Allcare Community Care Services Trafford Limited

Allcare Community Care Services

Inspection report

Business Centre High Street East
Wallsend
Tyne And Wear
NE28 7AT

Date of inspection visit:
08 August 2018
09 August 2018
10 August 2018
22 August 2018
23 August 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place between 8 and 23 August 2018. This service is a domiciliary care agency based in North Tyneside. It provides personal care to people living in their own homes throughout North Tyneside, Newcastle and Gateshead. Services were provided to adults with a range of health and social care needs, predominantly older adults and people approaching the end of their lives. At the time of our inspection there were approximately 45 people receiving a service in their own homes.

Following the last inspection in May 2018, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well-led to at least 'Good'. We found the provider had failed to achieve this.

Whilst we received the initial action plan in May 2018, the provider did not share an updated version with us at this inspection, which we asked them for, so we could see what improvements had been made.

There was still no registered manager in post. The nominated individual for the provider organisation had applied to become the registered manager. The application was still in progress at the time of this inspection. A nominated individual is a 'registered person' with CQC. They can also be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The operations director was referred to by people, relatives and care staff as 'the manager'.

At the last inspection the service was rated 'Inadequate'. At this inspection the rating remained the same. Therefore, the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it 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.

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.

This inspection was carried out to follow up on the urgent action we asked the provider to take following the

serious concerns raised in May 2018. After the last inspection, we imposed a restrictive condition on the provider's registration which meant they were unable to accept any new care packages. This restriction is still in place. We also issued the provider with a fixed penalty notice for failing to notify us of a specific incident. Other enforcement action is still in progress which we will report on when all representations and appeals processes have been concluded.

Following our last inspection, one local authority placed this service into organisational safeguarding due to the amount of serious concerns around the safety and governance of the service. This meant that health and social care professionals from the contracting local authorities and Clinical Commissioning Groups (CCG's) attended periodic meetings with the provider and CQC. The local authorities continued to have serious concerns about the service and at the time of this inspection one local authority had given the service notice to terminate their contract. Both local authorities were conducting urgent reviews of people's care needs and one local authority had begun to arrange a transfer of care packages to other providers.

During the inspection, we did not find sufficient evidence to show that robust checks on the quality and safety of the service had consistently and properly taken place. The documents given to us did not reflect all the issues we highlighted during this inspection and they failed to adequately explain what action, if any had been taken to properly address matters.

Record keeping remained poor throughout aspects of the service. There continued to be a lack of accurate and comprehensive details recorded which meant we could not be certain that issues had been identified and followed up properly. We found more incidents had not been fully investigated, recorded in detail, escalated or reported to the relevant external authorities if necessary. Incidents were not appropriately monitored to identify trends or to reduce the risk of repeated events.

Policies and procedures were available to support staff with the delivery of the service, although we found that staff did not always work in line with company policies and procedures. There was limited information available about what action had been taken when staff failed to follow procedures.

After the last inspection we asked the provider to retrospectively send us statutory notifications with regards to incidents or deaths which we identified had occurred at the service and had failed to be notified to us. We have not received all the information we asked for. At this inspection, we found more deaths which were not notified to the CQC as required by law.

The provider was also required by law to display the most recent performance ratings at their premises and we had asked them to share a summary of the last inspection report with people who use the service and staff. This had not been carried out.

The provider had employed a registered nurse in a clinical lead role since we last visited the service. However, they had not prioritised conducting care staff clinical competency checks and as such, care staff had still not been assessed as competent to carry out clinical care tasks. This meant people's safety remained at risk.

Complaints were still not being managed in line with the provider's complaints policy. Although some complaints had been briefly recorded, detailed investigation notes were not made. We found that the complaints procedure was still inconsistently followed. We also found more complaints were not responded to in a timely manner and they had not been monitored to identify any trends.

At the last inspection we found staff were not safely recruited. We asked the provider to ensure staff

recruitment was robust and where necessary carry out further checks on specific members of staff. We found this had not been achieved. Whilst the provider now had one or two printed-out references for each member of staff, these documents were not sufficient enough to show that thorough checks had been made, verified or obtained from appropriate sources. This meant people continued to be at risk because in-depth vetting checks had not been completed.

Existing care staff training had been reviewed and where necessary care staff had received training or a refresher session in key topics which included a theoretical awareness into end of life care and catheter care. However, other topics such as diabetes awareness and choking awareness had still not been delivered to a small number of care staff working with people with those specific needs. We were told that no new care staff had started employment since the last inspection, but we were shown evidence of some existing care staff refreshing their knowledge in nationally recognised induction standards and the operations director talked us through the induction process should they employ new care staff.

Staff supervision sessions and appraisals had been carried out and were scheduled in advance to give staff an opportunity to talk about their issues, learning needs or any plans for development. Some care staff raised issues with us which they felt were not properly addressed. Staff told us of low morale amongst the team and said they felt the management had not openly communicated with them about the findings of the last inspection and the action taken by the CQC.

The newly implemented support plans were an improvement on the previous ones. They contained more person-centred information. However, we found a number of inaccuracies or omissions within the new paperwork which the office staff addressed during the inspection.

Improved risk assessments were also in place. However, we found examples of missing risk assessments and we found that some of the risk assessments in place had information omitted. The risk assessments were not as person-centred as they could have been and we discussed this with the office staff for future improvements.

People were supported by their care workers to have choice and control of their lives and care staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, we found the office staff did not fully understand the principles of the Mental Capacity Act 2005 and best practice. Support plans did not always contain comprehensive information about capacity. In some cases, consent was not recorded from the person or a person acting legally on their behalf.

We received mixed feedback from people and relatives about the service they received. Some people told us they felt safe and were happy with the care provided whilst others told us of issues and complaints and a general decline in the quality of the service over the past few months.

People told us they received their medicine when they expected it. However, no practical competency checks had been carried out to ensure care staff remained competent to manage people's medicines safely following their training. Medicine administration records were not in place for all people who received support with their medicines. National Institute for Health and Care Excellence (NICE) guidance which had been shared with the provider following our last inspection had not been implemented. This meant there was not always an appropriate record of the support people received. The operations director addressed this during the inspection.

People told us their care workers used personal protective equipment to protect them from the risks of

infection and cross contamination.

People told us their care workers supported them with meals and drinks. Care staff made people meals of their choice and respected their preferences. The service referred people to external health professionals to ensure their ongoing health and social care needs were met.

Most people and relatives told us their care workers treated them with dignity and respect. We were told that overall care staff were kind and caring.

We identified four continued breaches and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have found one continued breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains inadequate.	**Inadequate**
Is the service effective? The service remains inadequate.	**Inadequate**
Is the service caring? The service continues to require improvement.	**Requires Improvement**
Is the service responsive? The service continues to require improvement.	**Requires Improvement**
Is the service well-led? The service remained inadequate.	**Inadequate**

Allcare Community Care Services

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.

Inspection site visits took place on 8 and 9 August 2018. Our arrival was announced. We gave the provider short notice of the inspection to ensure senior management would be present at the office location. The inspection consisted of two adult social care inspectors, an assistant inspector and one expert by experience. The assistant inspector conducted telephone interviews with care staff on 22 and 23 August 2018 and the expert by experience contacted people who used the service and relatives on 10 August 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we did not ask the provider to submit 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.

Prior to the inspection we reviewed all the information we held about Allcare Community Care Services including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of deaths or incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

Additionally, prior to our inspection we liaised with two local authorities who commission services and two local NHS clinical commissioning groups (CCG) to gather their feedback about the service.

During the inspection we spoke with 11 people who currently, or until very recently had used the service, and six relatives to gain their opinions. We spoke with staff including the operations director, two care coordinators and four care workers. The nominated individual (the provider's representative) was present for half of the first day of our site visit.

We reviewed records related to the quality and safety of the service which included looking at nine people's care records. We also checked 12 staff files for recruitment references and 8 staff files for training certificates.

During the inspection and afterwards we asked the operations director and the nominated individual to send us further information in relation to investigation reports and outcomes, specific staff records, an updated action plan and any provider audits. After three weeks of waiting for the information, we had only received a very small amount of what we requested. We gave the provider a final 24 hours to send us what we needed to conclude the report but this was not adhered to.

Inadequate

Is the service safe?

Our findings

At the last inspection we identified a breach of Regulation 12 entitled, Safe care and treatment and Regulation 19 entitled, Fit and proper persons employed. We continue to investigate the allegation of neglect which was documented in the last report and we are dealing with this outside of this inspection process.

After our last visit we asked the provider to ensure robust recruitment checks were carried out with specific members of staff who we identified as not having appropriate vetting checks completed. At this inspection we found the further information gathered was inadequate and people were still at risk of receiving care and support from staff who were not suitably vetted. Office staff had filed printed-out references for each staff member, however these were not all signed and dated by the referee who had completed them. Some references contained information which differed from that recorded by the applicant on application forms such as previous employment dates. The provider's own recruitment policy stated that each reference should be accompanied by a company stamp or letter headed paper to prove its validity. We found that most of the references we reviewed were not accompanied with this, therefore neither we nor the provider could be assured these were genuine references. The provider had failed to identify this failure to follow the company policy. The operations director told us that most references had been obtained via email and they would collate the original emails to prove validity. We did not receive proof of all the original emails. We were told no new care staff had been recruited since our last inspection.

At the last inspection, we considered the provider had not made every reasonable effort to gather information about potential employees to ensure they were of good character. At this inspection, we noted that most care staff who had positive disclosures on their Disclosure and Barring Service Check (DBS) had now been subjected to a risk assessment to ensure their suitability to work with vulnerable people. However, one member of care staff had still not been approved as safe to start work by the registered person as per the provider's recruitment policy. This person had continued to work for the company without this assessment or suitable references. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Fit and proper persons employed.

Risk assessments had been improved but still contained inaccuracies or had information missing about some risks. The office staff started to address these during the inspection. We found risk assessments now contained more details of the risks people faced and how care workers should manage these. However, they were not consistently completed or robust. For example, one person whose skin integrity was at risk of breakdown had nothing documented on what actions care staff should take if there was any change to the integrity of the skin and how care staff should support the person to maintain their skin integrity. Another person who was assessed as being at a "medium" risk of falls did not have a completed falls risk assessment. A third person had four separate risks assessed on same document. Information recorded in this risk assessment about Chronic Obstructive Pulmonary Disease (COPD) stated, "Start Rescue Pack if GP advises."

However, it did not state what this was, where it was stored or any specific instructions of what care staff should do. This person was also assessed as at "medium" risk of falls with no falls risk assessment in place. We were not made aware of any impact this failure had had on people who used the service, but due to poor record keeping we were unable to ascertain if any of these failures had led to an incident. However, the failure to robustly record the risks people faced meant that people were placed at potential risk of avoidable harm.

At the last inspection, records were not properly made of investigations or outcomes to clarify the level of seriousness of incidents which affected the health, safety and welfare of people who used the service. We found this remained the same during this inspection. Office staff had still not always recorded the action they had taken (if any) to deal with incidents and what the outcomes were. This included incidents of when care workers had reported a "no reply" or when people reported "missed calls". The provider had failed to monitor this properly and therefore we could not be sure the incidents had been properly managed to protect people from risk of harm. The operations director told us they were in the process of investigating some serious incidents but was unable to share the reports at the time of this inspection. We asked for these to be shared once concluded. We did not receive this information.

After our last inspection, the Clinical Commissioning Group carried out a monitoring visit and identified that not all people who received support with their medicines had the appropriate records in place. The National Institute for Health and Care Excellence (NICE) have produced guidance for care at home staff in relation to supporting people with medicines. It states that even if care staff only provide a verbal prompt, a medicine administration record should be in place to record what support is given. This information was shared with the operations director following the monitoring visit, however, we found this had not been implemented. The operations manager told us they were still uncertain about this and we asked them to contact the local NHS medicine optimisation team for advice from a lead community pharmacist, which they did. Following this, the operations manager instructed the office and care staff to arrange for MARs to be completed and placed in every home where support with medicines was provided.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

People and relatives continued to have mixed opinions about staffing levels. Comments included, "Yes they do stay the amount of time they should, they always call me if they are going to be late as well"; "They don't always come at the same time, but they do always come. Sometimes they may have to leave a little early if they have to get to someone else, they are very busy you see" and, "They used to be very good but in the last few months they have not been. Staff do not always sign in and out so I don't always know who has gone to support my [family member] and how long they have stayed or what they have done as they don't always document things. I wish I knew it is a huge worry for me and my family."

During this inspection we spoke to care workers about their rotas. One care worker told us, "We're in a car, the driver gets mileage, but no time in between. You are working into your own time." Another said, "The rotas overlapped and we weren't given any travel time." And a third said, "Sometimes with the office they make it quite difficult, you get about eight or nine rotas at a time on a weekly basis. I put my availability in and they've literally taken my weekend off me. I feel like it always targets me."

We asked people if they felt safe in their home with the care staff that came to support them. All people advised us that they felt safe with their care workers and the relatives we spoke with confirmed this.

People confirmed that care staff continued to use personal protective equipment (PPE) such as disposable

gloves to reduce the possibility of cross contamination.

Inadequate

Is the service effective?

Our findings

At the last inspection we identified a breach of Regulation 18 entitled, Staffing. We asked the provider to ensure all care staff were assessed as competent with clinical care tasks as well as moving and handling and the safe handling of medicines.

The provider had employed a registered nurse in a clinical lead role and told us they would be responsible as a qualified person to assess the competence of care staff. At this inspection we found this had not be completed. No formal competency checks have been completed with care staff. The operations director told us the nurse had carried out observations on three care staff and the two care coordinators but these had not been recorded. They told us, they would ask the nurse to record these and forward them to us. We did not receive this information. This meant we were unable to check if people were at risk of receiving care from staff who were not properly trained, competent or supported to deliver safe care and treatment.

The Clinical Commissioning Group representative told us they had serious concerns about care staff not being assessed as competent, especially due to the complex clinical support some people needed. They told us they are working with the local authority commissioners to review people's care packages and arrange a transfer to another provider.

A care worker told us, "They did take a nurse on, [name of nurse], and we were under the impression she was going to train us about trachea, stoma, (complex clinical care tasks) but since she's started I've never met her and I've never had any training or dealings with her." Another care worker said, "I've only met her (the nurse) briefly once not on a professional level." And a third care worker told us they'd met the nurse briefly once on a training course.

The nominated individual told us that the clinical lead nurse would be responsible for completing support plans and risk assessments. However, we found that all the new support plans and risk assessment documentation we inspected had been completed by the two care coordinators. We asked to see their training records as they were not recorded on the training matrix. There was no evidence contained in their staff files to show they had been appropriately trained in a care coordinators role, including care planning or risk assessing. The only training we could identify was for the role of a care worker. Furthermore, we asked for their training information to be inputted onto the training matrix and this was not done.

Care workers had now been trained in key topics and refresher training had been arranged for staff who were overdue an awareness session in safeguarding adults, medicines and moving and handling theory. Additional theoretical training in topics such as end of life care and catheter care had been delivered to care staff. However, diabetes and choking awareness sessions had not been arranged for those care staff who worked with people with these specific needs. This demonstrated that some people were still not being cared for by staff who had the skills and knowledge to deliver safe care and treatment. One relative told us, "I do not feel they were that well-trained, no."

There were 45 staff employed however, only 24 formal supervisions have been completed. The feedback we

received from care staff indicated that they did not feel supported through supervision sessions.

One care worker told us, "We have them (supervisions) every three months, I've had I think two supervisions and one appraisal since I started over a year ago. Office staff do them, they say whatever you want, but whatever you say doesn't really get resolved. They seem to not listen, I just feel like every time you go with a problem they're not bothered. I've never had office staff come out to do a spot check." Another care worker said, "(I've) just been called in for supervision or training, no meetings, never been any spot checks or any supervisors popping out to see how things were."

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Staffing.

Staff supervisions had taken place and future meetings were scheduled. These were now recorded on a central spreadsheet to keep track of what was due and by when. The paperwork indicated that a discussion was held between a care worker and a member of the office staff. Topics discussed included, working hours, appearance, attendance, training/development, actions from previous supervision, concerns at present, and follow up action. We found the office staff had conducted 18 supervisions in May, five in June and none in July. In August the supervision paperwork had been improved and one had been completed. Items added to the discussion included, safeguarding, health and safety, workload and performance. We saw some were recorded as telephone supervisions, and those which were face to face had been signed by the care worker.

We were shown a tracker which showed care worker spot checks continued to be carried out by office staff on an unannounced basis. The form prompted the office staff to check matters such as punctuality, appearance, uniform, ID and the use of PPE. We reviewed these spot checks and there were no issues highlighted.

After the last inspection we asked the provider to ensure that any unqualified care workers were given a robust induction in line with the nationally recognised 15 standards for induction of care staff. In line with best practice, this should have included being assessed as competent in those 15 standards and be signed off by a qualified and registered person. The operations director showed us four workbooks belonging to existing care staff who were undertaking the 'Care Certificate'. They told us these would be assessed by the nurse and signed off by the nominated individual. The Care Certificate is a benchmark for induction of staff who are new to the care industry. We were told no new care staff had been employed since our last inspection, but the operations director talked us through the updated process for inducting new care staff which included the Care Certificate workbooks, if applicable.

We asked people and relatives if care workers had the right skills to support them. Most people and relatives told us they thought care staff were trained and gave the support they needed. People's comments included, "I get help with personal care, medication, getting dressed and going to any appointments." "I have help going to the toilet and need prompts to eat so they do my microwave meals for me." A relative said, "I don't feel the new staff do (have the right skills), no, in the last few months no. Otherwise they would have informed me of my [family member] not eating etc."

We asked the office staff including the operations director to share with us any positive examples of how they have supported people to achieve a positive outcome. We did not receive this information. The local authority shared with us some positive but mostly negative examples. The positive examples included two very elderly people being supported to live independently at home. The negative examples included people who were receiving a poor service resulting in them requesting to be transferred to another provider as Allcare Community Care Services were not meeting their needs or expectations.

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. We checked whether the service was working within the principles of the MCA. We saw the service used initial local authority assessments to inform them about people's mental capacity.

Through discussions, we found the office staff did not fully understand the principles of the Mental Capacity Act 2005 and best practice. Support plans did not always contain comprehensive information about mental capacity. For example, in some cases there was no information recorded about a person's capacity in their support plan. In other cases, people were assessed as having capacity but where a risk assessment asked if a person could cancel their own visits, the 'No' option was ticked with a note stating only a relative could do this. However, there was no supporting evidence to show a relative had the legal right to make decisions about the person's care.

In some cases, consent to care and treatment was not recorded from the person or a person acting legally on their behalf. The office staff had not obtained copies of Lasting Power of Attorney (LPA) arrangements which meant they did not know if relatives could legally make decisions. An LPA is a legal document that allows a person to appoint someone to help them make decisions or to make decisions on their behalf. It gives the person more control over what happens to them if they have an accident or an illness and can't make their own decisions. The office staff told us they would refer people back to a local authority care manager for advice about complex decision making.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

We asked people if the care workers always asked for consent before carrying out any tasks. Everyone we spoke with said their care workers did. Comments included, "Yes they are quite good like that"; "They do respect your privacy and dignity and ask for consent yes" and, "They always treat you with respect and ask first, yes."

People told us their care workers continued to ensure they had enough to eat and drink and made meals of their choice. Care workers continued to have regard for supporting nutrition and hydration needs.

The service continued to support people to access external health and social care professionals such as GP's and district nurses.

Requires Improvement

Is the service caring?

Our findings

Due to the continued shortfalls at the service, care staff continued to be limited in their ability to provide people with a completely caring service. This meant that people were still not always at the centre of the care they received. Although people and relatives made positive comments about individual care workers, the care staff were not fully supported by the provider in order to deliver a good caring service.

The provider had not produced up to date information and an explanation to share with people about the service's last inspection outcome or the action they planned to take to rectify the issues identified. When we publish an inspection report and share this with the provider, we ask them to share a summary of the report with people who use the service and staff. The provider had not made this information about the service accessible to people who may not have access to the internet. The outcome of the last inspection was not explained to people or communicated to them in a way in which they would understand it.

The two care coordinators had drafted new support plans for people and we deemed these were an improvement on the previous ones. We found they contained more person-centred information about people's likes, dislikes and routine. They were individually written to capture the personal preferences of how people wanted their care to be delivered. A detailed section about the person's routine was included to give care workers an idea of how best to support each person. However, we found elements of people's care needs had been missed or were not up to date in most of the support plans we reviewed. For example, one person's records contained contradictory information about the level of support required. Two other people's records contained information about requiring support with securing their home and using an emergency pendant to summon help. However, information for care staff about these needs was not properly documented in their support plans. This meant care workers may not have realised those people needed that support. The office staff started to update all the issues we highlighted with support plans during the inspection.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The provider's training matrix now showed that care staff had attended equality and diversity training. The operations director told us that some care staff had used the Care Certificate workbook on 'Equality and Diversity' to refresh their knowledge and update their skills with current best practice guidance.

People and relatives told us their care workers were kind and caring, although some relatives told us of a decline in the standards of care in recent months. People's comments included, "Staff are lovely they really are, cannot do enough to help you, very happy"; "Most of the staff are nice, you do tend to have your favourites but doesn't everyone"; "We have had the same ones, they seem to all rotate between each other and are wonderful, no problems at all" and, "Most of the staff are good, kind and caring, some are better than others." A relative said, "They used to be really good but the last few months there is different staff and it has really gone downhill sadly."

Everyone we spoke with told us the care staff treated them or their relations with respect and protected privacy and dignity. One person said, "They do respect your dignity." Relatives told us, "They are really respectful towards my [family member], had no problems"; "They are really respectful and kind when helping my [family member], can't really fault them" and, "I feel they are very respectful to my [family member] and that's very important to me and my [family member]."

The office staff often informally advocated on people's behalf and would refer them to a local authority care manager or an independent advocate if people needed further assistance. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. At the last inspection the operations director told us that no-one had any legal arrangements in place in line with the principles of the Mental Capacity Act 2005 (MCA). At this inspection, we discovered that the service had and continued to provide care to people who they thought had a Lasting Power of Attorney (LPA) in place. However, they had not collected the appropriate information to prove that relatives had the legal right to formally advocate on their family member's behalf.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we identified a breach of Regulation 16 entitled, Receiving and responding to complaints. This was because the provider had not ensured that an effective system was operated correctly to identify, receive, address, record and respond to complaints properly and in a timely manner.

At this inspection, we found this aspect of the service remained the same. Whilst three complaints had been briefly recorded, we noted that the provider's complaints policy had still not been consistently followed. There was a lack of investigation notes and none of the complaints were accompanied by an outcome letter with an explanation. The provider had also not acknowledged the complaints in a timely manner. For example, one complaint received on 9 May 2018 was not acknowledged by the operations director until 22 May 2018, when they responded to the initial email. A follow up acknowledgement letter was not sent to the complainant by the provider's nominated individual until 4 July 2018 which stated an investigation would take place and an outcome provided. There was no evidence of any further correspondence in regards to this matter in the complaints file.

Furthermore, there was still no audit of complaints in place and therefore the provider was unable to monitor complaints over time to ensure compliance with company policies and regulations or to look for trends and identify areas of the service that may need to be addressed or improved.

Complaints which had continued to be logged by the two care coordinators on the electronic 'customer contact log' still did not contain any information about investigations, outcomes or lessons learned. This information had not been cross referenced with the central 'complaints file'. This meant we were unable to determine the seriousness of the complaint or check if any action had been taken to rectify the complainant's issues, either formally or informally due to poor record keeping.

Since our last inspection, we have received numerous complaints and whistle blowing allegations made by people, relatives and staff about the service. We have shared all this information, anonymously (where requested) with the provider. The provider acknowledged receipt of these from the CQC, however they failed to respond to us with information about an investigation, outcomes and findings. The provider told us that they believed the complaints and whistle blowing information to be malicious, but did not show us that they had investigated the matters before deciding upon this conclusion. At this inspection, we did not see any evidence in the complaints file that these issues had been recorded, investigated or concluded. We asked the operations director about this and they told us that the provider's nominated individual would have this information at his office in Stockport. We asked for this information to be sent to us. We did not receive this information.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Receiving and responding to complaints.

People and relatives told us they were aware of the complaints process and would have no hesitation to ring the office and complain if they felt the need.

The new support plans which had been written in a person-centred manner now contained more information including information on people's social needs and religious beliefs (where shared). However, the documentation was not always signed by the person where they were able to, and where people were unable to sign themselves, their legally authorised representative had not always signed on their behalf. The office staff were unaware of which relatives had proper legal authorisation because they hadn't requested to see the official documentation. This meant that people may not have been correctly consulted about their care, and therefore the quality and continuity of care may not have been maintained.

The two care coordinators had carried out a review with people who used the service or their relatives and had updated the paperwork. All the care records we inspected contained a recent 'customer review'. The two care coordinators told us most of these had been completed face to face. We noted these were also not always signed or had a record of who had been present at the meeting.

People had rated the service quite highly in their customer review and where some people had raised an issue we saw this was recorded. However, no follow up action or an outcome was noted. For example, in a review dated 22 April 2018, a person requested certain care workers did not attend to their care anymore. The reason was not recorded, nor was an outcome. We asked the operations director about this. They told us it involved a care worker who had spoken to the person inappropriately and that this incident was still under investigation. A record about this incident was not stored in the 'incident' or 'complaints' file but we were given a copy of the incident record form. This record contained limited information and did not include any information to explain a delay of over two months in the investigation process or in taking any disciplinary action following a conclusion.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The service continued to provide end of life care to people. The new support plans included information (where this had been shared) about people's wishes and preferences regarding how they wanted to be cared for as they approached the end of their lives. The provider shared information with us after the last inspection which showed that refresher training was organised for care staff in relation to this aspect of their role. At this inspection, we saw in care staff files that an end of life training refresher course had been delivered.

Inadequate

Is the service well-led?

Our findings

At the last inspection we identified a breach of Regulation 17 entitled, Good governance. This was because the systems and processes in place were not robust enough to effectively monitor the service and ensure compliance with the regulations. At this inspection we found multiple regulations continued to be breached. This meant people continued to be at serious risk of harm.

We asked people and relatives if they thought the service was well-led. We received mixed feedback. Comments from people included, "I feel it is fine and well led, I've not had a reason to complain"; "I feel the only thing they could do better at is letting us know what time they come. I know they can't always do this but just to have a guideline would be great"; "I think they do the best that they can"; "Knowing which staff are on duty would be helpful" and, "If we always had the same staff this would really help."

One relative said, "I do not feel it is well led, no. The management should always inform you if there are any problems or update you with any changes regarding your family member and they have not. It is down to the staff as well." Another relative said, "I did not think the management were good and I do not feel it was well led. I am pleased we no longer use their service."

After receiving the initial action plan in May 2018, we asked the provider to send us an updated version at a meeting held on 1 August 2018. This was to enable us to see the progress they had made ahead of our planned re-inspection. At this inspection, we reminded the provider that we had still not received this information and requested it be sent on afterwards. We did not receive this information. Furthermore, we specifically asked for a significant amount of further evidence after this inspection which could not be given to us during the site visits. Apart from an updated training matrix and a small amount of information about one member of office staff, we did not receive all the information we requested.

At this inspection we asked to see a number of audits which related to the quality and safety of the service. The records we were given remained insufficient to prove that robust checks were being carried out on the service. This demonstrated that the systems and processes in place were still not operated effectively enough to ensure compliance with the regulations.

Audits and checks on the service continued to be inconsistently or incomprehensively completed. We were not able to review an updated version of the action plan drafted after the last inspection which meant we were uncertain that any identified actions had been followed up properly. This demonstrated that the provider had failed to closely monitor the progress against each action or had acted in a timely manner when progress was not achieved as expected.

Checks of some paperwork in place had been carried out by the nominated individual and in some cases, we saw they had countersigned the records completed by the two care coordinators. However, we identified issues with some of these records which meant the nominated individual had not checked them thoroughly to ensure accuracy and completeness.

We considered that record keeping in aspects of the service continued to be poor. The provider had repeatedly failed to ensure that records related to the care provided to people and the records related to staff employed at the service were accurate, up to date and fully completed. This meant that some staff could have found it difficult to fully understand people's needs and they may not have been able to provide suitable person-centred care and treatment which would keep people safe from avoidable harm or abuse.

At the last inspection we identified that the information passed between the office staff whilst working 'out of hours' was not comprehensively recorded or securely transferred and written records were not centralised to monitor and audit. At this inspection the office staff told us they had implemented a 'handover record sheet' and they shared the records for July 2018 with us. We saw the new handover records were not being fully completed by the staff on duty. The 'follow up' column had not been completed for all of July 2018. The records did not state which member of staff was on-call and what (if any) information was passed to another member of staff or a manager for action. These records had no evidence of a review carried out by a senior manager or an audit by the provider. Therefore, the provider was unable to show us that they had seen these records and addressed the issues or the poor record keeping we highlighted. This meant they were not able to ensure that they held an accurate record of all decisions taken in relation to the care and treatment of people who used the service.

The operations director told us that they had still not managed to arrange any care staff meetings. They said this was due to other priorities which needed to be addressed at the service. This meant the provider had not given care staff an opportunity to discuss their issues or share ideas about how to improve the service.

Care staff told us the provider had not explained the outcome of the last inspection to them or what they had planned to do to address it. They told us of rumours they had overhead and stories which were being passed between staff. Care staff said they were concerned about their jobs and felt the provider lacked empathy for how the outcome would impact on their lives. One care worker said, "I'm leaving them, we don't know where we stand, we've had no meetings, no e-mails, no people phoning you and telling you what's going on. Not a word." Another care worker said, "I'm not very happy at the moment, we've never been told anything, we don't know if our jobs are safe. The lack of communication is absolutely shocking. Weeks ago, I heard, there had been some whistle blowing and CQC were involved and they'd been stopped from taking on packages, and to this day they (senior managers) have never said a word to us."

We found that the provider had not engaged with people who used the service or care staff about the findings of the last inspection or given them a formal opportunity to share their views about the service, for example in the form of a questionnaire or survey. The operations director told us they had planned to conduct an annual survey but this had been put on hold due to their other priorities. However, people had been asked if they were happy with the service they received during their customer review.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The provider is required by law to display the performance rating from their latest inspection carried out by the CQC at their principal place of business. During the site visits we could not see that the ratings were on display in the office. We asked the operations director if this had been actioned. They told us it had not been done. We asked them to arrange for this to be carried out. The operations director displayed the ratings on the wall of the office immediately.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Requirement as to display of performance assessments.

We also asked the operations director if the report summary from the last inspection had been shared with people who used the service and staff as requested by the CQC in a letter sent to the provider which accompanies the final inspection report. They told us this had not been done either. We asked them to carry out this task. The operations director arranged with the two care coordinators to send out the report summary. They told us they would draft a letter to send to people to explain what the summary was. We did not receive confirmation from the provider that this task had been completed.

At this inspection, we found three more deaths of people who used the service had not been notified to the CQC as legally required. We discussed this matter with the operations director because this had been raised at the last inspection. We are still dealing with this matter from the previous inspection and we will incorporate this new information and publish the outcome once the enforcement process is completed.

This is a continued breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009, entitled Notification of deaths.

The service still did not have a registered manager in place. This had remained the case since January 2018 when the previous registered manager resigned. The nominated individual had applied to be registered with the CQC and this was still in progress. The process had been delayed by the nominated individual who cancelled their scheduled 'fit persons' interview with the CQC. This appointment had been re-arranged.

At a meeting we held with the nominated individual immediately after the last inspection, they told us that they would be based at the office site Monday to Friday every week to oversee the daily management of the service. However, we found that people and care staff were not familiar with the nominated individual and they all continued to refer to the operations director as the 'manager'.

One care worker said, I've spoken to [operations director], the manager about (a personal issue), she seems to have a bit of an attitude with staff, if she doesn't get her own way she hangs up on you. She's hung up on me twice. I've had some issues regarding (personal issue), over 3 months now. I tried to contact [nominated individual], the owner I believe it is, and I'm awaiting. It's an open office policy but it doesn't feel approachable. [Nominated individual] usually goes to the Stockport office, he comes up here once a week on a Tuesday, I've worked here over a year and I've never seen him or spoke to him." Another care worker told us, "I've met [nominated individual] once from Stockport." Another care worker said, "There isn't one (a manager) in place as such."

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had continued to fail to notify the Commission of all deaths of people who used the service.

The enforcement action we took:

After the inspection in May 2018, we took steps to issue a fixed penalty notice. This was concluded and paid in October 2018.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider continued to fail to ensure that an effective system was operated correctly to identify, receive, address, record and respond to complaints properly and in a timely manner. Regulation 16 (1)(2)

The enforcement action we took:

We issued the provider with a notice of decision to cancel their registration. The provider appealed this decision to the First Tier Tribunal Court, however the appeal was dismissed on 21 March 2019. Therefore the provider's registration has been cancelled.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued to fail to ensure the service was robustly monitored for compliance with the regulations. Audits and checks of the service were not effective. Record keeping continued to be poor and as such the provider had not ensured that they held a full and accurate record of the care and treatment people needed and received.

	Regulation 17 (1)(2)(a)(c)(e)(f)

The enforcement action we took:

We issued the provider with a notice of decision to cancel their registration. The provider appealed this decision to the First Tier Tribunal Court, however the appeal was dismissed on 21 March 2019. Therefore the provider's registration has been cancelled.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider continued to fail to ensure staff were robustly vetted and checked. Regulation 19(1)(a)(b)(2)

The enforcement action we took:

We issued the provider with a notice of decision to cancel their registration. The provider appealed this decision to the First Tier Tribunal Court, however the appeal was dismissed on 21 March 2019. Therefore the provider's registration has been cancelled.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were assessed as competent to carry out their role. Regulation 18 (2)(a)

The enforcement action we took:

We issued the provider with a notice of decision to cancel their registration. The provider appealed this decision to the First Tier Tribunal Court, however the appeal was dismissed on 21 March 2019. Therefore the provider's registration has been cancelled.