Cornerstone Care Services Professionals Ltd

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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?	**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
Cornerstone Care Services Professionals Ltd is a domiciliary care agency that provides personal care to people living in their own homes. At the time of our inspection the service was supporting five people.

People's experience of using this service and what we found
The service did not appropriately respond to and report allegations of abuse to keep people safe. Staff were not recruited in a safe manner to ensure they were fit to provide care and support to people. The deployment of staff did not meet people's needs. Accidents and incidents were not recorded and analysed to prevent recurrence. We found that medicines were not always managed in a safe way and people's risks were not recorded to ensure staff knew how to keep people safe.

The systems in place did not ensure staff were supported and had access to training to enable them to provide effective care and support. 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. Assessments were not undertaken to determine people's needs before they moved into the service. The service did not work with other relevant healthcare professionals to ensure people were safe.

It was not always clear that people were involved in the planning and reviewing of their care. Care plans did not ask questions about all the protected characteristics relating to equality and diversity. Staff were not aware of how to protect people from discrimination. People were not always encouraged to be as independent as possible.

We recommended the provider review procedures to ensure equality and diversity is considered at all levels of care and ensure people's independence is promoted.

Staff were not equipped with the skills to provide end of life care to people and people were not given an opportunity to discuss their end of life wishes.

The governance systems in place did not identify the shortfalls we found during our inspection.

People were protected from the risk of harm associated with the spread of infection.

People's nutritional needs were met.

People told us they were treated in a caring manner by staff. Staff understood how to support people in a way that respected their dignity and privacy.

People told us they received individualised care that met their needs. The care plans discussed people's

preferences. People's care plans were recently reviewed to ensure their needs were documented and up to date. Information could be made available to people in an accessible format. People told us they felt able to make a complaint and were confident that complaints would be listened to and acted on.

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 requires improvement (published 28 September 2018). The service is now rated inadequate.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the full report.

Enforcement
We have identified breaches in relation to safeguarding people from abuse; recruiting staff that are suitable for the role; providing safe care and support to people; obtaining consent from people to receive care and support; ensuring staff are well supported and trained to provide effective care; person centred care and overall governance.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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.

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

Cornerstone Care Services Professionals Ltd

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.

Inspection team
The inspection was carried out by one inspector.

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 did not have a manager registered with the Care Quality Commission. This means that the provider is 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 we needed to be sure that the provider would be in the office to support the inspection.

What we did before the inspection
Due to technical problems, the provider was not able to complete a Provider Information Return. 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 plan to make. We took this into account when we inspected the service and made the judgements in this report.

What we did before the inspection
We reviewed the information we already held about this service. This included details of its registration, previous inspection reports, notifications of serious incidents and any whistle blowing or complaints we had received. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with one person and two relatives of people who used the service about their experience of the care provided. We spoke with 5 members of staff including the provider.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. We also looked at 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.

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

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The systems in place did not ensure people were protected from the risk of abuse. We found records from a Local Authority to advise an allegation of abuse had been closed; however, there were no records or investigations completed by the service regarding this allegation, and CQC had not been notified. We also found notes to evidence a person had fallen three times in short time period and on two occasions the service had not acted in the best interest of the person to ensure they were safe and well. The service did not keep a record of any safeguarding incidents and there was no way of tracking trends and outcomes of potential abuse.
- The service had an up to date safeguarding policy in place that said all safeguarding training should be refreshed annually; however, the training matrix did not evidence this. The provider, and staff were unable to tell us when staff had last completed safeguarding training. This showed the provider did not implement and follow their policy which meant staff were not supported to understand how to keep people safe.
- The provider did not demonstrate an understanding of what a safeguarding concern was and who should be notified in the event of any concerns or allegations of abuse. The CQC had not received any safeguarding notifications. This means there was a risk that people would not be kept safe from potential harm and abuse.

We found no evidence that people had been harmed however, there were inadequate systems in place to safeguard people from the risk of abuse. 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.

- However, people and their relatives told us that they felt safe in the company of staff. Staff demonstrated an understanding of how to keep people safe. One staff member said, "[Safeguarding means] taking good care of people and making sure you don't get any case where they are harmed. You always report to your manager."

Recruitment

- We found that staff were not always recruited in a safe manner and we could not be assured that people were always cared for by staff who were suitable for the role.
- We requested to look at five staff files; three for managers and two for care staff. We were advised that management recruitment records were not available. We found one care staff did not have a DBS check in place. A DBS helps employers make safer recruitment decisions and prevent unsuitable people from

working with vulnerable groups. The provider had an email to confirm their DBS application had been received but no assurance of the outcome to evidence the staff member was safe to support people. Both care staff had unexplained gaps in their employment history. The service recruitment policy said that two professional references should be sought but for one care staff, the service had only obtained one professional reference. Furthermore, for both care staff we found that they had completed their inductions and signed their contract to commence work before the service had received references. This means the provider could not be sure staff were safe and suitable to provide care and support to people.

The provider had failed to ensure that recruitment procedures were robust, and that staff were of good character and had the skills required for the role. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

● The staff rota did not evidence people's support needs were being met by enough staff. One person's care plan said, "I need full assistance of two carers with all areas of personal care," but their rota showed that for their evening call they only had one staff member visit them. A second person's care plan said, "I need assistance of 1-2 carers when transferring from one place to another." It was not clear if this person needed one or two staff to support them to move safely around their home and their rota showed that for their evening call they only had one staff member visit them. We spoke with the provider about this and they told us they were unclear about the person's support needs and could therefore not comment further.

● The service kept no record of late or missed calls and there was no system in place for the management to have oversight of when staff were arriving and leaving people's homes.

● This means the provider could not be sure people were receiving care and support in line with their needs to ensure they were safe and well cared for.

The provider had failed to ensure people's needs were met through the number of staff deployed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, we spoke with people and relatives about time management and they were happy with the service. One relative told us, "[Staff are] very good at being on time. Their timekeeping is very good." One person confirmed, "[Staff are] on time."

● We spoke with the provider about our concerns related to staffing levels and how they monitored visits. They told us they were in the process of implementing a system where staff will use smartphones to log in and out of people's homes and the management team will receive a notification if staff are running late. They advised this would be in place by September 2019. As of September 2019, we had received no assurances this measure has been put in place

Learning lessons when things go wrong

● Accidents and incidents were not being reviewed and action was not being taken to minimise re-occurrence and to keep people safe.

● We found there were records to document when accidents and incidents had occurred, but these were not investigated further or analysed for trends. For example, we noted that on three occasions within ten days one person was found to have fallen. On the first two occasions the service did not take suitable action to ensure this person was safe and did not identify any learning they could take to prevent this happening again. On the third occasion, this person was admitted to hospital because of their fall.

● This demonstrated that the service did not effectively monitor the care and support provided to people ensuring lessons could be learnt to minimise risks and ensure people were always safe.

Accidents and incidents were not recorded and analysed to identify patterns and reduce the risk of harm to people. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People's risk assessments did not identify people's specific risks, and these were not reviewed on a regular basis to ensure they reflected people's up to date support needs. For example, under one person's nutritional risk assessment it said, "Carers need to check lips, eyes and skin." But there was no further information, so it was not clear what staff were checking for, or what this person's nutritional needs were. A second person's risk assessment had a hospital admission form in place to support them to receive appropriate medical care if they went into hospital; however, this was mostly blank. There were no contact details, no records attached, no list of medicines and the guidance regarding their mobility needs was conflicting. A third person's initial needs assessment identified they had dementia and a history of falls. However, there was no risk assessment in place for this.

● Staff told us they would read the risk assessments for guidance on how to support people. However, staff were not provided with enough instructions to guide them on how to keep people safe when faced with these risks. For example, we saw that one person needed, 'Repositioning several times during the day.' There were no instructions on how often, or how staff were to do this.

● The provider had failed to assess individual risks to people to ensure they received care and support that kept them safe from harm.

Risk assessments were not adequate and did not guide staff to know how to provide safe care and treatment. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives felt staff were able to manage risk well to keep people safe. Staff demonstrated an understanding of how to keep people safe and told us they found the risk assessments helpful. One staff member said, "Risk assessments, yes very helpful, if you don't read the care plan you don't know what to do for the client. You learn how to care for them."

Using medicines safely

● The systems in place to ensure medicines were being managed in a safe way were inadequate and we found that people had not always received their medicines in a safe way.

● One person's care plan said, "[Staff] are to ensure that I have my prescribed topical creams at the correct timings." We reviewed this person's medicine administration record (MAR) and found there was no record of this person's prescribed topical creams and it was therefore not clear if the person was receiving these medicines, what they were for or when they should be administered. This person's care plan also said, 'Nurse administers injections,' but there was no record of what these injections were, or what they were prescribed for. This person's medicine risk assessment said, "[Person] does not take medication," and their hospital passport was blank under the medicines section. A hospital passport is a document completed by the provider to ensure that when people are admitted to hospital all relevant health and social care professionals know about the person's care and support needs.

● A second person's care plan said, 'My [relative] prepares all medicines for me and puts them in dosette boxes. I want [staff] to support me with taking my prescribed medication which comes in blister packs, see MAR sheet.' However, we found this person had no medicines risk assessment in place and their MAR charts did not indicate the dosage of each medicine; what the medicines are prescribed for or how many tablets the person received during each visit. We also found that the MAR charts had been incorrectly completed and were not signed by staff. This meant if any concerns or errors were identified the service could not be

clear which staff member was responsible for the administering of medicines. We also found a third MAR chart that had not been signed at all, so it was not possible to know if the person received their medicines.
● We were advised by the provider they did not carry out MAR audits which means there was no oversight of the safe management of medicines.
● Records confirmed staff were not assessed for their competency to ensure they were able to manage and administer medicines in a safe way, and spot checks carried out by the provider did not look at medicines. Records also showed that eight out of 13 staff members had not received up to date training regarding medicines. This meant the service could not be sure medicines were being managed in a safe way which could put people at risk of harm.

The provider had failed to ensure medicines were managed in a safe way. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they trusted staff to manage their medicines. One person said, "Yes, it is done properly." Staff told us they felt comfortable supporting people to take their medicines. One staff member told us, "We use the MAR sheets and tick what has been given and make sure we have given the right dosage."

Preventing and controlling infection
● People and their relatives told us that staff always wore personal protective equipment (PPE). One relative told us, "[Staff] wear gloves and plastic overalls. They always wash their hands. They are very thorough."
● The service had an infection control policy in place and spot checks confirmed staff were taking appropriate measures to protect people from cross infection. We saw there were gloves, aprons and hand wash available for staff in the office. Staff confirmed, "They are provided, every Friday we go to the office and get them."

Inadequate

Is the service effective?

Our findings

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

At 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 people's care, support and outcomes.

Staff support: induction, training, skills and experience

- We reviewed staff training records and found that not all staff had completed essential and relevant training. For example, none had completed training on how to support people living with dementia or multiple sclerosis or how to support people using a catheter. Staff were providing support to people affected by these conditions, which meant people were at risk of receiving inadequate care and support.
- Furthermore, the training matrix did not show that all staff were up to date with training in line with the policy, which said training should be completed annually. This included the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
- We found there was no guidance available to tell us how often training should be done. The provider acknowledged the training matrix was not up to date. They did not know what training staff had or had not completed and when training was due. This demonstrated that staff were not supported to ensure they had the suitable skills and knowledge to deliver effective care and support to people.
- The service had a supervision policy in place that said staff were to receive six supervisions a year; however, records confirmed staff had only received four supervisions per year. We could not find any records to confirm any annual appraisals had been completed. There was no system in place to schedule supervisions or appraisals. This means staff were not provided with adequate support to enable them to complete their role effectively, review their performance and discuss concerns they may have.
- We reviewed induction records and found there was no evidence of new staff having shadowed more experienced staff members to learn how to carry out their duties. Furthermore, induction records confirmed all staff were inducted in one working day which contradicted their induction policy that said, "It'll take some weeks to avoid overloading staff." There were limited details about what the induction involved. This meant the provider could not be sure that staff were competent and ready to provide safe care and support to people.

The provider had failed to ensure staff received adequate training and support. There was insufficient evidence to show that staff were appropriately trained to be able to carry out their role effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, people and staff felt the service provided adequate training and support to enable staff to carry out their roles effectively. One person told us, "Yes, [staff] are skilled." One staff member said, "We have time

to tell [management] what we need, they are helpful."

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

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

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

We checked whether the service was working within the principles of the MCA.

● We looked at three people's care plan and saw that MCA assessments had not been completed and there were no consent forms in place for two people. The third person's care plan contained a consent form that had been signed by their next of kin, but there were no records to confirm this next of kin was the relevant person who could give legal consent for this person to receive care and support. Furthermore, this person had an MCA assessment in place that said, "I'm able to make myself understood," and confirmed this person did have the mental capacity to make decisions regarding care and support. However, this form was not dated or signed by the person and did not discuss the person's diagnosis of dementia or why the service had got the signature of their next of kin. There were no other signatures throughout this person's care plan to indicate this person had consented to receiving care and support.
● Staff told us they had not heard of the MCA. Records showed no staff had completed MCA training.

The service was not providing care and support in line with the MCA. As a result, people were at risk of having decisions made without their consent and not in line with their best interests. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, relatives and staff told us consent was obtained before providing care and support. One relative told us, "Yes [staff] always explain. If [person] doesn't like it, they will stop." One staff member said, "If the person doesn't want me to help, I listen. I always get permission to do things."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service received referrals from the local authority that contained information about people's individual care and support needs. However, the service did not complete pre-admission assessments to identify people's support needs and determine if they could support people effectively.
● This showed that the service was not assessing people's needs and choices to ensure they could deliver effective care and support.

The provider had failed to carry out an assessment of needs and preferences of the person to provide effective care and support. This was a breach of Regulation 9 (Person-centred care) 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

● There was no evidence of engagement with other services to offer holistic care and support in line with people's needs.

● We reviewed individual care plans and found that contact details of other health and social care professionals were not always completed. Of the three care plans we reviewed only one person had a hospital admission form in place to support them and ensure other relevant health and social care professionals would know about their support needs. However, this was mostly blank as it contained no next of kin details, no list of medicines the person received, and no relevant medical documents were attached.

● People and relatives told us they were not aware of the service working with other health and social care professionals to provide care and support. One relative told us, "Not as far as I know."

● We found records to confirm that one person had fallen three times; on two of these occasions the service had not contacted other health and social care professionals to seek guidance and ensure this person received support to keep them safe and well.

● This meant the service had inadequate systems in place to ensure people had access to healthcare services and received appropriate care and support in a timely manner. This put people at risk of harm.

The provider had failed to actively work with other relevant professionals to make sure that care and treatment was safe for people using the service. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they knew how to respond to emergencies when people required medical assistance. One staff member said, "When people are critical, we call an [ambulance] and get help."

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

● People's care files asked questions about support needs at mealtimes, including whether people could prepare their own food, if they had any special dietary needs and what their preferences were. One person's care plan said, "My catheter needs to be checked on each visit. If there is a small amount of urine in the bag, then encourage me to drink more and leave drinks within easy reach for me."

● One relative told us, "[Person] can eat and drink by [themselves] but [staff] always make sure [person] has water by [them]. Another relative confirmed there are, "No problems" with staff using a person's specialist feeding equipment. A staff member confirmed, "Yes we always leave a drink by [people]."

● This showed that the service worked well to ensure people maintained a balanced diet and stayed well.

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 told us their care plans were regularly reviewed. However, people could not confirm they were involved in the review process. We reviewed people's care plans and found there were no records or signatures to confirm people and their relatives were involved in making decisions and reviewing their care package.
● This showed that the systems in place did not always ensure people and their relatives were consulted and therefore, their care and support may not have been tailored to their needs and preferences.

The provider had failed to support people to participate in making decisions relating to their care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● People and their relatives told us that staff were caring. One relative told us, "[Staff] are very kind."
● Staff were able to give examples of how they provided kind and compassionate care and understood what people liked to make them feel more comfortable.
● Within individual care plans we did see some evidence of people's protected characteristics being discussed. For example, people's cultural and religious needs were taken into consideration. One person's care plan said, "[Staff] can sing memorial Christian songs to me or sing along side when it is being played."
● The service had an equality and diversity policy in place that said, "We recognise the diversity, values and human rights of people who use our services. We aim to celebrate differences between individuals."
● However, we did not see evidence of other protected characteristics being discussed as there was no record of people's sexuality or relationship needs. Records confirmed staff had not completed training in equality and diversity and they did not know of anyone's cultural needs when we spoke with them.
● This showed that the service did not always have systems in place to ensure staff were working in line with best practice to protect them from potential discrimination.

We recommend the provider review best practice guidance to ensure equality and diversity is considered as part of people's care package.

Respecting and promoting people's privacy, dignity and independence
● People and their relatives told us that they were treated with dignity and respect. Staff confirmed they

supported people in a dignified manner. One staff member told us, "You have to always make sure the person is covered and in a private space."

● Staff were able to give examples of where they supported people to remain independent. One staff member told us, "We encourage [person] to always brush [their] teeth."

● However, people and relatives we spoke with were not able to give any examples of where staff encouraged independence. We could not see any examples of this being considered in people's care plans. This means the systems in place did not always encourage a culture where people's independence was promoted to improve their sense of wellbeing and keep them well.

We recommend the provider review the service provided to people to ensure independence was promoted.

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 requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

End of life care and support

- The service was providing support to people at the end of their life. We checked whether the service had explored people's preferences and choices in relation to end of life care and if systems were in place to enable staff to provide adequate end of life care.
- Records showed that staff had not completed training in end of life care. We spoke with three members of staff; two said they had not received end of life training. One staff member confirmed they had, "We just did end of life, it was helpful. They teach you how to manage your emotions and support people for the best."
- Within people's care plans it varied as to whether end of life care had been discussed with people to ensure their wishes were known. One person's care plan said, "[Person] does not like talking about end of life. [Person] wants to be comfortable and pain free in the end." However, there were no records to indicate how this person would be pain free when receiving end of life care.
- Two people's care plans said they had a 'Do Not Attempt Resuscitation' (DNAR) form in place. A DNAR form is a document issued and signed by a senior healthcare professional, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR) on a person. However, neither care plan contained the actual form and the peoples end of life wishes had not been explored.
- This showed the service was inconsistent in its approach to end of life support and the systems in place did not always ensure staff were able to provide end of life care that met people's needs.

The provider had failed to assess and respond appropriately to people's changing needs to ensure they received care that met their needs and preferences This demonstrated a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans recorded their needs and preferences. They were personalised to enable staff to provide person-centred care to people. For example, one person's care plan said, "I like to have my hair neat. I like to wear nightdresses not pyjamas." Another person's care plan said, "I need carers to be patient and don't hurry me." People and their relatives were happy with the way staff supported them and felt their care was person-centred. One relative told us, "[Staff] always try to communicate. [Staff] will see [person's] face, [person] will let you know if [person] doesn't like it, [staff] listen." Staff confirmed "Care plans are helpful, they show you how to talk to people."
- Records showed care plans had been reviewed for May, June and July 2019. This meant staff were providing care and support that reflects people's current needs.

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.

● The provider had not heard of AIS. However, the service was not currently providing care and support to people with specific communication needs. We discussed with the provider about making important documents available for people in an accessible format including information about safeguarding and complaints. The registered manager told us they would develop this following the inspection.

Improving care quality in response to complaints or concerns

● The service had a policy and procedure for dealing with any concerns or complaints. No complaints had been received.

● People and their relatives told us they had no reason to complain but would feel comfortable to do so. One person said, "No, but I would be able to do so." A relative confirmed, "If we had to, yeah, no problem, we would call [provider]. But we are 100% fine."

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 requires improvement. 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.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider did not know of their legal obligation to notify the Care Quality Commission of any incidents that affected people in receipt of a regulated activity, such as personal care. We have not received relevant safeguarding notifications, notifications about people having a serious injury or other incidents in the service. This meant CQC could not maintain oversight of the running of the service to ensure people were safe and well cared for.

The provider had failed to send to the Care Quality Commission relevant information regarding the safety of people using the service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found widespread shortfalls with risk assessments; medicines; safe recruitment practices and staffing levels and the analysis of accidents and incidents. We also found the systems in place to protect people from harm and abuse were inadequate. There were shortfalls identified with staff training, inductions, supervisions and appraisals. The service was not working in line with the Mental Capacity Act 2005. The service did not assess people's care and support needs prior to accepting care packages. We did not find a consistent approach to people and their relatives being involved in their care and the service was failing to ensure it protected people from discrimination. People were not supported to remain independent. Care plans were not regularly reviewed to reflect people's up to date support needs and we found that the systems in place to manage end of life care were insufficient.

● We found that daily records of people's care were not audited; it was not always clear which records related to which person as they did not have any names or identifiable information on them. This meant the provider did not know what care and support was being provided to what person.

● There was no registered manager in place and the service did not have a clear recruitment plan to assure us there would be a registered manager to manage the service more effectively. This meant the provider did not have a robust management team to oversee the running of the service and ensure they were providing safe and effective care and support to people.

The above failures demonstrate the service is providing inadequate care and support to people through

their lack of robust quality assurance systems. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care. Working in partnership with others

- The provider did not complete any people, relative, staff or relevant health and social care professional surveys. This means they were not aware of what people and staff thought of the service and were not receiving ideas and suggestions to improve the service and the experience of people receiving care and support.
- Feedback from other relevant health and social care professionals that we had gathered before the inspection identified similar concerns.
- The service did not work in partnership with other health and social care professionals to ensure a culture of continuous learning and development

The provider has failed to seek and act on feedback from relevant persons to continually evaluating and improving the service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People, relatives and staff spoke positively about the management team and specifically about the provider. One staff member told us, "[Provider] is a very good manager, if you want help she always helps. She always listens." One relative said, "For me, they are very good, I would like to keep them forever."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out an assessment of needs and preferences of the person to provide effective care and support. People were not involved in making decisions relating to their care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The systems in place did not ensure all people using the service, and those lawfully acting on their behalf, had given consent before any care or treatment was provided.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established and operated effectively to investigate and prevent abuse of people.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment systems in place did not ensure staff were of good character and had the qualifications, skills and experience necessary for their role.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training and professional development to enable them to carry out their duties. People's needs were not met through the number of staff deployed.

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 Care and treatment was not being provided in a safe way.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established to ensure the service operated effectively and provided safe care and treatment to people.

The enforcement action we took:

Warning Notice