Springwell Care Ltd

Springwell Care Ltd

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced comprehensive inspection of Springwell Care Limited on 24 and 26 October 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 11 November 2016 inspection had been made. In addition, prior to the inspection we received concerns from a number of sources regarding recruitment, staffing and overall service provision.

Springwell Care Ltd is a domiciliary care agency based in Enfield, North London which provides personal care to people living in Hertfordshire, Buckinghamshire and Enfield. At the time of the inspection there were 22 people using the service. The service provides personal care to older people some of whom are living with dementia or have physical disabilities.

The service had a registered manager who was also the registered provider. 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.

The provider did not ensure safe staff recruitment. Not all staff had undergone appropriate recruitment checks prior to working with vulnerable people as identity checks had not been carried out, references not obtained and criminal records checks not completed.

People were at risk of receiving late or missed care visits as there were insufficient staff available to cover care visits as a result of non-payment of wages. Missed visits occurred during and after the inspection.

People were not always receiving care from staff who were competent, skilled and experienced. There was a risk that people were receiving care from staff who had not received training to meet the needs of people with certain health conditions. The provider did not keep appropriate records of training. Staff did not receive regular documented supervisions or appraisals.

Many people and relatives that we spoke with said that they had made complaints. The provider did not effectively record complaints that were received or the actions taken with regards to complaints. Complaints were not analysed to ensure improvements could be made.

Care plans were not in place for all people receiving support. People's preferences were not appropriately recorded and care plans were not always reviewed on a regular basis.

Effective systems were not in place to assess and monitor the quality of the service. Although some quality checking had been undertaken these had not been used to improve the quality of care for people.

Overall governance of the service was ineffective and staff told us that they were not supported by the

registered manager. Most staff had not been paid and the registered manager was unresponsive to concerns raised by staff. We observed poor staff morale throughout the inspection.

The provider did not adequately assess risk for all people using the service.

Records indicated that people received their medicines, as prescribed. However, we could not be assured that staff were trained and competent to administer medicines.

We received positive feedback from most people and relatives who told us staff were caring and responsive to their needs. However, some people and relatives told us they often received care from different care staff who did not know them or their care needs.

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, where a rating of inadequate for any key question or overall remains, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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 and the service is again rated inadequate for any key question or overall, we will take action to prevent the provider from continuing to provide 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.

We identified seven regulation breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. Staff recruitment was not safe. Systems were not in place to ensure staff were recruited safely. Recruitment records were inconsistent and did not contain all required information.

There were insufficient staff deployed to ensure people received care visits. People regularly experienced late or missed visits.

Risk assessments were not in place for all people who used the service.

Improvements had been made to how medicines were managed. However, we found errors in recording and could not be assured that all staff were trained and competent to administer medicines.

Is the service effective?

Inadequate

The service was not effective. Not all staff received training prior to providing care to people.

Not all staff received an induction when commencing employment. Staff did not receive regular supervisions and an annual appraisal.

Staff had not received training in the Mental Capacity Act 2005. Consent to care was inconsistent.

Is the service caring?

Requires Improvement

The service was not always caring. People and relatives spoke positively of care staff.

However, we received feedback people often received care from different carers who did not know them or understand their needs.

Is the service responsive?

Inadequate

The service was not responsive. Care plans were not in place for

all people who used the service. Not all people's care preferences were respected.

Care plan reviews were inconsistent and it was not evident that people and relatives were involved in planning their care.

Complaints were not used to drive improvements to the service and not all people and relative felt confident that they could complain.

Is the service well-led?

Inadequate

The service was not well led. We observed poor staff morale and many staff told us they were not supported. We received mixed comments from people and staff regarding the overall management of the service.

Ratings of the last CQC inspection had not been displayed on the provider's website and at the location.

Although there were some systems in place to assure quality of care provided, we identified significant concerns with overall governance of the service.

Springwell Care Ltd

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 checked 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 24 and 26 October 2017 and the first day of the inspection was unannounced. We did not give the provider advance notice of the inspection because we had received concerns regarding recruitment and staffing.

The inspection was carried out by one inspector and on 26 October 2017, phone calls were made to people, relatives and staff by three inspectors.

Before the inspection we reviewed the information we held about the service such as statutory notifications and safeguarding alerts. We considered information which had been shared with us by the local authority and communication made to CQC raising concerns. We looked at the action plan the service had provided to the CQC following the last inspection.

During the inspection we spoke with two people who used the service and thirteen relatives. We spoke with the registered manager, an administrator, two senior care staff and eight care staff. We liaised with three placing authorities and one social care professional.

We spent some time looking at documents and records that related to people's care and the management of the service. We looked at six people's care plans and risk assessments. We reviewed thirteen staff files. We looked at other documents held at the service such as medicines administration records, rotas and quality assurance records.

Inadequate

Is the service safe?

Our findings

The provider had recently commenced providing care packages for people who lived in Buckinghamshire. We established that one of the staff members working in the Buckinghamshire area had not undergone any recruitment checks and there was no record of this person being employed. This staff member was providing personal care to one person whilst unaccompanied or unsupervised. When asked about this during the inspection, the registered manager told us that the staff member was not providing care to any people and was in the process of being recruited. We raised a safeguarding alert with the local safeguarding authority and it was established through their enquiries that this person was providing personal care to one person. Following the inspection, the registered manager sent a criminal records check from the Disclosure and Barring Service (DBS) from another employer dated the week of the inspection, a copy of identification and evidence of a national vocational qualification. However, this person had already been working with vulnerable people without any checks in place to ensure they were safe to do so.

We reviewed 12 staff files and found significant concerns with how staff were recruited. Of the 12 staff files reviewed, we found no record of a DBS check having been completed for two staff and found that for a further four staff members, DBS checks were from a previous employer. It is best practice for services to apply for DBS checks on behalf of their own service to ensure that information is current. Following the inspection, the registered manager sent an 'Adults First' check for one of the two staff members without a DBS check in place dated the day after the inspection. We found that references were not obtained for four staff members. For one staff member, we found that a reference had been accepted from the person's close relative. We found that identification checks such as a passport and visa documents were not obtained for three staff members.

During the inspection, the registered manager told us that recruitment and DBS checks were maintained on a spreadsheet which she did not have access to. We requested a copy of the spreadsheet and evidence that all staff had undergone recruitment checks by a deadline. We did not receive the spreadsheet and the supporting evidence received by the deadline did not provide reassurances that all staff had undergone the recruitment checks required. In addition, we received confirmation from four staff members that staff were providing care without having undergone recruitment checks.

The service had a recruitment policy which we looked at. However, the registered manager had not been following their policy regarding safe staff recruitment. We were not satisfied that the registered manager was following safe recruitment practices and that all staff employed were suitable for the role they were engaged to perform, which placed people at risk of harm.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On commencement of the inspection we established that there were significant issues with staffing levels and deployment of staff to ensure people's care needs were met due to the non-payment of wages owed to care staff. Throughout both days of the inspection we witnessed care staff coming into the provider's office

to request updates on their wages and telephone calls to the office to cancel their rostered shifts as they had not been paid. We witnessed office based staff phone other care staff to see if the care visits could be covered for later in the day.

We received consistent feedback from staff that this occurred on a regular basis and a senior staff member had to then ensure the visits were covered.

On the evening of Friday 27 October 2017, two staff members contacted a member of the CQC inspection team to advise that staff had handed back care visits over the weekend which they were unable to cover themselves. We were advised that the registered manager had not provided support to the staff to ensure the visits were covered. We immediately contacted the local authority where the people were living and advised them of the concerns raised. We established contact with the registered manager who assured us the care visits would be made and provided a list of staff who would cover the visits. We established that the registered manager made some of the care visits herself over the weekend. We received confirmation from the local placing authority on Monday 30 October that people received their care visits.

On Monday 30 October 2017 we were advised by a staff member that two people living in Buckinghamshire did not receive care visits that day as there were no staff in the area. We alerted the local authority who made arrangements to ensure the safety and well-being of the people affected.

On Thursday 2 November 2017 we were informed by a local authority that one person did not receive a care visit on the morning of 1 November 2017.

We received a mixed response from people and relatives regarding timeliness of care visits. One person told us, "Comes in morning, came today at 7.30am, yesterday 11.30am due to other work commitments." A second person told us, "Sometimes they are late but on the whole quite good."

A relative told us that their regular carers came on time but replacement carers come in late in the morning and put their relative to bed early in the evening. Another relative told us, "[Person's] two regular carers are excellent. The problem is when the carers need a day off. They are supposed come at 7:30am and they came at 9:30am. [Person] was in bed 15 hours." The relative further elaborated, "One day last week no one turned up." A third relative told us, "Few problems with time keeping. Sometimes on a Saturday they have written down they are still there at 9.30am but they have left." A fourth relative told us that they found their relative in bed at 6:00pm or 6.30pm and not supported to get up again until 8.00am. They told us, "[Person] is supposed to have four visits a day but how can they fit in four visits and get her in bed at 6pm." A fifth relative told us, "Sometimes they stay 10 minutes. They document wrong times. The neighbour watches out. They leave the care running and pop in and out." One staff member told us, "If I take time off then everything goes to shambles. Our clients call us directly to tell us no one has turned up for the shift."

We looked at how care visits were scheduled. The provider was in the process of implementing an electronic care management package, however not all people and staff were set up on the system at the time of inspection. We looked at rotas and found that some visits had been scheduled back to back with no allocated travel time in between. We saw that on 23 October 2017, one care staff had three visits scheduled back to back and had to travel 5.4 miles between the first and second visit and six miles between the second and third visit. Some care staff told us they had difficulties ensuring they were on time as a result. A staff member told us, "We get the rota every week on a Friday. We don't get travel time. I have to judge my own rota." This meant that people did not receive consistent care at times of their preference or to ensure they were safe.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all people supported by the service had a documented risk assessment in place. Specific risks to people's health and welfare had been identified but these had not been assessed and guidance had not been provided for care workers to ensure that the people being supported were safe and any identified risks mitigated. We asked the registered manager if they supported people with diabetes to which the registered manager replied, "No." However, we found that one person had a diagnosis of diabetes. A risk assessment was not in place to identify the signs and symptoms a person may display when they became unwell due to this conditions or what action staff should take to keep the person safe.

Another person's risk assessment had not been reviewed or updated since July 2016 despite the person having significant care needs which included hoisting and pressure ulcer monitoring.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we last inspected in November 2016, we found that medicines were not safely managed as people had not received their medicines as prescribed and Medicines Administration Records (MAR's) contained errors and gaps in recording. At this inspection, we found that although some concerns had been addressed and improvements had been made, we could not be assured that medicines were managed safely.

We received a mixed response when we asked people and their relatives for feedback on how their medicines were managed. One relative told us that their relative was prescribed a time specific medicine and they mostly received their medicines on time. Another relative told us, "We have a huge issue with the medicines. [Relative] was given anti-psychotic medicines at the wrong time. Because the carers read the blister pack upside down. We have issues with the timings of medicines." We discussed this feedback with the registered manager who confirmed that care staff did make a medicines error and underwent re-training.

We looked at MAR's for four people and found one MAR contained numerous gaps in recording. We discussed our findings with the registered manager who told us that the person had been in hospital on the dates. However, when we reviewed the person's care notes completed by care staff, we found that they had received care on those dates and staff had recorded administering medicines to the person in the care notes.

There were systems in place to audit MAR's and when MAR's were returned to the office they were checked for errors. We saw that at this inspection, the names of the individual medicines prescribed were listed on the people's MAR.

We were unable to establish that all staff had been trained and assessed as competent to support people with their medicines as training records were not available for all staff at the time of the inspection. This is elaborated on further in the 'effective' section of the report.

The provider had a safeguarding policy in place. However, we were unable to ascertain if all staff had received safeguarding training. The registered manager told us that staff received safeguarding training as part of completion of the Care Certificate on induction. Two staff members told us they had received safeguarding training when they commenced employment with Springwell Care Limited. However, records available at the inspection did not support this. This is elaborated on further in the 'effective' section of the

report. One staff member told us that safeguarding was, "Is how to treat people. Not good to shout to people." A second staff member told us that as a result of the staffing concerns, "We are left in an uncomfortable position. This may become a safeguarding issue; we have managed to cover so far."

Inadequate

Is the service effective?

Our findings

We received mixed comments from people and relatives when we asked if staff were skilled to meet people's needs. One person told us, "On the whole quite good." A relative told us, "Some good, others not." A second relative told us, "[Named care staff] are excellent; occasionally our replacement carers do not have the same expertise."

We received a mixed response from staff when we asked them about induction and training. One staff member told us, "I did have an induction training. We talked about the care that we do, hygiene, safeguarding." A second staff member told us, "None of the new carers are trained. You get one day training. You can't learn a thing in one day." A third staff member told us, "I had no induction. I am still waiting. I have not had any training with Springwell."

We discussed training and inductions with the registered manager who told us that staff complete a two day care certificate when they commenced employment. The care certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The two day course included fifteen topics such as safeguarding, fluids and nutrition, life support and health and safety. In seven of the 12 staff files reviewed, we found no evidence of training from Springwell Care Limited. In one staff file, we found evidence of training with the provider in November 2015. In four staff files, we found no record of an induction. We found that one staff member, who had not undergone any recruitment checks prior to providing care had also not completed any training prior to providing care. The registered manager told us that she had been delayed in printing the certificates to evidence that staff had completed training. However, we were not supplied with these certificates during or after the inspection.

We asked the registered manager about specific training in medicines management. The registered manager told us, "We also emphasise, two hours on certain others – medication. We go through again. I liaise with another company to do meds training. We sit down when they on breaks." There was insufficient evidence to show that staff received appropriate and adequate training that met their needs and enabled them to carry out their role.

Not all staff had a documented spot check or supervision session. This meant that their competency in delivering care tasks such as medicines administration or moving and handling was not checked on by a senior staff member to ensure they were safe to complete these care tasks. We asked staff members about whether they received supervision and we received a mixed response. Comments received from staff included, "[Registered Manager] has sat down with me a couple of times to see how I am doing but nothing in the last two months", "For the first two weeks [registered manager] popped round at clients homes" and "I have had two supervisions. The last one was about two months ago." We looked at supervision records contained in staff files and found that for one staff member, their supervision record for December 2016 and February 2017 was identical. We looked at the staff files of two people who had been employed for more than one year; we found no record of an annual appraisal.

This was in breach of Regulation 18 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 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. At our last inspection, we found that although consent to care had been obtained appropriately, staff members had not received training in MCA which was reflected in their knowledge. At this inspection, we found no records that staff had completed training in MCA. The registered manager told us that staff received MCA training as part of their completion of the care certificate. However, as noted above, we found that seven staff files contained no records of staff having received any training.

We checked whether people consented to their care. In some files, we found that people had consented to their care. In one file, we found no consent form. We asked the registered manager about this and were advised that the consent form was in the person's home and had not yet been brought to the office to be photocopied.

People and relatives we spoke with did not require assistance from the provider to access healthcare services.

We did not receive feedback from people or relatives about their experience of being supported to eat or drink. Care records detailed when people required assistance with meal preparation and daily records seen evidenced that people were supported to eat and drink.

Requires Improvement

Is the service caring?

Our findings

We asked people and relatives that we spoke with if they felt that care workers treated them kindly and with compassion. Feedback from people included, "Carers are good, is very caring" and "Always very friendly." One relative told us, "Care workers are very nice." A second relative told us, "The two regular carers are good with [person]. They are patient and try hard to get [person] to do personal care." A third relative told us, "Carers are kind and caring." A fourth relative told us, "[Person] loves them. They are kind, no concerns whatsoever. The care workers are lovely; they are special and really good."

However, we received mixed feedback from people and relatives about the continuity of care provided. A person told us, "Staff are looking for other work, so had two carers, will be getting another one next week." A relative told us, "Sometimes we know who's coming as replacement other times not." A second relative told us, "[Regular carers] who come who are lovely but if another person comes in as replacement [person] gets agitated as it's not managed very well as some staff don't get that [person] gets agitated." This meant that people sometimes received care from staff that were not always familiar with the person or their care needs which could have caused people anxiety or distress

The impression we received from care staff when we spoke to them was that despite difficulties encountered as a result of non-payment of wages, they completed care visits to ensure people received care. A staff member told us, "I can't give up my job as I can't just leave my clients."

We looked at compliments received by the service and saw compliments had been received from relatives which complimented the caring nature of care staff. One compliment read, 'Very happy with carers. [Named carer] very good." A second compliment read, 'Thank you to the carers. Built a great relationship.'

Due to the concerns noted on the commencement of the inspection, we focused people and relatives feedback on addressing the concerns, as such, we did not ask people and relatives about other aspects of whether the service was caring.

Inadequate

Is the service responsive?

Our findings

One person's care package commenced in September 2017. A pre-assessment and registration form had been partially completed, which identified that the person had specific medical and mobility issues which staff should have been made aware of. However, a care plan had not been completed. This meant that not all people supported by Springwell Care Limited had a care plan in place to provide guidance for staff to support the person according to their needs and requirements and in a person centred way.

One person's registration form had noted that the person had no preference on whether male or female staff provided support. However, it was established that the person had refused to allow a male carer to provide personal care. We saw that another person's registration document was blank where asked about gender preferences of care staff. The person's relative told us that it had been communicated to the service at the commencement of care that the person requested female care staff only. A male care staff had attended care visits to the person and waited in the car whilst their female colleague provided care. This person required moving and handling assistance from two care staff which meant that care was not provided in line with the person's assessed needs.

Care plans reviewed contained a section called 'How Springwell can make life easier for you'. We found that in all care records reviewed the information contained in the section was the same. It stated, 'I would like to stay in my own home, with the support of carers and my informal carers. Providing me with nutrition and hydration for all my meals, drinks and snacks in the day. I would like the carer to assist me with all my personal care needs, washing, dressing and medication. I would like to feel safe in my own home knowing that I have someone with me all the time." This was not person centred and did not detail the individual wishes and preferences of that person.

Reviews of people's care needs were inconsistent. We saw that some people's care records were updated following incidents or changes to their care needs. We saw that following concerns identified with a person's medicines management, their care plan had been updated to advise staff not to leave until they saw the person swallow their medicines. Care files contained a document called monthly care plan review. For one person we saw that their care plan was last reviewed in June 2017. For another person, their care plan was last documented as having been reviewed in June 2017 and prior to that, their care plan was last reviewed in October 2016. It was not evident that people or their relatives were involved in their care reviews. A relative told us that that they had not been involved in any care reviews with the service. This person's care package commenced in July 2016.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked how the service handled complaints. When we last inspected, we found that not all complaints were recorded or analysed. At this inspection, we found that improvements to complaints handling had not been made. The service had a complaints policy in place and we saw that three complaints had been recorded since we last inspected. We received mixed feedback from people and relatives about how they felt

complaints or concerns were handled. Some relatives told us that issues were resolved when they raised concerns such as replacement care staff and ensuring staff wore identification badges. A relative told us, "[Registered Manager] is willing to address issues, has sometimes covered carers if gone off sick. [Registered Manager] has responded to complaints, mother will ring [Registered Manager]." A second relative told us regarding late visits, "Spoke to [Registered Manager] and she said she would sort it out. Resolution has been a bit hit and miss."

However, one person and one relative told us that they did not want to raise concerns as they did not want to appear critical. One person who regularly experienced late visits told us, "I don't want to upset anyone so haven't complained to manager in case no-one comes at all." We could not be assured based on feedback from people and relatives that all complaints made to the service were appropriately logged.

This was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had been last inspected on 11 November 2016 and the report had been published on the CQC website on 11 January 2017. A letter was sent to the provider and registered manager with the final report informing the provider that they were required to display their rating. It is a legal requirement for providers to display the CQC performance ratings. Providers must ensure that their rating(s) are displayed conspicuously and legibly at the location delivering a regulated service and also the website. Prior to the inspection, we checked the provider's website and saw that the rating was not displayed on the provider's website. When we commenced the inspection at the provider's registered office, we saw that the rating was also not displayed. We discussed this with the registered manager who told us that she was not aware the rating had to be displayed.

This was in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and relatives if they felt that the service was well run. Comments received from people included, "[Registered Manager] is very good actually. Very caring." A relative told us, "[Registered Manager] is willing to address issues, has sometimes covered carers if gone off sick." A second relative told us, "[Registered Manager] is occasionally bit brusque." A third relative told us, "I have raised lateness on a number of occasions. There is no one to speak to at the office. The organisation or allocating clients to carers is remiss. They are a bit disorganised. It's hit and miss."

We received overwhelmingly poor feedback from staff we spoke to regarding the overall management of the service, the responsiveness of the registered manager and the continued late or incorrect payments of wages to care staff and how that impacted on the service people received. We observed poor staff morale throughout the inspection.

Feedback received from staff regarding the overall management of the service included, "It's all being run wrong. You have to bug them for a folder or a care plan. I am having to tell them", "I feel that no one cares about the clients", "I have worked for a lot of companies and this is probably the worst. Communication is disgusting, organisation is disgusting" and "In emergencies [Registered Manager] will not pick up the phone. Yesterday I called her as I couldn't access the key safe but I couldn't get hold of anyone." We heard from staff that the registered manager did not often come into the office and did not communicate with staff.

On commencement of the inspection, we became aware that there were significant concerns with the overall governance of the service. We saw that as a result of many staff not being paid, care staff called to cancel their shifts. We observed office based staff try to ensure care visits were completed and we were told that senior staff members worked additional days and hours to cover care visits. We observed and staff spoke positively of the efforts made by senior care staff to try to ensure people received care visits. Staff told us, "[Staff member] is very efficient. They try their best. Anytime I ring [staff member] will help me" and "[Staff member] deals with everything and its more pressure on their shoulders." We observed office based staff attend the office during the inspection to provide support to their colleagues despite having not been paid.

We identified concerns about the integrity of the registered manager throughout the inspection. The registered manager was evasive when asked about a specific staff member working with people who had not been safely recruited or trained. The registered manager told us that this staff member was not working with people when this was in fact not the case. In addition, the registered manager told us throughout and following the inspection that all care staff had been paid their outstanding wages when this had not been the case.

We found that documentation around staff recruitment was inconsistent and not safe. We found that staff had not undergone recruitment checks to ensure they were suitable to work with vulnerable people.

Staff did not receive regular effective supervisions and appraisals. Staff training was inconsistent and records were not kept up to date.

Not all people had care plans or risk assessments in place and care plan reviews were not taking place on a regular basis.

Call monitoring was ineffective as people experienced regular late visits. The registered manager told us that she had developed a call audit; however, we did not see any evidence to support this.

There were no staff meetings documented. Staff told us that they did not attend meetings. One staff member told us, "Used to have office staff meetings but have not had any whole staff team meetings." A second staff member told us, "No team meetings. I have suggested that but nothing has been done."

The above information in well-led showed that the service was failing to ensure that there was adequate oversight and governance of the service. Systems and processes were not in place to ensure that any issues could be identified and resolved. The service had also not identified any of the issues we identified as part of this inspection.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some quality assurance systems were in place. We saw that some MAR charts had been audited and we saw that some spot checks had taken place with areas for improvement for staff identified.

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 Regulation 9(1) The provider did not ensure up to date care plans were in place for all people who used the service. The provider did not ensure people received care according to their preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16(1) The provider did not ensure that all complaints were logged and used to make improvements to the service. The provider did not ensure that all people and relatives were supported to make a complaint, if necessary.

Regulated activity	Regulation

Personal care

Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments

Regulation 20(A)

The provider did not ensure their rating from their last CQC inspection as displayed in their registered location and on their website.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The service did not have effective systems in place to record and monitor the quality and safety of service provision.

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration on 10 January 2018.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19(1) The provider did not ensure a robust recruitment procedure by ensuring staff employed were of good character and had the skills and experience which were necessary for the work to be performed by them.

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration on 10 January 2018.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The provider did not ensure there were sufficient levels of staff were suitably deployed to ensure all other regulatory requirements were met. The provider did not ensure all staff received support, training, professional development, supervision and appraisals.

The enforcement action we took:

We issued a Notice of Decision to cancel the providers registration on 10 January 2018.