High Care Plus Limited

# High Care Plus Ltd

## Inspection report

Kingsgate
62 High Street
Redhill
RH1 1SG

Date of inspection visit:
29 October 2019

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
High Care Plus Ltd is a domiciliary care service providing personal care to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the service supported 23 people with personal care needs.

People's experience of using this service and what we found
There was a lack of managerial and provider oversight of the service which meant risks to people's welfare and safety were not being robustly managed. Systems in place had not ensured people received their care calls. This had led to people's care calls being missed or provided later than planned. The provider did not have robust systems in place to monitor staff practice, knowledge of people and understanding of their needs.

Risks to people's safety were not always assessed and acted upon. Medicines processes were not safely managed and records did not evidence that people were receiving their medicines in line with their prescriptions. Robust recruitment processes were not in place and the provider had not monitored staff training and support. Staff had not completed training appropriate to people's specific needs such as dementia, epilepsy and pressure care.

Systems were not in place to monitor and report concerns such as safeguarding, complaints and accidents and incidents. This meant the local authority were not aware of potential risks and appropriate action was not always taken to minimise the risk of concern happening again. The provider had failed to notify CQC of significant concerns in line with their statutory responsibilities.

People's needs were not always fully assessed. Not all those receiving care had a care plan in place to guide staff on how their care should be provided. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We received positive feedback from people regarding the staff who supported them. They told us they were caring and respected their privacy.

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

Rating at last inspection
This service was registered with us on 26 November 2018 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about people's care calls being missed and staff not taking action where there was no response on arrival at a person's care call. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. The provider has taken action to minimise risks to people's safety and are working with the local authority to monitor the service.

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

Enforcement

We have identified breaches in relation to the safe recruitment, training and deployment of staff, the monitoring of risks to people safety, the failure to report safeguarding concerns and to record and monitor accidents and incidents, complaints and missed calls. Person-centred care was not embedded into practice, assessments were not robustly completed and care plans were not completed for all those receiving a service. There was a lack of management oversight of the service and quality assurance systems had not been implemented.

Full information about CQC's regulatory response to these concerns can be found at the end of this report.

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

The overall rating for this service is 'Inadequate' and the service 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.

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

# High Care Plus 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 four inspectors. Two inspectors visited the office location, one inspector visited people in their homes and a fourth inspector conducted telephone interviews with people, their relatives and staff.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also a director of High Care Plus Ltd. We have referred to them as the provider throughout the report.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or provider would be in the office to support the inspection.

Inspection activity started on 29 October 2019 and ended on 8 November 2019. We visited the office location on 29 October 2019.

What we did before the inspection
Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events

which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority to discuss information they had received in relation to concerns raised by people and their families

We used all of this information to plan our inspection.

During the inspection-
As part of our inspection we visited three people in their homes who received a service from High Care Plus to seek their views on care. In addition, we spoke with four people and two relatives on the phone to ask their opinion of the service they received. We also spoke with the provider and a second director of High Care Plus Ltd. We reviewed a range of documents about people's care and how the service was managed. We looked at seven care plans, seven staff files, medication administration records, risk assessments, policies and procedures and internal audits that had been completed.

After the inspection
Due to the concerns identified during our inspection we continued to request assurances from the provider regarding measures they had taken to ensure people's safety. We liaised closely with the local authority to ensure people's care was monitored.

In addition, we sought clarification from the provider to validate evidence found. We asked for updates regarding people's care, risks to their safety and well-being, staff rostering information, recruitment and training checks. We spoke with four staff members employed by the service.

Inadequate

# Is the service safe?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk management plans were not in place to support people's safety and well-being. Two people's records assessed they were at high risk of developing pressure sores. There was no guidance for staff regarding how risks should be reduced or what signs staff should look for to indicate to staff whether a referral to a healthcare professional was required. This meant there was a risk people would not receive the care they required and concerns may not be reported in a timely manner.
- One person's records stated they were experiencing swallowing difficulties. Despite these concerns being recognised there was no evidence of action being taken to ensure the person was not at risk of choking.
- Risk management guidance was not in place in relation to specific risks associated with people's health conditions. These included epilepsy, catheter care and people living with dementia. There was no evidence available to confirm staff had received training in how to support people with these needs. This meant risks to people's well-being may not be identified and responded to in a safe and timely manner.
- We identified three of the seven care files viewed did not have risk assessments in place. This meant there was a risk staff would be unaware of risks to their safety when providing their care. The provider told us they had completed additional risk assessments for some people. However, these had not been printed and made available for staff to follow.
- The providers PIR (provider information return) stated, 'To monitor and ensure that the service we provide is safe, we have put in place Risk assessments, care plans which are tailored to individual needs (Person Centred Plan), Risk management forms to help our contingency plans and a continuous development (Training) programme'. And, 'We have introduced a risk stratification matrix that classes all the individuals under what risk category they belong.' We found that the systems described had not been consistently implemented. This meant there was a risk people would not receive a service which ensured their needs were met safely.
- Not all accidents and incidents had been recorded in order to ensure concerns were identified and action taken to minimise the risk of them happening again. The provider told us one person had experienced a fall which had required medical professionals being called for assistance. This had not been recorded and no evidence was available to show what action had been taken to minimise risks.
- Contingency plans developed by the provider did not cover concerns such as staff sickness and missed calls to ensure appropriate action was taken to keep people safe.

Using medicines safely

- Safe medicines management systems were not always followed. Medicines administration records (MAR) were not always accurately completed. This meant the provider was unable to know if people had received their medicines in line with their prescriptions.
- One persons MAR contained gaps in recording in order to confirm their medicines had been administered.

A second person who was supported with their medicines did not have a MAR chart in place. This meant the provider was unable to confirm if they had received their medicines in accordance with their prescribed instructions.

● Where staff had added hand-written entries of prescribed medicines this was not signed by staff to confirm it had been transcribed accurately. There was no guidance available to staff regarding when to administer PRN medicines (as and when required). Where people required staff to support them to apply topical creams there were no body maps to show which area of the body specific creams should be applied to.

● The provider told us that although staff had received training in supporting people with their medicines, they were aware of on-going concerns. The provider told us staff had not completed competency assessments in relation to medicines administration and recording. This meant the provider was unable to assure themselves that staff were able to complete this area of their role safely.

The failure to ensure risks to people's safety were assessed and mitigated, accidents and incidents were recorded and monitored and that people received their medicines safely was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People's views of staff arriving to provide their care and missed calls varied. Some people and their relatives told us they had experienced missed and late calls. One person told us, "They seem to find it difficult in the mornings, so I'm not always sure what time they will arrive. The later calls are better. I've only had one missed call." A relative told us, "Staff turn up on time. They are hardly ever late, but if they are they phone."

● The provider had failed to plan and monitor care calls to ensure staff arrived. Prior to the inspection we were informed of concerns that a number of people's care calls had been missed. The provider confirmed this was the case. They told us due to staff recently leaving they had found it difficult to plan and monitor people's care calls. They were unable to confirm how many care calls had been missed and had not ensured these were recorded to minimise the risk of the same mistakes happening again.

● Information received from people, relatives and the local authority identified six missed calls which had placed people at risk. The calls related to one person at high risk of pressure sores needing to spend the night in their wheelchair, an incident of a person being distressed due to waiting for a number of hours for staff to arrive and one person missing a health appointment due to not receiving their support. The provider had not reported these concerns to the local authority safeguarding team.

● We asked the provider for copies of the staff rota which they were unable to provide during the inspection visit. This meant the provider was unable to assure themselves that all care calls had been scheduled and that staff were aware of who they were supporting and when. Rotas were sent to us following the inspection. These contained errors such as staff being rostered to attend two care calls at the same time and staff travelling from one care call to the next without any travel time.

● We requested a list of all the care calls people were due to receive each week. The list provided did not contain three people who received support. The provider told us the care co-ordinator fitted these calls in and they were not listed on the rota. This meant there was a risk these people would not receive consistent care and their calls may be missed.

● The provider did not have a system in place for monitoring care calls. They told us that as a result of complaints regarding late and missed calls they were looking to purchase an electronic call monitoring system. This would alert them of the time staff arrived at care calls and how long they stayed. No interim system had been developed to ensure people's calls were provided whilst planning for the electronic monitoring system.

● The duration of people's care calls was not monitored to ensure people received the care they required.

People's views regarding if staff stayed for the full length of the calls varied with some people stating this was always the case and others telling us staff regularly cut calls short. As not all records were available the provider could not confirm that people were receiving the length of care calls they were assessed as needing and being charged for.

● Following the inspection, the local authority and CQC requested assurances that the provider had implemented a system to monitor all care calls. Evidence was not received for 10 days following our inspection which was outside the timescales originally set.

The failure to ensure sufficient staff were deployed to safely deliver people's care was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. The providers PIR (Provider Information Return) stated, "High Care Plus has a robust recruitment process that considers fit and proper individuals." We found this was not the case.

● We requested a full list of staff names employed at the service on three occasions both during and following the inspection. On each occasion different names had been supplied. Of the seven recruitment files reviewed during the inspection, four care staff did not have a DBS and four staff had only one reference regarding their suitability for the role.

● Following the inspection, the provider stated they had found all the required evidence. The provider said that although they had applied for DBS checks and reference for each of the staff members concerned they had not recorded when they had been received. The provider confirmed that prior to our inspection they had failed to check the information received in order to assure themselves the staff employed were suitable for their roles.

● Following the inspection, we were informed by the local authority that the provider had contacted them regarding concerns on a DBS for one staff member. The staff member concerned was not on the list of staff employed given to us by the provider. When asked, the provider told us this had been an error on their part and they had not previously fully reviewed the staff members DBS. As a consequence, the local authority were required to find cover for the staff member in question. The person being supported was left in the position of receiving care from a staff member they did not know at short notice.

● There were no previous employment histories for two staff members and identified gaps in the employment histories of a further two staff members. The failure to ensure robust recruitment checks meant people were at risk of receiving support from staff who were not suitable to work in care services.

The failure to ensure safe recruitment processes were followed was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they felt safe with the staff supporting them. One person told us, "Yes I feel safe with them. They are all friendly." One relative told us, "I think she safe with them. I get a feel for them and I have felt anything dodgy."

● We found systems and processes were not always followed to protect from potential abuse or harm. The provider had failed to inform the local authority of incidents such as missed care calls and a staff member not providing care in line with a persons needs. This meant the local authority were unable to consider these incidents under safeguarding guidance to help ensure people's safety.

● Not all staff were able to describe the type of concerns which may constitute abuse or how concerns should be reported. They were unaware of how to report concerns to the local authority.

● The provider had a file in place where two safeguarding concerns had been recorded. However, both of these concerns related to information requested by the local authority following concerns being raised by

people and their families. The file did not contain any information regarding the provider sharing concerns with the local authority.

The failure to ensure safeguarding concerns were appropriately reported and that staff were aware of their responsibilities 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.

Preventing and controlling infection

- People and their relatives told us staff always wore gloves and had had access to aprons when providing their care. One person told us, "They wear gloves and aprons and have covers to put over their shoes."
- Staff confirmed they were aware of the need to wear personal protective equipment to minimise the risk of spreading infection. They told us the provider ensured this equipment was made available to them.

Requires Improvement

# Is the service effective?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People's views on the training and competence of staff varied. One person told us, "I don't always feel they are trained as well as they could be. My (regular carer) is, but the others don't always do things properly, like washing me." One relative told us, "When I compare the staff from High Care Plus with (previous agency) they aren't as well trained as those, but they do look like they know what they are doing." A third person told us, "I feel they are trained and know what they're doing."
- Staff training was not effective in ensuring staff understood their responsibilities in providing safe care. Examples of this included staff's lack of knowledge regarding safeguarding procedures and the failure to follow reporting procedures and unsafe medicines practices. This was of particular concerns as a number of the staff employed had no previous experience of working in a care environment.
- The provider had not consistently monitored staff training to assure themselves staff were competent and working within the most up to date guidance. During the inspection the provider was unable to provide evidence of the training staff had received. They told us they had recently developed a staff training and monitoring spreadsheet but had not yet had time to complete this. They told us evidence of staff training was within each staff members file. However, of the seven staff files viewed, five contained no evidence of staff training and two contained training certificates from previous employers, some dating back to 2016.
- The Care Certificate is a set of agreed standards that health and social care staff should demonstrate in their daily working lives. The provider told us staff were required to complete Care Certificate workbooks which were then assessed. However, they were unable to tell us how many staff had completed the Care Certificate and failed to provide evidence when requested during the inspection.
- At the time of our inspection we requested evidence of staff induction and supervision. We were told this would be within staff files. However, induction information was not consistently completed in staff files and there was limited evidence of supervisions taking place.
- Following the inspection, the provider forwarded a training matrix which also contained confirmation that supervisions had taken place. However, there was no accompanying evidence to confirm the accuracy of this information.

The failure to ensure staff induction, training and supervision was consistently monitored and that staff were competent in their role was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier

lives, access healthcare services and support;
● People and their relatives told us the agency visited them to discuss their needs prior to them receiving care. One person told us, "They filled in the forms when they first came." A second person said us, "They did ask me when I first had them and my daughter told them (about their needs)."
● Despite these comments people's needs were not always comprehensively assessed prior to them receiving support from the service. This meant there was a risk important information regarding people's needs may be missed and that staff would not be fully aware of people's health needs. Three people's records viewed did not contain evidence of an assessment taking place. The provider told us that although an assessment was always completed it was not always as thorough as it should be.
● Where evidence of assessments taking place was available information was not fully completed and did not contain details regarding how people wanted their support to be provided, what was important to them or significant risks. For example, assessments did not fully record the gender of staff people preferred to provide their support, how their health needs should be supported and how they preferred to take their medicines.
● We asked the provider for evidence of working with other agencies and healthcare professionals in order to ensure people received safe and effective care. The provider told us any healthcare concerns reported to them would be recorded within daily notes and on the electronic system. However, they were only able to provide one example of where staff had reported concerns regarding a person's mobility and this had been actioned. They acknowledged that whilst there had been other occasions these had not been recorded in order for staff to be aware of any previous concerns.
● No records were available on the electronic system regarding contact with other agencies or social care professionals. The provider told us the system had not yet been fully implemented. We requested the provider reviewed their records following the inspection and forwarded details of how people were supported with their health care needs. However, no information was provided regarding this. This meant the provider was not able to fully assure themselves that people's healthcare needs were being monitored and action taken when required.

The failure to ensure people's needs were comprehensively assessed and to evidence people were supported with their healthcare needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA

● People's legal rights were not always protected as the principles of the MCA were not consistently followed. One person's records contained a consent form regarding receiving care from the service, signed by a family member. This stated the person did not have capacity to sign the document. However, no capacity assessment had been completed to determine this was the case and no best interests decisions

recorded. There was no evidence to demonstrate the family member who had signed giving consent had the legal authority to do so.

● Consent to care forms were not always in place to show people or their legal representatives had signed to consent to receiving care from the service. Consent to care forms had not been signed in four of the seven care files viewed.

● Staff spoken with were unable to describe principles of the MCA and how this may impact on their work. When asked about the MCA staff asked us what this meant and had no knowledge of this legislation.

The failure to ensure the principles of the MCA were understood and followed by staff was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service caring?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect. People and relatives told us individual staff members were caring in their approach. However, due to concerns found in all other areas of people's care the service cannot be described as wholly caring.

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

- People were aware of their care file and knew staff wrote notes. However, people were unable to say how they had been involved in developing their care plan. Not all of the people we spoke with had seen a copy of their care plan.
- There were no records that evidenced people or relatives were involved in decisions about planning their care. People told us they were not always aware when their care would be provided which demonstrated a lack of control over their own care.
- People's preferences were not always met. One person's records stated they preferred female carers. However, records for a week in September identified the care had been provided by two male staff.

We recommend the provider develops systems which fully involve people in their care and their preferences are respected.

- The provider told us they completed quality assurance calls and spot checks where people were able to comment on their care plans. However, records showed these had not been completed consistently in order to obtain consistent feedback.
- Staff told us they gave people choices when supporting them with their care. One staff member told us, "I will speak and ask them what they want to drink, to wear, things like that." A second staff member told us, "I ask them for everything. I do my job and I'm polite."

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with dignity and their diversity respected. People told us that staff were caring in their approach. One person told us, "These two (staff) are very good. Marvellous. We have a bit of a joke and they have time to talk to me." A second person said, "Staff are accommodating. We have a bit of a chat, I like seeing them." "One relative told us, "They are nice people to have around the home."
- People and their relatives told us they were supported by regular staff who they knew during the week although there were more changes at weekends. One person told us, "It's more or less the same during the week but a bit more hit and miss at the weekends." One relative said, "Monday to Friday we tend to get the same staff. Weekends it varies between three and four regulars, but occasionally get one we have never seen before. A second relative said, "They are first class. We have a good relationship with them. They are so kind."

Respecting and promoting people's privacy, dignity and independence

● People and their relatives told us that staff respected their privacy and their home. One person told us, "They are very respectful, they don't act out of line. One example is they will always ask if they want to use the toilet. They don't just assume, they always ask first. One relative told us, "Staff respect the environment."

● Staff respected people's independence. One person told us, "They could let themselves in as we have a key safe. But they always knock on the door and give me time to come and answer it." The person told us this was what they preferred staff to do. One relative told us, "They will close the doors (when supporting with personal care) and they seem respectful and nice."

● We observed staff supporting people in a dignified and respectful manner. Staff ensured people's care was provided in private where appropriate and offered people choices.

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

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 AIS standards were not implemented. Care plans did not contain comprehensive information regarding people's communication needs. There was little information provided regarding people's sensory needs and how these should be met by staff.
- Care plans did contain details of how people would be able to communicate their concerns in an emergency situation and what provision had been made for this. This was of particular concerns for those people living alone and those living with dementia. Emergency contact details for peoples loved ones or next of kin were not recorded in every person's records.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- We received mixed views regarding the responsiveness of the service people received. One person told us, "There is a plan in the file that they write in at every visit. I can look at this if I want, and I have done in the past." The person told us they were satisfied with the service provided. Another person told us, "We haven't been able to rely on them to do what we've asked and the staff don't seem to have the understanding or common sense."
- Not all people using the service had a care plan in place which meant there was a risk people's needs would not be met. We reviewed seven people's care records and found four people did not have care plans in place. Of the three people we visited one person's file in their home did not contain any care plan for staff to follow.

This meant people's needs were not always met.The rota system used was designed to provide staff with an overview of each person's needs they were scheduled to support. However, these details had not been entered onto the system for the majority of people receiving care. The lack of care plans and information to guide staff on the care people required meant there was a risk that staff would not be aware of their individual needs and how they preferred their support to be provided.

- Staff we spoke to were able to give basic details of the care people required but were not able to give more personalised information regarding people's preferences and life histories. In some instances staff also provided contradictory information regarding people's needs.
- At the start of our inspection we asked the provider if all care plans were up to date. The told us they were and stated, "We are doing our best. Our care plans are really person centred." We found this was not the case. Although some people's records contained some personal information regarding their family, hobbies

and interests, others contained little detail regarding people's life history and preferences.
● Care plans regarding the support people wanted at the end of their life had not been completed and there was no evidence these discussions had taken place. The provider acknowledged this was not an area they had approached people about. They told us they were looking to find training for staff on supporting people at the end of their life.

The failure to ensure care plans were implemented, that people's needs were known to staff and that care was received in line with people's preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
● We received mixed views on how responsive the provider was when complaints were raised. One person told us, "I have not needed to make a complaint, but they would know about it if I was unhappy, I wouldn't worry about telling them." Another person told us, "They're very nice about it and apologise but it doesn't change anything.
● The provider had not recorded and responded to complaints raised by people and their relatives. The provider told us that three people were looking for a new care provider due to their calls being repeatedly late. However, there was no record to show the details of people's concerns or that a response had been given.
● The providers PIR stated, 'High Care Plus (complaints officer) is obliged to acknowledge receipt of all complaints within 48 hours'. We found no evidence this had taken place.
● There was no evidence available to demonstrate the provider had fully investigated people's concerns in order to ascertain why staff continued to arrive late for care calls.

The failure to respond to complaints raised regarding people's care was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to plan the growth of the service in a sustainable manner which led to people's care being disrupted. The provider acknowledged they had accepted care packages over too large a geographical area. This meant they did not have the capacity of staff to meet the care calls safely and effectively. Following the inspection, the provider took the decision to request the local authority find a new care provider for three people.
- There was a lack of confidence in the providers ability to supply information and evidence in a clear and transparent manner. At the start of our inspection the provider told us they employed eight care staff. Later in the inspection they provided a list of 11 staff members. Following the inspection, a list of 14 staff members was sent to us. We later found the provider had failed to supply details of a further three staff members, two of whom were known to have concerns regarding their employment.
- In addition, significant changes were made to information we requested when concerns regarding the accuracy were raised with the provider. This included changes to basic details such as the number and names of the people they were supporting, a rota of when people's support was scheduled and staff training records. This made it difficult to understand the risks to people and how these were being managed.
- The provider told us they completed spot checks and phone calls to monitor staff performance. We saw a small number of these visits had been completed, there was no overall record to demonstrate these were completed regularly for all staff members employed. Information forwarded following the inspection did not provide dates these took place, any outcomes or evidence of their completion.
- There was a lack of management oversight of the service which put people at risk. The provider was unable to supply evidence or information relating to the safety of people's care such as incidents and accidents, safeguarding reports, investigations of missed calls or evidence complaints were recorded and responded to.
- As reported, gaps and concerns in documentation were identified in all areas of people's care records. The provider acknowledged they had fallen behind with ensuring people's records were accurately maintained.
- Quality assurance was not robust and failed to identify shortfalls in the service. Audits of call records had not been completed since May 2019. The provider told us this task had been delegated to other senior staff but not completed. Records showed that previous audits did not report on if staff stayed at care calls for the allocated time or comment on the lack of personalised information recorded.
- No further audits had been completed to assess the quality of the service. This meant concerns regarding the lack of care plans, risk management plans, medicines errors and management systems had not been

identified and acted upon.
● The provider had not been transparent regarding the information they provided to the CQC prior to our inspection. This meant we were unable to effectively monitor the service people received. The provider submitted their PIR in July 2019. As highlighted throughout this report, the provider was aware at this time that the systems they reported were in place to ensure people received a safe, effective, caring, responsive and well-led service had not been fully implemented or monitored.

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; Continuous learning and improving care;
● The provider had failed to learn from concerns and mistakes. No action had been taken to implement additional monitoring systems where missed and late calls had been reported. This had led to the same concerns happening again resulting people being put at further risk.
● The provider had not acted in a transparent manner when things went wrong. The provider had failed to share information with the relevant authorities such as safeguarding concerns, missed calls, accidents and incidents. People told us the provider had offered a verbal apology when things went wrong. However, no explanation was provided to people in writing and no investigation recorded unless requested.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider told us they monitored people's views of the service by conducting telephone surveys. We found these had not been consistently completed and people's feedback was not always taken into account. The majority of the survey's viewed on file had been completed in the first half of 2019. Five forms were seen and four people had reflected there was an issue with staff timekeeping. However, the provider had not taken action to address this.
● Staff meetings were not held regularly to facilitate team work and give staff the opportunity to share information. Only two staff meetings had taken place since the service was registered. Minutes from the last staff meeting showed staff expressing concerns regarding distances between care calls. Staff were informed they would face disciplinary action should late calls continue. There was no evidence of reflection, discussion or acknowledgment of why staff were arriving late for calls in order to look at how improvements could be made.

The failure to ensure good governance of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events. As reported, we identified safeguarding concerns during the inspection which the provider had failed to notify us of. This meant we were unable to effectively monitor the service provided.

Failing to submit statutory notifications was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify the CQC of significant events in line with their statutory responsibilities |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure people's needs were comprehensively assessed and to evidence people were supported with their healthcare needs<br><br>The provider had failed to ensure care plans were implemented, that people's needs were known to staff and that care was received in line with people's preferences |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure the principles of the MCA were understood and followed by staff |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure safeguarding |

concerns were appropriately reported and that staff were aware of their responsibilities

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had failed to respond to complaints raised regarding people's care |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to ensure safe recruitment processes were followed |

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<br><br>The provider had failed to ensure risks to people's safety were assessed and mitigated, accidents and incidents were recorded and monitored and that robust medicines processes were in place. |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure good governance of the service |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure sufficient staff were deployed to safely deliver people's care<br><br>The provider had failed to ensure staff induction, training and supervision was consistently monitored and that staff were competent in their role |

**The enforcement action we took:**

We issued a Warning Notice