Water Gate Support Services Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 17 and 19 April 2018 and was announced. This was their first inspection since registration with the Care Quality Commission on 11 April 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger adults with complex care needs. At the time of the inspection they were supporting seven people in the London Boroughs of Hackney, Enfield, Islington and Tower Hamlets. Not everyone using Water Gate Support Services Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 service did not have appropriate systems in place to protect people from harm. People who lived with specific and complex health conditions had not had the risks associated with these conditions assessed. Risk assessments were not in place to ensure their safety and welfare. There was no guidance for staff to ensure care tasks were carried out safely or evidence that reviews took place if people's needs changed.

People were supported with their medicines without a proper assessment in place to ensure they received their medicines safely and effectively. No records were available to confirm the level of support that people needed or if staff had received the necessary training.

The service did not follow a robust recruitment process to ensure staff had the necessary checks and were suitable to work with people using the service. References had not been sought and not all background checks had been completed.

People were not always protected from the risk of potential abuse because there was no evidence the provider responded or acted appropriately to incidents or concerns. There was no evidence any disciplinary procedures had been followed in response to the concerns we were told about.

Staff did not receive the required induction, training, shadowing opportunities and supervision to undertake their role. The registered manager acknowledged they were in the process of looking for a company to carry out their mandatory training. There was no evidence staff had received training in complex areas of care, such as percutaneous endoscopic gastrostomy (PEG) feed management.

Requirements of the Mental Capacity Act 2005 (MCA) were not met. The provider did not have a clear understanding that there should be signed consent forms in place and no records were available to confirm

this for all of the people using the service. There was no evidence to show that staff had received training on the MCA.

People who were supported with their nutrition and hydration did not have their needs assessed, risks identified or preferences recorded. There was no information or guidance for staff to follow to support them to manage people's nutritional needs and minimise the risk of their health being compromised.

People's relatives told us that their regular care workers were kind and caring and knew how to support them. However when replacement care workers were used people received inconsistent levels of care, with issues about training and missed visits being highlighted by relatives.

People were at risk of receiving care that was not person centred or specific to their needs as assessments had not been carried out and care plans were not in place. There was no assurance that the care people received reflected their wishes and how they wanted to be cared for, including end of life care.

The registered manager told us that they had not received any complaints or concerns in the past year. However, relatives and health and social care professionals told us otherwise. There was not an effective system in place to deal with people's complaints as no records were available to show the concerns and complaints had been followed up appropriately.

The provider failed to have effective quality assurance and management systems in place to monitor the care and support provided to people who used the service.

There was a lack of leadership, direction and oversight of people's care which led to people experiencing inconsistent care and put them at risk of unsafe care. There was a lack of an open and transparent culture as we were given misleading and inaccurate information throughout the inspection.

Issues with non-payment of staff had an extremely negative impact on the service that people received. Relatives and health and social care professionals told us that there were times when care workers had not turned up. Relatives spoke positively about their regular care workers who continued to work despite their payment issues.

Due to the concerns we found at this inspection we served the provider with an Urgent Notice of Decision (NoD) on 27 April 2018 under our regulatory powers to impose a condition on their registration. The registered provider must not provide personal care to any new person without the prior written agreement of the CQC. This also included any person who had previously received personal care. We also asked the provider to send us in an urgent action plan to set out how they intended to address the concerns we identified.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care, consent, safe care and treatment, acting on complaints, good governance, staffing and fit and proper persons employed. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and wellbeing had not been assessed and were not monitored to ensure people were safe. There was no guidance in place for care workers to ensure care tasks were carried out safely.

Appropriate policies and procedures were not in place to ensure that people received their medicines safely and effectively.

Robust recruitment procedures were not followed to minimise the risk of unsuitable people being employed.

The provider did not have a good understanding of the policies and procedures in place to safeguard people from abuse and avoidable harm. There was no system in place to report and follow up incidents and no evidence that any disciplinary procedures had been followed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the support and training they needed to carry out their role effectively.

Shadowing opportunities, supervision and checks on staff were not in place to monitor their capability and understanding of the tasks they were required to undertake.

The provider did not have a clear understanding of the principles of the Mental Capacity Act 2005 and assessments had not been completed to show that people had consented to the care and support they received.

People's nutritional needs and preferences had not been assessed and there was no further information for care workers to manage them appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People's relatives commented positively about their regular care workers caring attitude however felt replacement care workers were less reliable and provided different levels of care.

Positive comments were received about regular care workers who continued to work with people despite them not being paid.

People were not always involved in making decisions about their care and the support they received.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans for people were not in place as the provider had failed to complete an assessment of people's needs.

There was not an effective system in place to deal with people's complaints. There were no records available to show concerns and complaints had been followed up and information was not used as an opportunity to learn and improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

There were no effective systems in place to monitor the quality of the service or identify the concerns that we found.

We were told information throughout the inspection that we found not to be true. The provider had not completed their Provider Information Return (PIR), which they have a legal obligation to do so.

People and their relatives were unhappy with how the service was managed. Care workers were frustrated with regular payment issues, which had a negative impact on the care people received. Health and social care professionals had removed care packages due to concerns received.

Water Gate Support Services Limited

Detailed findings

Background to this inspection

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

We received anonymous information of concern on 26 March 2018 and 4 April 2018 in relation to unsafe recruitment practices, no training being provided and that care workers were not being paid. We spoke with local authorities to see if they had received any similar concerns and followed this up at the inspection.

The inspection took place on 17 and 19 April 2018 and was announced. The provider was given 24 hours' notice because we needed to ensure somebody would be available to assist us with the inspection.

The inspection was carried out by one inspector. Inspection activity started on 17 April and ended on 1 May 2018. We visited the office location on 17 and 19 April 2018 to see the registered manager, director and to review care records and policies and procedures. Following the site visit we made calls to people who used the service, their relatives, care workers and health and social care professionals.

Before the inspection we reviewed the information the CQC held about the service. This included their registration documents and information from members of the public. We also spoke with local authority commissioning teams and used their feedback to inform our planning.

Before the inspection we requested the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This form was not completed.

We were unable to speak with any of the people using the service as they were all unable to communicate

with us but we spoke with four relatives. We also spoke with nine staff members. This included the registered manager, the director and seven care workers. We looked at five people's care records, nine staff recruitment and training files and records related to the management of the service.

Following the inspection we spoke with eight health and social care professionals who worked with people using the service for their views and feedback.

Inadequate

Is the service safe?

Our findings

The service did not have appropriate systems in place to protect people from harm. People who lived with specific health conditions had not had the risks associated with these conditions assessed by the provider to ensure their safety and welfare. On the first day of the inspection the registered manager told us that people's risk assessments were not available in the office as they were kept in people's homes. When we returned on the second day the registered manager was unable to provide us with risk assessments for all of the people using the service or an explanation as to why they were not in place. Two relatives told us that when the care package was transferred from the previous care agency, the registered manager did not carry out any assessment. A third relative confirmed they only had an assessment in place from the hospital. A health and social care professional also confirmed that the provider had not carried out an assessment for a person they were working with. They added they had informed the registered manager the local authority assessment was for guidance and the provider had to carry out their own assessments but this had not been done.

All packages of care were complex and there was no guidance in place for staff to carry out the care tasks safely. One person was at risk of falls and was unable to move independently. They also needed to be transferred with the use of a hoist. They had a condition which affected their ability to clear respiratory secretions and staff needed to support a relative with suctioning and cleaning a tracheostomy tube. They were at risk of having seizures and a mouth guard needed to be used to reduce injury to their teeth and gums. A care worker confirmed they supported the person with a PEG feed and that they needed to be supervised at all times. This is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. There was no information in place on how to carry out any of their care and support safely.

Another person needed to be supported in the community. The local authority assessment stated that they required supervision at all times and could not access the community alone without significant pain, distress, anxiety or risk to self or others and could display some behaviour that would challenge the service. There was no risk assessment in place or any guidance or information for staff to follow on how to support them safely in the community. A third person had an NHS continuing healthcare assessment which stated they needed full support with moving and handling, continence management and monitoring skin as they were at risk of developing pressure sores. They also had a turning regime in place as they needed to be repositioned every three hours during the night. There was no information in place or any guidance for staff to follow on how to support them safely. From reviewing a sample of daily logs, turning regimes were not always being recorded.

For two people, there were no records at all about their care and support needs and how any risks were being managed.

The above indicated that the provider was not doing all that was possible to mitigate risks to people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection the registered manager told us that none of the people they were supporting were being assisted with their medicines and it was the responsibility of family members or other health care professionals. Their medicines policy stated that a medicines assessment would be completed but there were no assessments in place so we did not know what level of support people needed with their medicines and had no assurances that people received their medicines safely.

For one person, daily logs confirmed that they were being supported with their medicines but there was no record of what medicines they were being supported with. A relative said, "They do support [family member] with medicines, the night care worker gives the morning medicines and we do it during the day." Daily logs also confirmed that they were being supported with eye drops but there was no information about this and no evidence of any medicine administration records (MARs) being completed. For three other people, daily logs confirmed they were being supported with topical creams and pain relieving gel but there was no information about the kind of creams, whether it had been prescribed or guidance for care workers to follow. A care worker told us that they supported one person with nebulisers, which daily log records confirmed. There were no records available to highlight how this was being managed.

Information about people's medicines were not recorded. Medicines were not managed in a way which ensured people received them in a safe and effective manner with regard for the risks associated with them. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no safe recruitment processes in place and the provider could not demonstrate their recruitment procedures ensured that staff working for the organisation were honest, reliable and trustworthy or had the appropriate qualifications, skills and experience for the role they were undertaking. This put people's safety at risk.

There was no system in place to ensure Disclosure and Barring Service (DBS) checks for staff had been completed before they started work with the provider. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. For two care workers, there was no DBS in place and the provider was unable to evidence that one had been applied for. The provider had a recruitment policy that said applicants must have a full DBS check and the portability of a DBS would only be used if it had been authorised within the last three months and was an enhanced check. Two care workers had a DBS from their previous employer but the authorisation dates were not in line with the providers three month policy and there was no evidence to show a new check had been applied for. For another care worker a record showed a DBS check had been made on 29 November 2017 and confirmed there had been a disclosure and advised the provider to review the document before making a recruitment decision. There was no interview assessment record to show that this had been discussed at the interview and no evidence that a risk assessment had been carried out to discuss the disclosure that had been returned. There was also no copy of the DBS to show the provider was aware of what the disclosure was. We also received correspondence from a health and social care professional on 19 April 2018 that a care package had been transferred to another provider as they had found out the care worker did not have a DBS in place.

When reviewing daily logs for one person on the second day of the inspection, we came across two care workers who were regularly working with this person, but whose names had not been given to us on the care worker list at the start of the inspection. We raised this with the registered manager and they were unable to provide a staff file for either of them and acknowledged the necessary recruitment records were not available. We emailed the registered manager on the 20 April 2018 to request information about three care workers recruitment status but had not received a reply by the time the draft report was sent to the provider.

For all of the staff files we reviewed, there was only evidence of one reference in place for one care worker from their previous care agency. However, it was dated and signed 7 October 2016 but the care worker had applied nine months later on 25 July 2017. We spoke to the registered manager about this who was unable to provide an explanation for this and said that the operations manager, who was not present at the inspection as they were on leave for a month, was responsible for this. For the other care workers, there was no evidence of any references being sought despite eight of them all having previous experience and their most recent employer being in health and social care. The provider's recruitment policy stated that they must take up two references but they had not followed their own policies and procedures.

The above indicated the provider did not operate a robust and effective recruitment procedure to minimise the risk of unsuitable people from working with people who use care and support services. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no systems in place to safeguard people from potential abuse and we could not be assured that all incidents would be responded to appropriately, investigated and reviewed to ensure people's safety. On the first day of the inspection, the registered manager told us that there had been no incidents or safeguarding concerns since the service had been registered in April 2017. However, we received feedback from health and social care professionals that informed us a number of people's care packages had to be transferred to another provider due to concerns. There were no formal records of any incidents that had occurred or evidence that any investigations had been carried out when concerns had been raised. Two relatives told us about incidents where care workers had not turned up for calls and replacements were not sent. One relative added, "When they didn't turn up, I had to look after my [family member] and it had a big impact on us." A health and social care professional told us that eight people had been transferred to another provider due to concerns with the service. One issue related to only one care worker turning up for a visit which required two staff. There was no evidence that any incidents had been recorded or followed up, or whether any disciplinary processes had been followed. There was also no evidence to show that issues had been discussed with staff or any learning had taken place to make improvements when concerns were raised.

There were no systems in place to monitor the timekeeping of care workers or to ensure that calls had been made. Relatives told us that one of the biggest issues was care workers not turning up and not being notified by the office. One relative added, "There are too many problems. Even this week, a care worker hasn't turned up every morning [Monday, Tuesday and Wednesday] and they couldn't find a replacement." Another relative said, "If they don't turn up, it is left to me."

As no care records were available we were not assured that the provider could ensure people were protected by the prevention and control of infection. Although there was an infection control policy in place, there were no records to confirm staff were reminded of their responsibilities to ensure infection control procedures were followed. Whilst care workers we spoke with were aware of their responsibilities and the need for personal protective equipment (PPE), such as gloves and aprons, we were told that they were not always made available. Comments included, "I went to get some gloves but they didn't have any in stock" and "We have to beg for gloves and there have been times I've had to buy my own."

Inadequate

Is the service effective?

Our findings

Relatives we spoke with told us they were happy with the regular care workers that supported their family members. They had previously worked with people when they were being supported by previous care agencies. However, there were no effective systems in place to ensure that staff received the appropriate induction, training and supervision to support them in their roles. One relative told us that the service did not provide any training for new staff and they had to rely on their previous care workers to be able to meet their family member's needs. They added, "They brought about seven staff, but they weren't able to do the job."

One the first day of the inspection, the registered manager told us that staff completed a three day induction which covered the 15 standards of the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Eight of the nine staff files we viewed had a Care Certificate Induction certificate in place saying they had completed the three day induction. None of the certificates had been signed or dated so we could not be assured when the training had taken place. For one care worker there was no evidence of an induction certificate in place. Of the seven care workers we spoke with, two told us that they had never been given any training and had not completed the Care Certificate, even though there was a certificate in their staff file. Four care workers told us that their induction had only been one day.

The provider's training policy stated that the induction would also consist of seven mandatory training courses. These included moving and handling, safeguarding, food hygiene, infection control, fire safety, medicines and first aid. For all of staff files we reviewed, there was no evidence that mandatory training had been completed. The registered manager told us that he was trying to find a training provider to carry out the mandatory training topics. There was also no training matrix in place to give an overview of any training that staff had received. Two care workers told us they had to rely on training from relatives to know how to support the person they were providing care for.

There were also no training records in place to confirm that care workers had received training to support people with more specific and complex health conditions. One person's local authority assessment said a percutaneous endoscopic gastrostomy (PEG) feed was in place for all nutrition and hydration. This is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Daily logs confirmed care workers were supporting this person with their PEG management, including the disconnecting and flushing of tubes in preparation. There was no information about this procedure and no guidance for care workers to follow to effectively manage the PEG regime.

There were no records to show that staff had the opportunity to have any shadowing visits before they started work with people or that they received regular supervision. The registered manager told us these records were kept in people's homes but we did not see any records when we returned for the second day. None of the care workers we spoke with told us that they had received any shadowing visits or had any supervision meetings since they started with the provider.

The issues above highlight the lack of appropriate training and support for staff to allow them to carry out their roles effectively. This was a 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 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.

There was no evidence to show that staff had received any training on the MCA, which care workers confirmed. For six of the people using the service there were no assessments in place so we could not see any records to show that people had consented to their care. For one person with an initial assessment form in place, capacity issues had been discussed however the assessment had not been signed by a representative. The provider did not have a clear understanding that care records needed to be in place and should be signed by the person to show their agreement to the care and support provided and that there should be a clear indication of an assessment of their capacity if they were unable to do this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For six of the people using the service there were no assessments in place so we could not see any records to show what support they needed with nutrition and hydration. In one person's NHS continuing healthcare assessment, it said care workers were to support them at mealtimes and encourage their nutrition and hydration. It also included the need for nutritional supplements due to their current health conditions. Daily logs confirmed care workers were supporting this person with food and drink but there was no information about the care and support provided. For two people being supported with a PEG to meet their nutritional needs, there was no information available. For one person with an initial assessment in place, the nutrition and hydration section was blank.

People's needs and choices were not assessed and their care and support was not delivered in line with evidence based guidance to achieve effective outcomes. Relatives told us that they received little to no support from the provider to maintain their family member's health. One relative told us that communication was a big problem and did not hear back from the office if they raised concerns. A care worker told us that they had to rely on the family to get updated about any changes as they did not receive this information from the provider. Health and social care professionals told us there were problems and due to concerns they were looking to withdraw packages of care. One healthcare professional said there were issues with being updated about how a person's health was and there were more negatives than positives with the provider.

As we were unable to see care records it was difficult to determine whether people were supported to maintain their health and access healthcare services. The registered manager did show us correspondence for one person where they made contact with a health and social care professional when more support was required. However there was no information about people's GP's contact details or information for when staff might need to make referrals to other health and social care professionals if their needs changed. We also saw an assessment for one person that did not reflect their current circumstances as they were no longer being funded by the respective local authority. Despite us highlighting this to the provider and requesting the contact details for health and social care professionals responsible for the funding of their care, they were unable to provide this information.

Requires Improvement

Is the service caring?

Our findings

Relatives spoke positively about the support of their regular care workers and that they were kind and caring. Comments included, "The best thing about them is that we have good care workers", "I'd never want to lose my night staff. They go above and beyond and are very calm and attentive" and "I'm not happy with how it is managed but I have no issues with the regular care workers at all."

The majority of people's regular care workers had worked with them previously when they were being supported by another agency. They moved over with people when the care package was changed to the provider. One relative said, "The regular carer knows us and how to provide the care and support we need." Care workers spoke positively about how they were able to keep working with people they had worked with for long periods of time. One care worker said, "The best thing about the job is my client, that is why I am here." However relatives told us that issues occurred when regular care workers were not available which impacted upon the service they received.

One concern that was highlighted by relatives, care workers and health and social care professionals was payment issues that had a negative impact on the service. However we received positive comments about the caring attitudes of regular care workers who continued to work. One relative said, "The biggest issue has always been about payments and this has affected the carers coming in. It is commendable that they have turned up at times." Health and social care professionals confirmed that despite positive feedback received about regular care workers, care packages had been removed due to non-payment of staff. Care workers expressed their frustration with this and how it was a constant issue, but continued to provide support. Comments included, "We are still providing care despite not being paid as we can't leave [person]. He/she and the family need our help and support", "I nearly stopped going but I just couldn't leave [person]" and "I told the office I was unhappy and that I wouldn't go, but I couldn't do that as they needed my help."

The registered manager and the director told us that they had both been responsible for completing assessments of people's needs to ensure people were involved in decisions about their care. However, there were no records available to confirm that people using the service and their relatives had been fully involved in the planning of their care. For six people, there were no records in place from the provider. For two of these people, we had not been made aware that they were receiving care and support until the second day of the inspection. There were also no local authority assessments in place for them so we had no assurance that they had been involved in decisions about their care. For the seventh person, an initial assessment had been completed but there was no further information gathered about how they wanted their care and support to be carried out.

One relative told us that care workers respected their family member's privacy and dignity. They added, "I have to say, they do respect that. They are very caring and understanding in that matter, especially with the amount of pain he/she is in." Care workers we spoke with were aware of the importance of the need to ensure they respected people's privacy and dignity when they were supporting them in their home. However, there were no records available to confirm if people's preferences for personal care had been discussed. For example, one person was unable to mobilise and needed physical support from two staff

with all personal care tasks, including the use of a hoist. There was no information about how their personal care tasks were to be carried out or guidance for care workers to follow to ensure their privacy and dignity was maintained at all times.

Inadequate

Is the service responsive?

Our findings

People's care and treatment was put at risk as the provider had not completed an assessment of people's needs to ensure they received person centred care that was appropriate and reflected their personal preferences. We could not be assured that people's religious and cultural needs were being met, or whether people received accessible information in their preferred format.

For the seven people using the service, there were no care plans in place and we were only able to view the assessments from the funding authorities for four people. For one person, the registered manager told us on the first day of the inspection that it was a private care package. After making further enquiries with the local authority, we were told that the care package was funded through the local authority with a direct payment. A direct payment is the amount of money that the local authority has to pay to meet the needs of people and is given to them to purchase services that will meet their needs. The only information made available to us was an initial assessment that had been completed by the registered manager. The assessment form covered communication, mobility, medicines, personal care, nutrition and hydration, health and wellbeing and accessing the community. None of these areas had been fully completed and each section about the care and support for this person was blank.

One person's local authority assessment stated they were a wheelchair user and needed hoisting for all transfers. They also had a severe learning disability, suffered from seizures and had neuro sensory, bowel and spinal health conditions. There was no assessment or care plan in place or information for care workers on how they wanted to receive their care and treatment. We spoke with their relative who confirmed that the provider had not carried out an assessment and some care workers that had been sent were not able to meet their family member's needs.

Another person's continuing healthcare assessment stated the person had a number of health conditions which had led to a general deterioration in their health and wellbeing. The provider was responsible for supporting them with all personal care tasks, continence management and nutrition and hydration. There was no information available or guidance for care workers on how they wished to be cared for.

At the time of the inspection the provider was supporting one person who was receiving end of life care. We received positive feedback from their relative about some of the care workers and that they were calm and patient and able to meet their family member's needs. However the NHS continuing healthcare assessment that the provider had was from a previous funding authority and was not up to date. There was no information available to show how the person's care and support was to be carried out to ensure they were comfortable and treated with dignity at this stage of their life. There was no information available regarding the person's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) wishes. There was no evidence that the provider had been in contact with other health care professionals, such as hospices and palliative care teams for specialist training and best practice guidance.

The lack of detailed and effective person centred plans in place to meet the individual needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection the registered manager told us that they had not received any complaints or concerns since they had been registered. However, relatives and health and social care professionals we spoke with told us that they had raised a number of issues and complaints with the provider but they had not been effectively dealt with. There were no records of any complaints being received by people who used the service, their relatives or health and social care professionals.

One relative told us they had made a number of complaints about training, no assessment and care worker rotas. They added, "I'm not happy. I've made complaints and raised these issues but they do nothing about it." All of the health and social care professionals that we spoke with told us that they had raised issues with the provider and that care packages had been transferred due to concerns. One health and social care professional told us that complaints had been made due to concerns with how people's care was being managed. They said that despite raising the concerns and giving the provider an opportunity to improve, this had not happened. Due to this, they confirmed two people were in the process of being transferred to another provider at the time of the call. Another health and social care professional told us that they had used the service in the past for two people but both had ended poorly, which had impacted on the care package and caused a lot of undue stress for the family.

The provider did not record, investigate or take the necessary and proportionate action when concerns and complaints were received. People were at risk of issues and concerns not being followed up or the appropriate action being taken. There was also no evidence to show that the relevant people were notified of any concerns we were told about.

The lack of systems in place to monitor and effectively manage complaints 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

At the time of our inspection there was a registered manager in post. Our records showed he had been formally registered with the Care Quality Commission (CQC) since April 2017. He was present on both days and assisted with the inspection, along with the director.

There were no effective systems in place to assess, monitor or improve the level of service provided. This meant that issues and concerns were not routinely identified and the necessary action taken to improve the service, which impacted upon the service people received. Staff were also at risk of not following policies or procedures to mitigate any risks that would be identified through assessment and monitoring processes. It also led to relatives and health care professionals not being reassured that the service was being well managed.

There was no evidence or formal records of any audits that had been completed since registration. The registered manager told us that they were waiting to complete six monthly quality assurance visits but none had been completed at the time of the inspection. He also told us that they carried out monthly visits to people to check on the service but there were no formal records available to confirm they had been completed. One relative said, "They have done a few spot checks in the last six months." We spoke with the relative of one person who had been receiving care and support since July 2017. They told us that the provider had not carried out any checks at all, they added, "They've done nothing." A third relative told us that there had also been no quality assurance checks or observation visits since they started using the service in September 2017. Care workers confirmed this and six out of the seven we spoke with told us they had not received a monitoring visit since they started work with the provider. One care worker said, "I've only had one spot check since December."

Another care worker told us that people's daily logs were not checked or returned to the office. We were only able to view four people's daily logs as there were none available for three people. These had been brought back to the office on the morning of the second day of the inspection. There was no evidence to show that they had been checked and had not picked up any of the issues that we had found.

There were only four records available to show that a telephone monitoring call had been carried out since the service was registered. These four calls had been made between 16 and 28 February 2018 but no other formal records were available, even though three other people were using the service. There were also no records available for people who were no longer using the service. The director told us that they did this on a monthly basis but did not always keep a record of it.

The out of hours/on call service was managed by the director but there were no formal records of any calls that had been logged with information about what issues had arisen and if any action had been taken. The director said it was just managed over the phone and nothing was recorded. Although one care worker told us that they did not have any concerns with the on call service, four care workers highlighted issues and told us that it was not always answered or they would not always get a response. A care worker said, "When I call the office, they don't answer." We called the on call number on 27 April 2018 on two occasions, at 4:42pm

and 7:41pm. There was no response and a message stated the mailbox was full and we were unable to leave a message. This meant that people using the service or their relatives may have been unable to report any concerns such as late or missed calls and therefore there was a risk that people would not receive the care and treatment they required in such instances.

The lack of effective governance and quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns raised with us both prior to and during the inspection showed there was a lack of openness and transparency in the service. Throughout the course of the inspection we were told information that we found was not true. On the first day of the inspection the registered manager told us that the service was only supporting five people. After a discussion with a health and social care professional on 18 April 2018, we were made aware of two more people who were being supported that we had not been told about. On the second day of the inspection the registered manager said he was unaware that these two people were receiving care and it had been managed by the director, who had not updated him. Further correspondence with the health and social care professional confirmed that he had been aware as he had been involved with completing the invoices and sending them to the brokerage team. We also saw an email addressed to the registered manager that confirmed when one of the packages of care would be starting. We were also told that a range of documents that were not available on the first day of the inspection were kept in people's homes but were not made available on the second day of the inspection. The registered manager told us that he did not know where they were.

Further to this, one of the issues highlighted by all relatives, care workers and health and social care professionals was the non-payment of staff. Relatives highlighted how this had had a negative impact on the whole service. One relative said, "I've lost so many good care workers because they have not been paid for months. I don't understand as I have paid the agency and they are still having payment issues." Comments from care workers included, "They always lie to us about the pay. We have to beg to get paid and just give excuses. I got my February pay in April", "I'm still waiting to get paid but whenever I call they say they will call back but never do. I called today and when I asked about my money they just put the phone down on me" and "It creates such a big problem for me and my everyday life as it is always a problem. I'm really not happy but they haven't done anything about it." A health and social care professional told us that care workers regularly complained to them about not being paid. They told us that one care worker had not been paid since February for 347 hours worked. When we spoke to the director and registered manager about this, they told us it was because the local authorities' commissioners had not paid them. However, they told us after the inspection on 30 April 2018 that the staff payment issues were only related to cut off periods for staff timesheets.

Due to this, the majority of feedback we received from care workers about how the service was managed was negative, with six of the seven care workers highlighting the impact it had on them. One care worker said, "I think they are OK, they might not answer the call but I do feel reassured that somebody will call me back." However, negative comments included, "I do not think it is well managed at all, we never get any answers. They do not care about us", "If anything, I actually don't want to contact the office, I'm happy just supporting my client" and "I'm not supported at all. We work very hard and it isn't nice for us, it needs to be improved."

One relative felt they had good communication with the office and told us that they did not have any concerns. However, feedback from the other three relatives we spoke with was not as positive. Comments included, "There is absolutely no communication, it is awful. The manager has promised many things but he has never visited or called back. I expect nothing from them and we are suffering" and "I have to follow up

everything and they have been unable to manage our complex needs. They sit in the office and take the money but don't do anything."

Health and social care professionals confirmed that there had been issues with communication and how the service was managed. One health and social care professional told us that they were not always updated about changes to care packages and had difficulties in getting a response from the provider. Another health and social care professional felt that care packages were accepted without the consideration of how people's needs would be met, which caused frustration to people using the service and their relatives. We requested further information after the inspection related to our findings and documents that were not available but did not receive everything that we requested.

The provider had failed to submit their Provider Information Return (PIR). The PIR is an important element of the inspection process and asks the provider to give key information about the service, what the service does well and improvements they plan to make. The CQC sent a PIR request on 7 February 2018 but it had not been completed or returned, which the provider has a legal obligation to do so. The registered manager acknowledged that this had not been done.