Direct Health (UK) Limited

Direct Health (Kettering)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This announced inspection took place on the 13 and 14 July 2016. Direct Health (Kettering) provides personal care to people in their own homes, there were 162 people receiving care during this inspection.

The service is required to have a registered manager; a registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

There was no registered manager at the service. The person managing the service was a registered manager for a different location with the same provider. This manager had managed Direct Health (Kettering) for seven months.

There was a systematic failure in all areas of the service which led to people being neglected and abused. The provider had a lack of insight into the manager's failure to follow their processes. This meant that all aspects of the service were failing and people were not always receiving their planned care.

People were subject to alleged abuse which had not been reported to the appropriate authorities or acted upon. The lack of systems to prevent and identify abuse led to potentially abusive situations continuing for people for over four months. People continued to be at risk of harm due to the lack of managerial oversight and systems in place to protect people.

People were at risk of serious harm as they did not always receive their medicines safely. There was no system in place to establish what medicines people were prescribed, or to record these or administer people's medicines to them safely. There were no systems and processes in place to monitor that people had received all of their prescribed medicines.

People were at risk of harm as there was no managerial oversight of telephone calls being received by office staff from people who used the service, their relatives and staff. Telephone calls were being received that identified that people were being subjected to abuse, missed calls, missed medicines, missed meals and changing care needs. These telephone calls were not acted upon or checked to ensure that appropriate action had been taken. Staff receiving calls failed to recognise the significance of what they were being told and issues such as suspected abuse and missed calls were not escalated to the manager.

People did not always receive their planned care, or receive calls at times that were their preference as there was a lack of co-ordinated allocation of calls. Staff allocated calls for the convenience of the staffing rotas and did not take into account the effect on people. As a result, people were left for long periods without personal care, meals and medicines and in some cases this meant a loss of dignity.

People's verbal complaints had not been acknowledged or responded to. Written complaints had been

acknowledged, but the information from the complaints did not drive improvement.

People were cared for by staff that did not have the guidance and support they needed to carry out their roles. Staff competencies were not checked and staff concerns were not taken seriously.

The provider's systems and processes designed to monitor the quality of the service were not always followed. Internal audits and checks did not identify issues which were affecting people's safety and well-being. The response to any issues that were identified were inadequate and did not improve the service.

We identified that the provider was in breach of eight of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and one Regulation of the Care Quality Commission (Registration) Regulations 2009 (Part 4). We took urgent action to impose conditions on the location's registration:-

1. to prevent the service taking any new packages of care and
2. provide analysis and reports relating to all aspects of medicines management, call allocation and calls to the service by service users, their relatives and staff.

We have taken further enforcement action of which you can see details at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will complete our enforcement action of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of abuse or improper treatment because the manager and co-ordinators did not follow the systems in place designed to protect people nor understand their roles and responsibilities to safeguard them.

People were at risk of harm as there was no system in place to manage people's prescribed medicines safely.

People did not receive their calls at their allocated times, nor for their allocated length of time as there was not a suitable system to deploy staff.

Risk assessments were in place and care plans to guide staff on how to mitigate the risks were in place.

Is the service effective?

Inadequate

The service was not effective.

People received care from staff that had not received sufficient guidance to implement their knowledge and skills. Staff did not receive adequate support to carry out their roles.

People did not always receive their meals, or their meals were not provided at suitable intervals in the day.

People were not always supported to access relevant health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA).

Is the service caring?

Inadequate

The service was not caring.

People's needs and preferences were not the priority of the manager and co-ordinators in planning times of their visits or

deploying care staff.

People were listened not to, their views were not acknowledged nor acted upon as care and support was not delivered in the way that people chose and preferred.

People's dignity was not always maintained as people were left for very long periods without personal care.

People had good relationships with regular care staff, but most people did not have regular care staff.

Is the service responsive?

Inadequate

This service was not responsive.

People's complaints were not responded to or acted upon to improve the service.

Staff did not have sufficient knowledge of new people to the service to meet their needs.

People were not re-assessed as their needs changed.

People's needs were not always met in line with their individual care plans, assessed needs or personal preferences.

Is the service well-led?

Inadequate

This service was not well-led.

There was not a registered manager was in post.

There was a systematic failure to manage all areas of the service leading to people being abused and not receiving their care as planned.

The provider did not have oversight of the management of the processes in place to assess, monitor and improve the quality and safety of the service. The provider's quality monitoring systems failed to identify and act on significant concerns.

People's feedback did not inform changes or improvements to the service.

Direct Health (Kettering)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 July 2016. The inspection was announced and was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who receives personal care at home. We gave 24 hours' notice of the inspection as it is an agency; we needed to be sure that they would be in.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with 15 people who used the service and seven people's relatives. We also looked at care records, daily records and medicine administration charts relating to 21 people. In total we spoke with 11 members of staff, including eight care staff, a supervisor, the manager and the provider. We looked at eight records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service including the rotas relating to 1000 hours of care and audits of daily records.

Inadequate

Is the service safe?

Our findings

During our inspection in June 2015 we identified that people that required support to take their prescribed medicines did not always have their medicines safely managed. This was a breach of Regulation 12 (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The manager provided an action plan which demonstrated their compliance with the regulations by February 2016.

During this inspection people were not protected from the risks associated with the management of medicines. There was no managerial oversight of the recording, administering or auditing of people's medicines. Staff did not know what medicines people were prescribed, when they were due or how to give them safely. People's medicine administration records (MAR) charts were not named; they did not hold information about people's allergies or GP. Staff did not record the medicines people were prescribed or the medicines they had administered. People were at risk of not receiving their prescribed medicines as staff did not have enough information about people's medicines and did not record what they had administered.

Records showed that some people received medicines too close together, such as Paracetamol which had been recorded as being given less than 4 hours apart, putting people's health at risk. One particular example of this was demonstrated on an un-named MAR chart, this meant that we did not know who this related to and could not take action to protect the person or refer them to their GP for medical assessment.

Care staff did not report when MAR charts had not been completed on previous visits; this could indicate that people had not received their prescribed medicines. People were at risk of their medical conditions deteriorating due to missed medicines; as staff did not keep reliable records of the medicines they had administered, they did not recognize when people had missed their medicines.

Staff had received training in the management of medicines, but their knowledge and skills had not been tested. The manager told us that care staff supervision included a medicines competency test, however, the staff supervision records we saw did not include a medicines competency.

The manager and co-ordinators had carried out audits of the MAR charts, they identified that the charts were not complete and that staff had not signed when they had administered medicines. The only action the manager had taken over the last three months was to send a memo to care staff to remind them to complete the MAR charts properly. There had been no action taken to establish what prescribed medicines were due, or to seek medical help for people who may not have received their prescribed medicines.

We raised a safeguarding alert in relation to medicines management for 27 people who were identified on inspection as at being at risk of harm due to poor medicines management.

This is a continued breach of Regulation 12 (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse and improper treatment. The provider did not operate an effective

system to prevent the abuse of service users. Care staff had received training in the safeguarding of vulnerable adults; they reported their repeated concerns to senior and on-call staff, however, these concerns were never reported to the local safeguarding team, investigated or acted upon. We found that there had been nine separate allegations of abuse reported by care staff to co-ordinators, both verbally and in writing. These written allegations had been filed away. This put people at risk of serious harm as repeated allegations of abuse had been ignored. Some of the allegations related to a member of staff, who continued to be deployed to people's homes to provide care to the same vulnerable people. We brought this to the attention of the manager who claimed to have never seen the allegations before; they carried out an immediate investigation. We also brought this to the attention of the provider and we raised the required safeguarding alerts.

Since September 2015 there had been 32 safeguarding incidents affecting 16 service users, where service users had been subjected to improper treatment or harm. Only five of these incidents had been reported to the Northamptonshire safeguarding team by staff at Direct Health (Kettering), all of the other alerts were raised by relatives and health professionals. Most of the reported incidents related to people not receiving their planned care due to late, early or missed calls. There was no reliable system of identifying when people were not receiving their planned care, and staff were not reporting when there were indications that people had not had their care, such as missing entries in log books or verbal complaints.

Where safeguarding alerts had been investigated by the manager, we found that the investigations were not thorough and did not prevent staff who had been accused of abuse from continuing to provide care to the person making the claims. In one particular example, a person's relative told us they were concerned that their relative always had bruising when one member of staff provided care. They told us "[Name] had a lot of bruises on her arms, we did mention that and we are still getting the same carer that we think did it. I've spoken to Direct Health regarding the bruises and we've noticed she's now got another bruise. The communication in the office often falls on deaf ears, they say they will ring you back but nine times out of ten they don't." Records showed that a previous safeguarding concern had been raised by the same person against the same member of staff. Even though the incident had been investigated, no disciplinary action had been taken, the member of staff had not been re-trained in moving and handling and they continued to be deployed to the same person. We brought this to the attention of the provider and raised a safeguarding alert.

People were at risk of financial abuse as there was no system in place to effectively manage the financial transactions made by care staff on behalf of service users. In January 2016 there had been an allegation of financial abuse which had been investigated and disciplinary action had been taken. The provider failed to protect people from potential financial abuse as they did not regularly monitor the financial transaction records. Audits carried out in July 2016 were for transactions that had taken place in 2015 and January 2016; they identified that receipts had not been collected and people had not signed to say they agreed with the financial transactions; however, no action had been taken to rectify this. We brought this to the attention of the provider and raised a safeguarding alert.

This is a breach of Regulation 13 (1, 2, 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their planned care calls at their allocated times. Of the 21 service user records we examined for the period 1 June to 12 July 2016, 11 service user records showed that care staff often arrived more than 30 minutes late or early for their planned call, and 11 service user records showed that staff did not stay for at least half of the time allocated to provide care. Records also showed that service users were having their personal care, meals and medicines either too close together or too far apart as staff

were deployed at times that did not take into account their needs for medicines and meals.

People told us they did not have regular allocated times. One person told us "I never know what time the girls [staff] are coming." We saw written feedback from people that care staff would arrive too early in the evening and too late in the morning, leaving them in soiled pads for long periods of time as they had not received their personal care for over 12 hours. One relative told us "[name] has two carers at a time. Times can vary from 7:30am to 11:00am, I can't always change her in the night on my own. [Name] has got dementia and it's frustrating when Direct Health doesn't understand her case." Records showed that people were not allocated the same time every day and that there were differences of up to three hours every day when care staff would arrive to provide care.

People did not receive a rota in advance, (unless they specifically requested one by email), telling them the time of their visit or the care staff that would provide the care. People told us this caused them anxiety, not knowing who was coming or at what time. One relative told us "[relative] has dementia and doesn't like a lot of new people ; she likes familiarity. I would say that evening and teatime calls are on time but the morning, no. We don't get a rota and find out in advance Who, What, Why, When, Where and How? Nobody rings us; we just wait until the day."

People's preferences for their care had not been accounted for in the planning of the deployment of staff. People told us that the staff 'in the office' did not listen, and care staff were sent at random times. One person told us "We get up about 7:30 in the morning. [My wife] has to wait till 9:45 to 10:30. I must say it's not nice if she needs the toilet and shower. It's a long time isn't? When you need the bathroom and want to be fresh for the day – you just want to go. It can also vary from 10:30 to 10:45 to 11am - and the day has gone by then. On a Saturday it's 11:15am so we can't go anywhere." People's records showed that care staff turned up at different times every day, for example, one person was due their care at 9:15am, but the daily records showed that in one week they had a call at 7:24am and 10:22am.

People who required two care staff to provide their care did not always have both staff turn up at the same time. One relative told us "Most workers turn up together and if they don't - I say no, it's a double up and I can't help you. I'm 81 now so they stay in the car and wait for the other carer to arrive." Another person's records showed the care staff arrived at different times.

There was no effective systems in place that identify when people did not receive their planned visit. Records showed that staff did not always use the electronic log-in system at people's houses to register when they provided care. This meant that there was no reliable way of identifying when people had missed their call. There was a risk that people were not receiving their planned personal care, meals and prescribed medicines. We identified that out of the 21 service user records we examined that three people may have missed 13 planned calls in June 2016. We found there was no evidence that these people had received their calls as there were no entries in the daily notes, medicine administration charts or electronic log-in. The manager was not aware of these potentially missed calls even though audits of the daily records and the electronic log-ins had been carried out. We brought these to the attention of the provider and raised three safeguarding alerts.

This is a breach of Regulations 18 (1) and 17 (2a,b and f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in June 2015 we found that the service was in breach of regulation 12 as the provider had not always assessed the risks to the health and safety of new service users. During this inspection we found that new service users had undergone risk assessments.

People were assessed for their potential risks associated with manual handling and mobility. People's needs had been reviewed in March 2016 so that risks were identified and acted upon as their needs changed. For example where people's mobility had deteriorated their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how they were to mitigate people's risks to ensure people's continued safety. For example one person no longer used their walking frame as they were cared for in bed; the risk assessments and care plans reflected this.

People could be assured that prior to commencing employment with the agency, all staff applied and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references.

Inadequate

Is the service effective?

Our findings

People's needs were not always met by staff that had the required knowledge and skills to support them appropriately.

Although staff received training that included all areas of care specified in the Care Certificate, there was no reliable means of checking that staff had applied this knowledge in practice. For example all staff had received training in managing medicines but staff did not record the medicines they had administered or followed any of the medicines policies and procedures set by the provider. Staff had received training in safeguarding of vulnerable adults, but senior staff and co-ordinators failed to follow the provider's policies and procedures and did not report alleged abuse to the manager or the relevant authorities. This resulted in people being subjected to the continuing risk of harm.

The manager told us that staff received spot checks at people's homes which included an assessment of their medicines competency. However of the eight supervision records we saw, only one member of staff had their medicines competency checked. One member of staff had worked for the service for over three months, they told us "I haven't done care work before, I haven't had any supervision or spot checks yet."

Staff supervision did not support staff in their roles or provide guidance to ensure they were following the providers' policies and procedures. Supervisions did not identify where staff required competency assessments or allow staff to discuss their concerns about the people using the service. Although care staff had received supervision from co-ordinators, they in turn lacked the support and vision required from the manager to drive improvement through supervision.

This is a breach of Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have sufficient food and drink in a timely way. Staff were not always deployed regularly enough for people to have their meals at meal times. One care staff told us "sometimes we are sent to people at 10:30am, it's too early to give someone their lunch." Some people required their meal to enable them to have their medicines, but their records showed that their care visits were at different times each day, not corresponding with a meal time. This meant that people were not always receiving assistance with their meals at a time when they would expect to be eating, there was a risk that people would not eat regularly enough to maintain their health and well-being because of this.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although care staff were vigilant to people's health and well-being and ensured people's changing health needs were reported to co-ordinators or on-call staff, these staff did not always act on the information that care staff gave them. For example one person's needs had changed and they required a shower chair, care staff had asked the co-ordinators for this to be arranged, but this had not happened. The care staff told us "I

spoke to the district nurse, they arranged one straight away, I don't know what the delay was in the office, it was easy to get." Another member of staff told us that they had alerted the office staff to someone having new medicines and asked them to inform other care staff, but this was not carried out. They told us "The co-ordinators don't pass messages on." Where care staff reported that people were unwell the co-ordinators referred people to their GP and notified their relatives.

This is a breach of the Regulation 12 (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. The care plans contained assessments of people's capacity to make decisions.

Inadequate

Is the service caring?

Our findings

People did not always receive care from regular staff which meant that staff found it difficult to build therapeutic relationships with people. Where there were regular care staff, people told us "Staff are very good and caring towards me, I get on with all of them", and "If I get regular carers, yes it's correct and if not, no. Different carers are not quite as caring towards me." Another person told us "We don't always have the same carers. Direct Health has such a lot of staff leaving and starting, you never know really who is going to be at the front door."

Staff did not always know the people they supported well; they were not able to tell us about people's interests or what was important to them. People's care was not always person centred, as the times staff were allocated were based on the times convenient to the organisation and not individuals. For example records showed that one person was due a care visit at 9am, however, the rota recorded that they were often allocated calls as early as 8am. In their daily notes staff had recorded that they woke the person to provide their care. Staff also recorded that when they did visit after 9am that the person was awake and receptive to care. Staff had not liaised with the co-ordinators to ensure that the person only had their calls from 9am to prevent having to wake them to provide care.

People had selected their preferred times for their care and these were recorded in their care plans. However, their allocated call times did not reflect people's preferred times. One person told us "I never know what time the carers are going to arrive." And other person told us "We just wish people would let us know what time they're coming and who is on the way." Records showed that staff arrived at care visits at different times each day, and were often over half an hour earlier or later than their allocated times. People and their relatives told us that they were not kept informed if staff were going to be late. Staff failed to ensure that people received their care at their preferred times.

People were not kept informed of the times they were allocated for their care. People told us they did not receive a rota; one person told us "We used to get a rota but not anymore, I don't find out until they come, it's a surprise." Another person told us "I don't receive a rota, I find out who's coming in the morning." Relatives told us that not knowing who was allocated to give care had caused anxiety; one relative told us "mum has just had a few new ones lately. She has dementia and doesn't like a lot of new people, she likes familiarity."

The provider did not manage the times that people received their care, which left some people feeling they had lost their dignity. People were left for long periods between personal care, one person told us "I sometimes wee myself which I can't help. This is because carers are late."

This is a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were arrangements in place to gather the views of people that received personal care in telephone surveys and formal questionnaires. People had provided negative feedback mostly about poor

communication and times of their calls. One person told us "Everything seems to be changing again so I don't know who to get in touch with." The feedback had been acknowledged but there had not been improvements to the service since their feedback in February 2016.
This is a breach of Regulation 17 (2e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated their awareness of the need to maintain people's dignity; they were able to provide examples of how they supported people in a dignified manner, such as using positive language to encourage people to be independent. One person told us "Everyone is perfectly respectful to your age without being patronising.

Inadequate

Is the service responsive?

Our findings

During our inspection of 18 June 2015 we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not always ensured that timely care planning had taken place to ensure the health, safety and welfare of new service users. During this inspection we found that there was a continued breach of this regulation.

People could not be confident that they would receive their care when they first used the service. People were assessed before they received care to determine if the service could meet their needs. However, information about people new to the service was not always shared with the staff providing their care. One person missed their first day of care because the communication between the office staff and the commissioners was not clear. A safeguarding alert was raised regarding this. One member of staff told us "I went to see a new client this morning. I didn't know what I was to do to help [name] I asked his wife who explained what they wanted. There was no care plan or paperwork, just a piece of paper with our logo on." They did not know whether they were supposed to provide the person's medicines. Although the manager later told us that the paperwork was in the house and did not understand how the care staff did not see this; the care staff did not have an introduction or handover from the assessor to inform them of the new person's needs. There is a risk that people new to the service would not receive their care as there were no suitable processes in place to ensure that care staff are aware of people's needs.

People's care plans had been updated in March 2016; this had been in response to the commissioner's request. People's care plans had not been updated unless they were due a regular review. When staff reported people's changing needs to the office staff, this information was not always acted upon, such as changes in medicines, mobility and manual handling needs. People were at risk of receiving care from staff that were not aware of their current care needs.

Care was not planned and delivered in line with people's individual preferences, choices and needs. Co-ordinators did not give consideration to people's preferred times that were recorded in their care plans. People did not receive their care at the time that would meet their needs for personal care, medicines and meals.

Although people had been involved in their assessments and care planning, their care was not always provided at the time they chose. People who used the service and their relatives told us that care staff did not arrive at the same times every day, one relative told us "One person told us "I get up in the morning; it's just that I can't stand, therefore staff come and shower me, they have been really late and that has annoyed me. They don't phone me to say that they're going to be late." The allocation of staff was erratic, records showed that some people were left without care for long periods of time, for example one person was at risk of acquiring pressure ulcers and required regular personal care. Their care was provided at times that left them for over 14 hours without personal care, which put them at high risk of acquiring pressure ulcers. We raised a safeguarding alert regarding this person.

Another person required their personal care, medicines and meals three times a day to maintain their health

and wellbeing. The staff had been allocated the lunch call so early in the day (10:30am) that this person was left for over seven and a half hours without personal care, medicines or food. They were at risk of being very hungry, going without drinks and medicines and not receiving the personal care when they need it. We raised a safeguarding alert regarding this person.

This is a breach of the Regulations, 12 (2a and b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were not confident that their complaints would be acted upon. People complained that the provider did not listen to them. One person told us "My husband and I have complained numerous times, mainly about timekeeping. Its only after I complained, this improved for a short time but then went back to the old way again." We saw that people and their relatives had contacted the office staff to discuss their allocated call times and staff, however we saw that no action had been taken. Staff also contacted the office staff to raise issues, they told us that "The office does not listen, it's like a black hole they never tell you what they have done about anything." The provider failed to listen and respond to concerns and complaints from people receiving care, their relatives and staff. There was a complaints procedure in place and written complaints were responded to, but verbal complaints were not accounted for and the provider did not follow their complaints procedure for these. People were at risk of poor care as the provider had not responded to people's verbal complaints to improve the service.

This is a breach of the Regulation 16 (1 and 2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. The manager of the service was a registered person at another of the provider's locations and was overseeing two locations. The manager did not have the managerial oversight or skills to implement the provider's systems and processes designed to protect people.

There was no clear leadership and staff found the manager unapproachable. There was a sign on the manager's door that said that staff should not disturb and entry to the manager's office was 'by appointment only.'

There was a systematic failure in all areas of the service which led to people being exposed to the risk of neglect, abuse and omissions in their care. The providers systems for assessing, monitoring, mitigating risks and improving the service were not being used by the manager or senior staff. The provider had a lack of insight into the manager's failure to follow their processes. This meant that all aspects of the service were failing and people were not always receiving their planned care.

There was no managerial oversight or audit of the calls that were received from people who used the service, their relatives or staff. Office staff received calls that alerted them to serious issues such as people not receiving their care, physical abuse and changes in people's needs. However, these were never acted upon and people continued to be at risk of harm due to the lack of systems to address the issues people raised.

The audits that had been carried out were not robust; they had not identified all of the issues found on this inspection, such as missed calls, late or early calls and short calls. The action taken to address their findings were not effective; the manager sent memo's and emails to staff to remind them of the importance of record keeping but did not take action to understand why the issues had arisen.

The provider told us that all daily records, MAR charts and financial records should be audited monthly; however, we saw that only 29 out of the 162 daily records were audited in July 2016, 20 of these had not been audited for over three months, and 9 had not been audited since 2015. We identified from these records that one person was subjected to continuing physical abuse because the provider had failed to act upon the concerns that had been raised to them. We also identified that people had missed calls and medicines and people were at risk of financial abuse. We raised multiple safeguarding alerts. This meant that due to the lack of managerial oversight poor practice was putting people at risk of not receiving their planned care, medicines and financial abuse.

People were at risk of harm as there was no system to understand people's medication and the importance of individual's timings of medicines. There was no managerial oversight to establish that MAR charts correlated with people's prescribed medicines and no regular checks to ensure people had their medicines administered safely. The audits did not identify that people were at risk of not receiving their medicines as prescribed, and they failed to refer people to their GP for medical advice where people had not had their

medicines.

There was no system to continually assess people's risks or update people's care plans when their needs changed. The manager had responded to the commissioners' request for an update in the risk assessments and care plans but there were no plans for the next assessment and communication about people's changing needs was unreliable due to a lack of systems in logging calls.

People were asked for their feedback about the service in formal surveys. People's comments had been recorded and analysed. In February 2016 most people complained that they did not receive rotas, their call times were not at the time they preferred and that staff were often very early or very late. The manager had responded by letter to each person, stating the action they were taking to improve the service. However, during this inspection we found that the service had not improved.
This is a breach of the Regulation 17 (1) (2a,b,e and f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not notify the Commission or the local safeguarding team of 10 separate incidents of alleged abuse. This allowed the abuse to continue for over four months.
This is a breach of Regulation 18 (1 and 2e) Notification of other incidents. Care Quality Commission (Registration) Regulations 2009 (Part 4).

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 did not notify the Commission without delay when there had been incidents of abuse or allegation of abuse. Regulation 18 (1)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that service users received care that met their needs or preferences. 9(1a and b)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that service users were provided with proper and safe management of medicines. 12 (2g) The provider did not ensure that service users' were always assessed for their risks and care plans were updated regularly to mitigate these risks. 12 (2a and b)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider did not have suitable systems and processes in place to protect and prevent abuse of service users or investigate immediately upon becoming aware of abuse.13 (2)(3)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not meet the nutrition and hydration needs of service users

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system to identify, receive, record, handle or respond to all complaints.16 (1)(2)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have the managerial oversight or effective systems and processes in place to assess, monitor and mitigate risks relating to the health, safety and welfare of service users, or systems to improve the quality and safety of service users.17 (1)(2a,b,e and f)

The enforcement action we took:

We imposed urgent conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not adequately deploy suitably skilled, experienced or supported staff to provide planned care to service users. 18 (1)(2a)

The enforcement action we took:

We imposed urgent conditions on the registration