Aamina Home Care 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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Aamina Homecare Ltd is a domiciliary care agency that provides home care services within North Lincolnshire, North East Lincolnshire and Lincolnshire.

This unannounced comprehensive inspection took place on 12 and 13 April 2017.

After the inspection the Care Quality Commission were notified of an incident following which a person who used the service died. This incident is subject to an on-going investigation.

The inspection was carried out by one adult social care inspector. At the last inspection of the service in April 2015 the service was rated as 'Good' overall. The responsive key question was rated as 'Requires Improvement'.

There was a registered manager in post at the time of this 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.

During this comprehensive inspection we found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and a breach of the Health and Social Care Act 2008 [Registration] Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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 registered provider's registration of the service, will be inspected again within six months. The expectation is that registered 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 registered 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 registered 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.

People did not receive safe care and support. We saw that staff failed to stay for adequate times to deliver the care and support people had been assessed as requiring safely. Call monitoring data showed people assessed as requiring 30 minutes of support received their care in six minutes or less. A person who required support for 45 minutes had their care delivered in six minutes. People who had been assessed as requiring the support of two staff to help them transfer and mobilise safely regularly received support from only one member of staff, this increased known risks such as falls. People did not receive their medicines safely or as prescribed. One person had been prescribed specific medicines that required a four hour gap between each administration. The registered provider had failed to ensure suitable gaps between their calls and subsequently staff had administered the medicines in an unsafe way.

People were not safeguarded from abuse by way of neglect. Call monitoring records showed and people we spoke with told us they experienced missed calls. This meant vulnerable people did not receive the basic care and support they required such as personal care, assistance to take prescribed medicines, mobilising and transferring and meal preparation. We saw evidence that confirmed appropriate action was not taken when safeguarding concerns were raised or when allegations of abuse were made.

The registered provider failed to ensure governance systems were in place and operated effectively. Care records, were not audited or reviewed to ensure they remained accurate and provided suitable information to enable staff to deliver effective care. This led to shortfalls in care and inadequate risk management.

People did not receive person centred care. We look at 17 people's care records and found that appropriate guidance was not available to ensure staff could meet their needs. People preferences for how their care and support was to be provided was not recorded. Two people's needs had not been assessed at the commencement of their care package which meant the registered provider was not fully aware of their needs.

Consent to care and treatment was not always in place and the principles of the Mental Capacity Act 2005 were not followed or adhered to. When people lacked capacity best interest meetings were not held and best interest decisions were not in place to deliver the care people required. During our discussions with staff it was clear their understanding of their obligations under the Act was limited.

Records showed that when complaints were received they were responded to with a generic letter. Complaints were not used to drive improvement across the service and prevent other people experiencing the same issues.

People were supported by care staff before the registered provider had assured themselves of their fitness to work with vulnerable people. Safe recruitment practise were not operated.

People were not always treated with dignity and respect. Staff failed to attend calls at agreed times and people were made to wait for the care and support they required. Private and sensitive information was not held confidentially and information about people's health was shared inappropriately.

The Care Quality Commission was not notified of specific events, namely allegations of abuse, as required under regulation.

The registered provider failed to display ratings either in their premises or on their website, as required

under regulation.

People did not receive effective care and support. The people who required support to prepare meals did not always receive this due to late and missed calls. When concerns with people's dietary intake were identified appropriate action was not taken. People received support from a range of healthcare professionals but we saw their advice and guidance was not incorporated into people's care records and there was no evidence to show staff had carried out their instructions. Staff told us they received the training and support they required to carry out their roles.

People did not always receive the support they required in a caring way. People were not always supported by caring staff. The actions of the registered provider prevented supportive relationships being developed by staff and the people who used the service and person centred care being delivered. Call monitoring records showed one person was supported by 19 different carers in a single month. Staff action's exposed people to the risk of neglect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People who used the service experienced missed calls and had their 30 minute calls delivered in as little as six minutes.

People who had been assessed as requiring two staff to mobilise and transfer safely regularly received support from only one member of staff.

Staff were not recruited safely and supported vulnerable people before relevant checks were completed.

Known risks were not recorded and risk assessments were not created to ensure staff knew how mitigate them and support people safely.

People did not receive their medicines as prescribed. People were put at risk because their medicines were not administered safely.

Allegations of abuse were not acted upon to ensure people were safe.

Is the service effective?

Inadequate

The service was not effective. Care and support was provided before consent had been obtained. The principles of the Mental Capacity Act 2005 were not adhered to.

People were supported to eat and drink but when concerns with their nutritional intake were identified, action was not always taken to ensure they ate and drank sufficiently.

Advice and guidance from relevant healthcare professionals was not always followed and information was not used to update people's care records.

Staff told us they felt supported and had completed training to equip them with the skills they required to carry out their roles.

Is the service caring?

Inadequate

The service was not always caring. The registered provider's actions did not demonstrate a caring approach and lacked consideration for people needs.

People were not always treated with dignity and respect. Private and sensitive information was not treated confidentially.

Appropriate information was not available to staff to ensure they supported people in a person centred way, in line with their preferences.

Is the service responsive?

Inadequate

The service was not responsive. Assessments of people's needs were not always carried out. As people's needs changed the registered provider failed to take appropriate action, such as reviewing care documents and risk assessments.

Complaints were not used to drive improvement across the service and shortfalls in care were not rectified. We saw that the registered provider responded to people's complaints with a generic letter.

Is the service well-led?

Inadequate

The service was not well-led. There was a clear lack of governance arrangements within the service. Systems and processes had not been developed to identify and mitigate risks or improve the quality of service provided.

The Care Quality Commission had not always been informed of incidents that affected the safety and wellbeing of people who used the service.

There were shortfalls in recording which meant information about people's care was not accurate and up to date, which placed them at risk of not receiving appropriate support.

The registered provider failed to display ratings internally or on their website as required.

Aamina Homecare Ltd

Detailed findings

Background to this inspection

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

This inspection commenced on 12 and 13 April 2017 and was unannounced.

Before the inspection, we contacted the local authority commissioning and safeguarding teams to gain their views on the service.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

During the inspection we spoke with seven people who used the service and two of their relatives. We also spoke with the registered manager, administrative and office staff, a care support officer and three members of staff.

We looked at 17 people's care plans along with the associated risk assessments and medication administration records (MARs). We also looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also checked a selection of documentation pertaining to the management and running of the service. This included training records, recruitment information for three members of staff, complaints information and a number of the registered provider's policies and quality assurance questionnaires.

Inadequate

Is the service safe?

Our findings

People who used the service told us they did not feel safe due to the registered provider's failure to ensure they received the care and support they had been assessed as requiring. One person said, "The staff can't get out of here fast enough, they come in check I'm still breathing and then go, they are here for less than 10 minutes most days." Another person told us, "I don't know who is coming, when they are coming or if they will turn up at all."

People who used the service experienced neglect due to missed calls. Staff did not attend scheduled calls and failed to deliver care at agreed times or stay for the designated amount of time required to provide care safely and effectively. A person who used the service said, "It used to make me so angry, I need help and that's obviously frustrating but when they [the care staff] don't bother to turn up and my wife has to help me instead, it puts us both at risk. She could get injured and if I fell, I wouldn't be able to get up."

Over an eight day period a person who had been assessed as requiring two calls a day, only received nine. This meant they did not receive the care and support they required which put them at risk. Another person who required two staff to support them from bed, with personal care and dressing did not receive any support for a two day period. In an additional 20 day period the same person experienced further missed calls and on three occasions had their care delivered by one person, , which meant the care and support people received was unsafe.

A person who experienced memory loss, mobility and mental health issues had been assessed as requiring support in the morning to complete personal care tasks, getting dressed, preparation of breakfast and medicines administration. Records showed that staff completed calls in as little as six minutes and calls were consistently delivered in less than ten minutes. From an expected 69 hours of care the person received less than 33 hours, which equates to less than 46%. Another person's assessment stated they had mental health issues, suffered from depression, were incontinent and had mobility issues. Their call monitoring data provided evidence that they received 86.19 hours from a scheduled 135 hours which is less than 64%.

The call monitoring data showed that people who had been assessed as requiring a 30 minute call to deliver the care they required safely were supported in five minutes or less. A person who required a 30 minute call from two members of staff was completed in 10 minutes. A person who required a 45 minute call had their call delivered in six minutes. Staff failed to ensure people received the care and support they required and the registered provider did not take action to prevent this occurring.

People were not protected from abuse because appropriate action was not taken when allegations of abuse were made. An allegation of abuse was reported to the office and registered manager by a member of staff. The registered manager instructed a member of office staff to report the allegation to the local authority safeguarding team but this did not occur and was not followed up by the registered manager. This meant a person was exposed to the risk of abuse for an extended period, because the allegation was not acted upon. The registered manager said, "I told (Name of the member of staff) to report it, I know she did try and speak to someone but it obviously didn't get reported. I should have followed it up but I thought (Name of the

member of staff) had done it."

The above information demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Records showed staff had completed safeguarding training and during our discussions they were knowledgeable about what constituted abuse as well as their responsibilities to report anything concerning they became aware of. One member of staff said, "I have seen things in the past, like poor moving and handling techniques and reported it straight away. I would escalate things to other agencies if I needed to."

People did not receive safe care and treatment and known risks were not mitigated as required. We reviewed the call monitoring data held within the service and saw that calls were not always attended by suitable numbers of staff. Records showed that on several occasions a person who had been assessed as requiring two staff to support them with their daily needs had their care delivered by one member of staff. This increased the likelihood of known risks occurring, such as falls and the possibility of the person sustaining injuries through inappropriate and unsafe care.

Another person who required two members of staff to operate specific equipment to help them with transferring, for example, from bed and to their wheelchair was supported by one member of staff at numerous calls. This meant that transfers were not undertaken safely and exposed the person to unacceptable levels of risk.

At the time of the inspection two people who used the service were being supported on a daily basis but the registered provider had failed to ensure an assessment of their needs had been carried out. A task list had been created that contained minimal information but no risk assessments had been developed to ensure staff were aware of how to deliver care and support safely. One of the two people displayed behaviours that challenged the service and others; no behavioural management plans had been created so staff were aware of how to prevent or de-escalate their behaviours and to ensure the person received the support they required safely and consistently.

Actions were not taken to reduce known risks. We reviewed the local authority's community service request and saw that a person had been assessed as being at risk of contracting chest and urine infections as well as developing pressures sores due to their reduced mobility. No risk assessments or strategies had been created to reduce the possibility of chest infections or pressures sores and no guidance had been created to ensure staff were aware of the risks and knew what action to take to mitigate them. Fluid charts were not introduced and targets for daily intake of fluids to prevent urine infections were not put in place. The local authority's community service request stated the person must not lie flat in bed due to respiratory problems but this information was not incorporated in to their care documents, which increased the risk the person would not receive the care and support they required.

The above information contributed to the breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People told us they did not receive their medicines as prescribed. One person explained, "I don't get my medicines when I should and that can have a big impact on me, it is concerning." A second person said, "How can I take my tablets when I should if they [the care staff] aren't here when I need to take them?"

Medicines were not administered safely. A person had been diagnosed with dementia; their local authority 'community care request' stated that they were becoming increasingly forgetful and would forget to take prescribed medication. The client assessment and risk assessment completed by The service also stated the person experienced memory loss and confusion. However, this assessment stated they did not need support in this area. The medication risk assessment stated the person was fully alert and orientated which contradicted earlier assessments and information. The failure to complete the risk assessment accurately meant that the person was not seen to be at risk and subsequently did not receive the support they required in this area.

One person had been prescribed a number of medications that required a minimum of four hour intervals between administrations. We saw from call monitoring data the registered provider had failed to ensure suitable gaps had been installed between the person's call times. When we cross referenced the person's daily diary sheets we saw that staff had administered their medicines in contrast with the prescriber's instructions. For example, staff had attended a call at 1.31pm and left at 2.01pm; the next call was completed between 4.08pm and 4.41pm. This meant that if the person's medicines were administered in the first minute of the first call and the last minute of the second call only three hours and 12 minutes would have passed between administrations. The person was exposed to the risk of receiving too high a dose of their prescribed medicines due to the lack of appropriate risk management by the registered provider.

The above information contributed to the breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We reviewed the processes used by the registered provider to ensure themselves prospective staff were suitable to work with vulnerable adults. We checked the recruitment records for three newly recruited members of staff and saw that appropriate checks had not been carried out. One member of staff had declared a conviction from 2007, only had one reference and there was no evidence to show that the considerable gaps in their employment history had been explored. A second member of staff had two personal references, a reference from their previous employer had not been obtained and the gaps in their employment history had not been accounted for.

There were issues with a third member of staffs references and they were working autonomously before their Disclosure and Barring Service (DBS) check was returned to the service. The registered manager explained, "Someone has made a clerical error, (Name of the member of staff) will have been working on double up calls until the DBS came back but someone must have just seen she was available and given her shifts."

There were no risk assessments in place to support any of the shortfalls we identified in the three recruitment files no information as to why the staff had been allowed to work without appropriate assurances being in place. There was no evidence to show that their competencies had been assessed to ensure they were fit for their roles. This meant that the registered provider had failed to assure themselves that the staff were of good character and suitable to work with vulnerable people, this exposed people who used the service to the risk of receiving care and support from unfit staff.

The above information demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Inadequate

Is the service effective?

Our findings

People told us that staff did not have the skills and competencies to meet their needs. Their comments included, "Not all of the staff are well trained, they would turn up and not have a clue what they were doing, I used to have to explain everything to them", "I'm not sure if they [the staff] had any training. They should know what I need before they came but they never did" and "The ones I saw regularly were good, they knew me and what I needed but they [the registered provider] always seem to lose the good staff and keep the others."

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, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people in their own homes and in the community who needed help with making decisions, an application should be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care was delivered to one person whose local authority 'community care request' stated they were undergoing assessments to ascertain if they were living with dementia. The member of staff who was completing the assessment of the person's needs for the registered provider did not complete the assessment due to perceiving the person lacked capacity. No action was taken to ensure a best interest meeting was arranged and no further liaison with appropriate health and social care professionals had taken place. Even though consent to the care package was not in place or agreed as being in the person's best interests care was provided.

We reviewed the care records and assessments of a second person and saw that they had no mental health issues recorded and at no time were concerns with their capacity noted. However, the service was contacted by a relative of the person who expressed concerns about their abilities to undertake certain care tasks independently. No assessments of the person's capacity was undertaken and staff commenced delivering care without appropriate consent being in place.

Care was delivered to a third person who lacked capacity and by their actions did not always consent to the care being delivered. The service failed to ensure the care and support being delivered had been agreed as in their best interest and was the least restrictive way to meet their needs. The service failed to work in accordance with the requirements of the Mental Capacity Act 2005.

Records showed 30 of 46 staff had completed training in relation to the Mental Capacity Act 2005. However, when we spoke with staff it was clear that their understanding of the Act was basic. Staff were not clear how

to ensure consent was in place to deliver care and support to a person who had been assessed as lacking capacity.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who required support to prepare meals were affected by staff failing to deliver support at agreed times. For example, one person had been referred to the service because they had not been eating properly and had lost a significant amount of weight. Their assessment stated they needed support to prepare meals and could not do this independently. We reviewed the call monitoring data and saw that the person had experienced a number of missed calls so would not have had any food prepared for them. On other occasions, calls were not adequately spaced between breakfast and lunch time. For example one person received their morning/breakfast call between 10.22am and 10.39am and their lunch call between 11.57am and 12.14pm.

People who used the service were supported to eat meals of their choosing. However, we found that when concerns had been identified, action was not always taken to ensure people ate and drank sufficiently. A person had been identified as being at risk of malnutrition in their initial assessment and the assessor had recommended that food and fluid charts were put in place at the commencement of the care package to enable their intake to be monitored. The charts were not introduced as advised which meant staff may not be fully aware of the person's eating habits or the support they required in this area. This exposed the person to the risk of not been referred to a relevant healthcare professionals in a timely way and subsequently not receiving the support they required.

We saw that people who used the service were supported by a range of healthcare professionals. However, when advice and guidance was provided we found evidence to show this was not always transferred to people's care records. For example, one person had been seen by a physiotherapist and had been advised to complete specific exercises. This information was not used to adapt and update the person's care plan which increased the risk of staff not delivering the care and support they required in this area.

Records showed staff had completed a range of training courses to gain the skills and knowledge to deliver care and support. This included safeguarding vulnerable adults, administration of medication, moving and handling, infection prevention and control, health and safety, food hygiene and fire awareness. Staff we spoke with told us they believed the training equipped them with the skills to carry out their roles effectively.

There was evidence to show that some staff had received adequate levels of supervision and appraisal. The registered manager explained, "We do two personal development reviews with the staff every year, obviously the new staff haven't all had that yet because they haven't been with us long enough."

The service had recently employed a new member of staff and the registered manager confirmed part of their role would be to complete observations of staff practice and deliver individual supervision. The supervision records we saw included discussions about training needs, care delivery and call monitoring times.

Inadequate

Is the service caring?

Our findings

When we asked people who used the service if they were supported by caring staff we received mixed responses. One person said, "I have to say some of the carers were great, the ones I saw regularly were brilliant. Some of the others didn't care one bit, let's just say I didn't think they were cut out for this line of work." A second person commented, "Most of the staff were friendly but I don't think I ever saw them twice. Some of their attitudes could have been better." Another person said, "I was happy with the carers, they always did their best. I never doubted how caring they were, I often wondered about their knowledge and abilities but not how caring they were."

Staff's actions did not always show that they had a caring nature. For example, a person who required support due to experiencing memory problems and hallucinations had experienced missed calls. The registered manager explained, "The carer went to the call but they saw the lights were off and the curtains were closed so they thought [Name of the person who used the service] was asleep, didn't want to disturb them and left." The person required support to take their prescribed medicines and to prepare meals, the neglectful actions of the member of staff meant this did not occur .

The registered provider failed to facilitate the development of caring and supportive relationships being developed between the people who used the service and the staff who supported them. For example, a person who was living with dementia and was known to display behaviours that challenged the service and others; was supported by 19 different members of staff in one month, which prevented any form of consistency or continuity in their care.

People were not treated with dignity and respect. People's rights to privacy were not respected and information about people's health care needs was not treated confidentially. We saw a record in a person's care file that the registered manager had sent an email to 56 members of staff stating that the person had recently been diagnosed with a particular health condition. The person was not supported by all of the members of staff who received the correspondence and did not have a right or need to know this information.

Calls were not delivered at agreed times, which showed a lack of respect for the people who used the service. For example, a person who required two staff to support them to get out of bed in the morning, to help them undress and dress after providing personal care was made to wait on one occasion for over an hour and 21 minutes because staff failed to attend at the agreed time. A person who required support from staff to get out of their chair or wheelchair and into bed on an evening received their call scheduled for 8.30pm at 9.49pm meaning they were left to wait an hour and 19 minutes for the support they required.

Other people experienced similar issues; a person who required support in the morning received their 8.15am to 8.45am call at 9.54am, 1 hour and 39 minutes late. Another person received their 1pm to 1.30pm call at 11.47am, 1 hour and 13 minutes early. Failing to deliver calls at agreed times was disruptive to people's lives and increased the chances of people not receiving the care and support they needed as well as impacting any social plans that have been made.

The above information contributed to the breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who used the service did not receive person centred care that met their needs and reflected their preferences. People's preferences regarding their care and support had not been recorded. Staff did not always know the people they were caring for and supporting because people's care plans lacked relevant information.

The care plans we saw contained no personal information about people such their family lives, where they grew up, previous occupations or their hobbies and interests. This type of information would have enabled staff to develop relationships with people and engage them in meaningful conversations. The registered manager told us, "We have never created person centred care plans. We just have task lists."

Inadequate

Is the service responsive?

Our findings

People we spoke with or their appointed representatives confirmed they were involved in their initial assessments. One person commented, "I was asked so many questions, they wanted to know everything about me, but then they wrote a couple of lines on a piece of paper. Everyday staff just came in and asked what help I needed anyway." A relative we spoke with confirmed, "I have power of attorney and was involved in the initial assessment."

We found evidence that showed people did not always have an assessment of their needs undertaken before care and support was delivered. This exposed people to the risk of not having their needs met and not receiving personalised care. The registered provider failed to ensure staff were fully aware of people's needs and how to deliver care and support in line with their preferences.

Records showed two people were receiving care and support from the registered provider even though an assessment of their needs had not been undertaken. One person had been receiving care and support since 3 February 2017. At the time of this inspection which was carried out on 12 and 13 April 2017, over two months since the commencement of the care package, an assessment of their needs had still not been completed. A generic task list was in place that lacked detail and relevant information to enable staff to deliver person centred care.

Diary sheets showed that the person displayed behaviours that challenged the service and others as well as refusing care. This information was not transferred to their care records and no guidance was created to direct staff on the preferred strategies to use to reduce any anxieties the person experienced.

A second person's care package also commenced in February 2017 and similarly the registered provider had failed to ensure an assessment of their needs had been carried out. A bullet point task list was in place that contained generic statements and no guidance to enable staff deliver person centred care.

The registered provider could not be assured that either person's care and support needs were met in line with their preferences because they failed to ensure a care plan was created that instructed staff how to deliver person centred care.

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider failed to ensure care records were updated as people needs changed and developed. Subsequently risks assessments were not created or updated to mitigate known risks.

One person's needs had increased over time and due to this staff had become responsible for administering their medicines. The registered provider failed to ensure their task list was updated to reflect this and their medication risk assessment was not reviewed. Due to the lack of appropriate guidance staff administered

the person's medicines without appropriate lengths of time lapsing, which put the person at risk.

Another person had developed a skin condition that could have serious implications if not treated in a timely way. The registered manager informed staff of the person's condition via email, their care records were not updated, a risk assessment was not developed and no guidance was created to ensure staff could recognise if the person's condition had deteriorated and needed medical attention. This put the person at risk of not receiving medical treatment as required.

The above information contributed to the breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We reviewed the complaints received by the registered provider and found that a number of people had raised similar concerns. Complaints had been made in relation to missed calls, staff failing to stay for the full duration of the call, staff failing to arrive at agreed times and only one member of staff delivering care when people had been assessed as requiring two staff to meet their needs safely.

The registered provider's response letters sent to complainants were identical. The registered provider attributed missed and late calls to unreliable staff who no longer worked within the service. They provided assurance that call monitoring records would be scrutinised to ensure people received the care they required consistently and effectively. However, it was clear from the call monitoring records and diary sheets that the registered provider had failed to take appropriate action following people's complaints, because missed and abridged calls continued. The registered provider had not used complaints to improve the quality of service provided and this led to more people experiencing the same shortfalls in care delivery.

People we spoke with told us they had made complaints and raised concerns about their care. One person said, "I have made complaints, not that anyone listened or anything changed. I was told my calls would be monitored but they still couldn't get staff here at the right times." Another person told us, "I had to complain about the service I was getting. The carers didn't arrive on time; if they turned up at all and when they did get here I had to tell them what to do because they didn't know."

The above information contributed to the breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, receiving and acting on complaints. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Inadequate

Is the service well-led?

Our findings

People who used the service told us it was not well-led. One person said, "When the carers get here they are generally okay. It's the office staff who never know what's going on, if I ask for a rota so I know who is coming they can never tell me. If I ring up and ask where my carers are they never know." Another person commented, "It's not a professional company, they are all hot air and empty promises." A relative we spoke with said, "We have felt let down, we wanted care for mum because she can't manage by herself and we all work. I thought knowing an agency was going in would be comforting but it wasn't. I was always worried about who was going, if they would turn up and if she would get the care we think she deserves."

The service was not well-led. The registered provider failed to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As demonstrated throughout this report the registered provider had failed to ensure compliance with regulations 9, 10, 11, 12, 13, 16, 17, 19 and 20A. They were also in breach of regulation 18 of the registration regulations. This meant the registered provider was in breach of regulation 8 which stipulates the registered provider must comply with regulations 9 to 20A.

The registered provider failed to operate systems that assessed, monitored and improved the quality of the service. We found that care records lacked relevant information and failed to include appropriate guidance to enable staff to provide care safely, effectively and in line with people's preferences. Risk assessments were not always created to ensure staff knew how to support people safely and when people's needs changed or developed risk assessments were not updated. When we asked the registered manager how they ensured people's care records were accurate, they said, "We haven't done any auditing for a long time. We have not been doing any checking, not really had quality assurance for a while now."

Due to the lack of information available to staff we asked the registered manager how they were assured staff delivered all of the care and support people required safely. The registered manager told us, "We used to do field observations but haven't had the staff so they stopped happening a while ago."

The registered provider's failure to review care records on a periodical basis meant shortfalls were not identified. This led to the lack of information in people's care records not being highlighted or rectified. Subsequently, staff were not aware of people's preferences or what action to take to mitigate known risks. When people's needs changed and staff were required to deliver additional support this information was not recorded which exposed people to the risk of not receiving the care and support they required.

The registered provider failed to ensure systems and processes were established and operated that assessed, monitored and improved the quality and safety of services provided and mitigated risks.

We reviewed the registered provider's call monitoring data and saw that people experienced missed calls and had their care delivered in reduced timescales. We asked the registered manager if the call monitoring data was monitored and what actions were taken when concerns were identified. The registered manager explained, "The person that used to monitor the call times left and we stopped doing it."

The failure to monitor this data led to people not having their needs met safely and effectively. People received as little as 46% of their commissioned call time and other people had 30 minute calls delivered in as little as five minutes. People received calls up to one hour and 13 minutes early and over and one hour and 39 minutes late. People who were prescribed time specific medications received calls at inappropriate times and were subsequently administered their medicines in contrast to the prescriber's instructions.

The registered provider did not operate effective systems to ensure people were not supported by unsuitable staff. Call monitoring data was cross referenced with a member of staff's recruitment information, specifically their Disclosure and Barring Service check. We saw that the member of staff worked autonomously before the registered provider had assured themselves the person was fit. The registered provider's failure exposed people to the risk of receiving care and support from people who had been barred from working in the care industry.

The above information contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider did not maintain accurate, complete and contemporaneous records in respect of each service user because assessments of people's needs were not undertaken. We asked to see the care records for two people and were informed by the registered that assessments had not been carried out even though their care package had commenced. No risk assessments had been created to ensure known risks were mitigated and people were supported safely.

The above information demonstrated a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

During the inspection we saw evidence that the registered manager was made aware of an allegation of abuse and failed to take appropriate action to ensure a person's safety. The registered manager did not report the allegation to the Commission as required under registration regulations.

The above information demonstrated a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

As part of the planning for this inspection the registered provider's website was viewed. The service's latest inspection rating was not available nor a link to where this information could be found. During the inspection it was apparent that the rating was not displayed in the service's premises.

The above information demonstrated a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Requirement as to display of performance assessments. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered manager had conducted satisfaction questionnaires in 2016 and 2017. We saw that people's feedback had been collated and some action had been taken such as providing staff with new uniforms. Other issues people raised such as late and missed calls had not been rectified.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to ensure the Care Quality Commission were notified of other incidents, namely allegations of abuse, as required.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 8 HSCA RA Regulations 2014 General The registered provider failed to ensure compliance with regulations 9 to 20A.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care because the registered provider failed to ensure care plans were developed to meet their needs and reflect their preferences.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect, private and sensitive information was not treated confidentially and they did not receive care and support at agreed times.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 were not followed and care was delivered without appropriate consent.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did receive safe care and treatment. Care was delivered to people by less staff than they had been assessed as requiring to support them safely. Known risks were not recorded and no action was taken to mitigate them. People's medicines were not administered safely or as prescribed.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abusive care practices and allegations of neglect were not acted upon to ensure people were safe.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not used to improve the service or the care and support people received.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The registered provider failed to operate systems and processes to assess monitor and mitigate risks or to improve the quality and safety of services provided.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate checks were not completed before staff supported vulnerable people autonomously. The registered provider failed to assure themselves of staff fitness.

The enforcement action we took:

We have issued a notice of proposal to cancel the registered provider's registration.