorded appropriately. We found concerns and complaints about staff and other aspects of care were recorded in people's daily notes. The registered manager was not aware of these issues and told us that records were not reviewed by anyone. As a result, no action was taken in response to concerns raised.
- People said they would phone the manager if they wanted to complain or they would contact the CQC.

They were not aware of any timeframes for when they could expect to receive a response from the service.

While no one came to harm, complaints were not being recorded or investigated. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) 2004.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

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

- There were no policies and procedures in place to support a culture of openness and transparency.
- Staff provided feedback about the service. Comments included, "Morale is low at the moment; it is the strain from staffing" and "Communication is poor."
- The provider did not have a policy regarding duty of candour to guide their practice.

We recommend the provider consider current guidance and implement a policy to aid and support their practice to ensure they meet the requirements in relation to duty of candour.

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

- The service was not well led or well managed. The provider failed to ensure effective governance arrangements were operated to monitor the safety and quality of the service. They were not aware of the widespread failings at the service which we identified during our inspection. These included poor oversight of adherence to government guidance regarding COVID-19, poor management of medicines, poor management of records and not adhering to the MCA 2005.
- The registered manager failed to demonstrate good leadership qualities and did not have sufficient oversight of the service. They had no awareness of concerns relating to the provision of care identified which included the lack of risk management. They failed to investigate concerns and incidents to ensure people's safety.
- The provider and registered manager failed to provide a range of information to us despite numerous requests made throughout the inspection.
- Staff reported concerns about the leadership of the service. They told us communication was poor and the lack of oversight by the registered manager impacted on them.
- There was no complaints policy and complaints could not be monitored due to the absence of an effective system to identify themes and trends or drive improvements.

Whilst we found no evidence that people had been harmed, we identified that systems were either not in

place or robust enough to demonstrate the service was operated safely and effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had failed to notify CQC of notifiable incidents that had occurred within the service. This included allegations, deaths and serious injuries.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

Continuous learning and improving care; Working in partnership with others
● There was limited evidence to show the provider was committed to improving care for people.
● The registered manager was not able to show us how lessons were learnt from incidents, investigations and complaints and used to drive quality and improve outcomes for people.
● When safeguarding incidents had been identified there was no evidence of lessons learned or outcomes shared with external agencies or staff.
● Satisfaction surveys were not completed by staff or with health and social care professionals to seek feedback on their service to improve quality.
● Further development of working in partnership with key organisations including local authority and safeguarding teams was required to ensure good outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were not fully engaged in the running of the service.
● The provider did not have a whistle blowing policy in place. However, the staff manual contained a section which covered whistleblowing with guidance on who to contact with concerns. When we spoke with staff, they told us they did not know who to speak to if the registered manager did not act on their concerns.
● Staff gave feedback about not feeling involved in the running of the service. Staff said they did not know the outcome of anything once they had reported it to the registered manager as they did not receive any feedback.
● There was limited information available to show how the provider considered the equality characteristics of staff and people who used the service.
● After the inspection, we received a statement from a relative of a person using the service telling us how pleased they were with the service they received and the kindness they received from staff.

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 Staff were unable to demonstrate an understanding of the Mental Capacity Act 2005 and what this meant for people using the service. The provider was not adhering to the principles of the Act by ensuring that people who lacked capacity had been assessed and were being supported in terms of the decision making abilities. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was no safeguarding policy in place for the service. There were no systems and procedures in place to monitor and record safeguarding incidents. Staff did not know how to report a safeguarding incident. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no complaints policy in place. The provider failed to have an effective system in place for managing complaints.

Regulation 16(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was an insufficient number of staff deployed to respond to people's needs. Staff had not received regular supervision and did not have an appraisal, therefore we could not be assured that they were fully supported to carry out their roles. Regulation 18(1)(2)(a)

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of events.

The enforcement action we took:

We issued a fixed penalty notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been completed to ensure people's needs had been fully considered so they, and staff were safe. There was no records kept to ensure the equipment in people's homes was maintained and safe to use. Risk assessments for medication had not been completed. Clear guidance was not in place to guide staff when medication should be administered. There provider did not comply with government guidance in elation to Covid-19. Regulation 12(1)(2)(a)(b)(e)(g)(h)

The enforcement action we took:

We issued a warning notice against the provider and the registered manager.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We identified a lack of robust oversight and leadership within the service. There was no systems and processes in place to assess and monitor the quality of services that were provided. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We issued a warning notice against the provider and the registered manager.