Caring for You Limited

Grove Domiciliary Care

Inspection report

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15 February 2017

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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

This inspection took place on 14 and 15 February 2017. The inspection was announced.

At our last inspection carried out on 17, 27 and 30 June 2016, we found the service was in breach of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (2014 Regulations) and one of the Care Quality Commission (Registration) Regulations 2009 (2009 Regulations). We served warning notices for breaches of four of the 2014 Regulations because people's medicines were not being managed safely, there were no systems in place to monitor the quality and safety of the service, there were not enough sufficiently skilled and experienced staff to meet the needs of people and keep them safe, and the provider did not operate an effective recruitment procedure to ensure staff were suitable to provide care to people. We told the provider they were to be compliant with these warning notices by 16 December 2016.

At this inspection we found the provider had not met the warning notices because the service continued to not manage people's medicines safely, systems were still not in place to monitor the overall quality and safety of the service, there continued to be insufficient staffing levels and staff were not sufficiently skilled and experienced to meet the needs of people and keep them safe. Recruitment checks remained incomplete prior to staff starting work.

We asked the provider to send us an action plan in response to the breach of three of the seven 2014 Regulations and one of the 2009 Regulations from the June 2016 inspection. We asked the provider to tell us what action they would take to meet people's needs and keep them safe. This was because people's needs may not have been met or met safely because care plans were not in place for people at the start of them receiving a service, safeguarding concerns had not been reported, identified and appropriately investigated, appropriate action had not been taken in response to complaints and the provider failed to notify the Commission of safeguarding concerns. The provider sent us an action plan on 5 October 2016, which stated they would be compliant with the Regulations by the 5 October 2016. At this inspection we found the provider had not met their action plan or the requirements of the Regulations because safeguarding concerns had not been identified and appropriately investigated and the Commission had not been notified of all safeguarding concerns received. Complaints were not investigated or responded to within given timescales.

Grove Domiciliary Care is a domiciliary care service, which provides care and support for people who live in their own homes in Fareham, Portchester, Warsash, Lee on Solent, Stubbington, Gosport and Portsmouth. At the time of this inspection, they provided care and support to an estimated 181 people with a range of needs including older people and those who lived with dementia. People were supported with personal care, medicines administration and meal preparation. The service employed a registered manager, a deputy manager, 74 care workers, three senior care workers, three care coordinators, two drivers who would transport care workers to visits who did not have their own mode of transport, and administrative staff based at the office premises.

The service had a 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. However the registered manager had been absent from the service since the 30 November 2016 and the provider's regional manager who was also the nominated individual of the provider was overseeing and managing the service in the registered manager's absence.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

Missed and late visits frequently occurred and staff were rushed resulting in poor manual handling techniques, incomplete care visits which resulted in neglect and care visits being too close together which resulted in people missing medicines and food and fluids.

People's dignity was not respected as a result of missed visits because it was apparent the service expected relatives to complete people's care when staff were unable to visit. People felt rushed and staff's attitude to this demonstrated they were not consistently kind or caring.

Risk assessments did not contain sufficient information to keep people safe from harm and manual handling equipment was being used incorrectly.

Medicines were not managed safely. Records were unclear regarding the support people required with taking their medicines. There were gaps present on peoples Medicine Administration Records and people were not receiving the right dose of their medicines or their medicines at the right time.

Appropriate recruitment checks had not been completed for all staff prior to starting work.

Safeguarding concerns were not managed appropriately to keep people safe from harm. A number of safeguarding concerns had been raised against the service. However records relating to safeguarding concerns were not accurate or up to date. The Commission had not been notified of all the safeguarding concerns received by the service. The overall feedback from external professionals was that people were not safe from abuse or harm from this service.

Staff had not received appropriate training to help them to complete their role effectively and safely. Not all staff had not received practical manual handling training and not all staff had received training on medicines. Medicines competency checks had not been carried out on those staff who had completed the medicines training. Not all staff had completed training on the Mental Capacity Act 2005 and people may not have consented to their care plans.

People's care plans were not personalised and lacked sufficient detail about how people would like to receive their care. Care plans did not include information on what people could do for themselves. Information contained within the initial assessments were insufficiently detailed, contradictory and unclear and were not always included in people's care plans. Care plans in people's home were out of date and did not contain the correct information.

The emergency out of hours service which was in place when the office was closed was not responsive and often switched off. Complaints had been received but were not investigated or responded to and there was no learning from complaints.

There was inadequate leadership within the service. People and staff did not feel that management were open and transparent and did not have confidence in the management team to deal with any concerns or issues.

The systems in place to assess the overall quality and safety of the service were inadequate and not fit for purpose.

People received support to seek advice from health care professionals. People felt listened to and were encouraged to make decisions about their care.

We identified a number of breaches of the Health and Social Care (Regulated Activity) Regulations 2014 and one breach 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 this report.

The Commission is considering the right regulatory response to the concerns we found.

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.

There were insufficient staffing levels to keep people safe and meet their needs.

Medicines were not managed safely

Recruitment processes were not robust.

Risk assessments were incomplete and not fit for purpose.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported or trained to have the knowledge and skills to carry out their role effectively.

People did not provide clear consent regarding their care plans.

People did not receive appropriate support with food and fluids

People were supported to have access to health care professionals.

Is the service caring?

Inadequate

The service was not caring.

People's dignity and privacy was not respected and staff actions demonstrated they were not consistently kind or caring.

People's care plans were not personalised but people felt listened to and were always asked what support they would like. However people did not always receive a visit.

Is the service responsive?

Inadequate

The service was not responsive.

Initial assessments were insufficiently detailed, contradictory

and unclear and information was not always included in people's care plans.

Care plans in people's homes were out of date and did not contain the correct information.

Complaints were not investigated or responded too appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Management and leadership of the service was considered weak. Staff and people felt management were not open or transparent and staff lacked confidence with their management ability.

Systems in place to assess the overall quality and safety of the service were not fit for purpose and records relating to people who used the service were inaccurate and incomplete.

Grove Domiciliary Care

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 February 2017 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure the manager would be available.

The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts areas of expertise included, people in the early stages of dementia and older people who used regulated services.

Before the inspection we reviewed safeguarding records and other information received about the service. We checked if notifications had been sent to us by the service. A notification is information about important events which the provider is required to tell us about by law. We spoke with the Local Authority safeguarding and commission teams. This inspection was brought forward as a result of receiving concerning information about the quality and safety of the service.

During the inspection we spoke with 22 people who were in receipt of personal care and nine relatives. We spoke with the nominated individual of the provider who was also the regional manager, one deputy manager, two care coordinators and 16 care workers.
We reviewed a range of records about people's care and how the service was managed. We looked at care plans for seven people which included specific records relating to people's health, choices, care, capacity, finances, medicines and risk assessments. We looked at daily reports of care, incident, safeguarding, complaints and compliments logs, financial transaction sheets, medication administration records, policies and procedures, service quality audits and minutes of meetings. We looked at recruitment and supervision records for ten staff and training records for 64 members of staff.

Inadequate

Is the service safe?

Our findings

At our previous inspection in June 2016 we found there were not enough staff to meet people's needs and keep them safe. This mostly affected people at the weekends due to high levels of staff sickness. As a result care workers were often late, too early, or sometimes did not arrive at all and people missed their medicines, meals and did not receive the care they should have had. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice and told the provider they were required to become compliant with this regulation by 16 December 2016. At this inspection we found the provider had not made the required improvements because people were still experiencing missed, late and reduced calls due to high sickness levels and insufficient staffing. As a result people continued to have their medicines and meals missed and received unsafe care.

We received information of concern from the local authority safeguarding teams, prior to and during the inspection about the same concerns with regards to people's missed and late visits. The local authority safeguarding teams advised us of missed visits where people had missed their medicines and were left in unsafe positions due to unsafe manual handling practices.

We received a mixed response from people and their relatives regarding the safety of the service they received. Prior to the inspection we received information of concern about the safety of the service from people and their relatives. People and their relatives were mostly concerned with the high volume of missed and late calls and how this impacted on people. One relative told us how care workers would arrive too late or too early which impacted on the times their relative would receive their medicines which were not given at times directed and the person would also miss their meals. Another relative told us how care staff had on two occasions not arrived until the afternoon to complete their relative's morning care which meant this persons medicine was not given at the right time and they had missed their breakfast and gone without a meal. We also received concerns from the local authority and external professionals about unsafe manual handling practices and medicines errors which had occurred on a number of occasions.

When we spoke with people and their relatives during the inspection people said they felt safe; however they continued to express concerns with missed and late visits. One relative said, "We get the same person and I feel that my [relative]) gets safe care because the carer knows [them] very well. The concern I do have is that when the usual carer is going to be away, they don't seem to be able to cover leave or shortfalls." Another relative told us issues occurred when their regular carer was off sick or on leave. They said, "When [carer] is off nobody lets me know if someone is coming or if they are going to be late." One person said, "I have regular carers and I feel safe with them because they know me." However, they did confirm their care workers were often late. Another person said, "Sometimes when the main carer has been away they [provider] have forgotten to sort out cover."

After speaking with people and their relatives as part of the inspection we continued to receive information of concern from people and their relatives about missed visits, late visits and only receiving a visit from one care worker when two care workers should have been scheduled. We also received information of concern about other unsafe manual handling practices, the lack of infection control practices carried out by care

staff, missed medicines and potential abusive care practice; in which a safeguarding alert was raised to the local authority.

We received information from staff during the inspection that missed visits were frequently occurring and had occurred as recently as Sunday 12 February 2017 and Tuesday 14 February 2017. Staff confirmed this was due to staff sickness and insufficient staffing levels. Staff also confirmed that people's medicines and meals would be missed due to visits not taking place or late visits occurring. One staff member told us how a person would experience, "several" missed visits and they had not received a visit on Saturday 11 February 2017. They said, "The visit was supposed to be at 7am but got missed." They told us they had contacted the office but did not get an answer. They stated the care worker did not turn up until lunchtime. They concluded the conversation by saying, "Happens often."

We looked at the scheduling documents for eleven people for the weeks commencing 6 and 13 February 2017 and found visit times were inconsistent and were being scheduled for times when care calls would not take place and care workers would not be working. For example, one person's schedule for the week commencing 6 February 2017 documented a visit time of 04:30am. We spoke with the nominated individual who told us that times were "squeezed in" on the schedules to electronically show that people were receiving a visit, but this would not be the person's actual visit time. This meant staff would already be late for the visit according to the electronic schedule; office and on call staff would not know where staff were at all times and visits would have to be reduced for the care staff to meet their schedules. People confirmed care staff would not stay for the full length of time because they were rushed. One person said, "Regular carer was off for personal reasons and no phone call from the office and sometimes these visits are rushed because they have another visit." Another said, "When my main carer is on leave I get an assortment of carers. Weekend carer rather speedy doesn't spend the full 30 minutes."

The failure to deploy sufficient numbers of staff was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to and during the inspection we received concerns about unsafe manual handling practices. Prior to the inspection one relative had informed the Commission that their relative had been "Left hanging out of the bed" on two occasions due to staff's lack of manual handling practices and poor techniques. During the inspection staff and local authority safeguarding teams confirmed equipment was not always used to safely position people in bed or onto other pieces of equipment.

During the inspection we looked at manual handling risk assessments for nine people. We found there was a lack of information regarding the manual handling techniques that should be used for all nine people. Care plans did not include details of risks identified in each person's care assessments and did not include any information on how staff should effectively manoeuvre or position people. Assessments and care plans did not acknowledge the equipment people required to keep them safe while mobilising or being transferred. Manual handling risk assessments were basic and did not describe the manual handling task in any detail. For example, one person's manual handling risk assessment stated they required support to be manoeuvred in and out of bed; however the section which required an explanation on how the tasks were to be completed and details of the equipment to be used just read, "With Assistance." There was no other information contained within this section or any other section of the assessment. This person also had a falls risk assessment which was completed on 5 July 2016 and indicated the person was at a high risk of falls. The guidelines included in the falls risk assessment document for people who were assessed as a high risk of falls stated, "Document any preventative action in care plan." This person's care plan did not contain this information.

We passed these concerns to the local authority safeguarding teams. Following their assessments and visits to people who were in receipt of manual handling tasks, they confirmed people had been put at risk due to insufficient manual handling equipment; poor practice; insufficient manual handling instructions and inaccurate information in people's care plans and risk assessments. The overall feedback from the local authority safeguarding team was that 50 percent of the people who were in receipt of support with manual handling were not safe from abuse or harm from this service.

A failure to provide care in a safe way for service users by not assessing the risks to the health and safety of service users receiving care and failing to do all that is reasonably practicable to mitigate any such risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015, we found that people's medicines were not managed, or administered safely. This was due to the fact that medicines administration records (MAR) were not always completed. The provider sent us an action plan and said they would be compliant with this regulation by the end of October 2015. At our inspection in June 2016 we found the provider had not made all of the improvements as stated in their action plan and had failed to ensure the proper and safe management of medicines. Therefore the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice and told the provider they were required to become compliant with this Regulation by 16 December 2016. At this inspection we found that the provider had not taken the appropriate steps to ensure people's medicines were managed safely.

Prior to and during this inspection we received a number of concerns from people, relatives, staff and the local authority safeguarding teams, regarding missed medicines. Mostly people did not receive their medicines due to late or missed visits; however we also found at this inspection people may not be receiving their medicines when visits were taking place because medicine records (MAR) had not always been completed. We also found people were not always receiving the correct amount of medicines and did not always receive their medicines as prescribed.

We viewed medicine records and MARs for five people and found MAR charts for December 2016 and January 2017 continued to show a number of gaps in the administration of medicines for four out of five people.

We found one person had not received their medicines as prescribed. For example, this person's MAR chart stated their medicines were to be given every 12 hours. This was also noted in their medicines list completed by staff. Their MARs for December 2016 showed that this medicine was given at 24 hour intervals on eleven occasions. There were 18 gaps present on the MARs where signatures had not been recorded to confirm if this medicine had been given. There were two occasions on 2 and 20 December 2016 where the letter F had been placed in the signature box, which indicated the person's relative had administered this medicine. There were no times of day recorded when this medicine had been given. This medicine was used to control the person's level of pain; therefore this meant the person was at risk of having their pain relief mismanaged.

One person's care assessment identified they required support with their medicine which they were required to take two tablets of every morning. However on 26 occasions between 1 and 31 December 2016 this person's MAR showed they had only received one tablet with no explanation why.

Records were also found to be unclear regarding the support people required with taking their medicines. For example, one person's care assessment stated, "No medication" indicating that this person did not require support with medicines. However, there was a completed MARs present in this person's care folder evidencing they were receiving support with their medicines.

A failure to ensure the proper and safe management of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in July 2015, we found that recruitment practices were not robust to ensure staff were suitable to work with people. We asked the provider to send us an action plan and they told us that as of 8 July 2015 this had been rectified. At our inspection in June 2016 we found recruitment procedures continued to be in breach of the Regulations. We served a warning notice and told the provider they were required to become compliant with this Regulation by 16 December 2016. At this inspection we found safe recruitment practices were still not being followed before new staff were employed to work with people.

We looked at the recruitment records for three new staff members who had been recruited after 16 December 2016. Two of these staff members had not commenced work and their DBS applications had not been processed at the time of the inspection; all other information and checks were in place for these two staff members. The Disclosure and Barring Service (BBS) helps employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable adults.

However records showed one new staff member had commenced work prior to their DBS being received. The staff member confirmed this. We spoke with the nominated individual who informed us they had completed an ISA adult first check for this staff member prior to them starting work. The ISA (Independent Safeguarding Authority) was created to help prevent unsuitable people from working with vulnerable adults. The ISA adult first check allows an applicant to start work while a full Enhanced Disclosure is being obtained. However, the staff member's recruitment records did not evidence an ISA check had been completed, requested or received. The nominated individual said they would send us this information electronically. This information was not received; therefore we could not be sure the appropriate checks had been completed for this staff member.

A failure to ensure safe recruitment processes were in place and followed and ensure persons employed were of good character was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the inspection in June 2016 we found the provider failed to identify and appropriately investigate safeguarding concerns and ensure all staff were following appropriate procedures. We found this to be a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan informing us of how and when they would be compliant with this Regulation. The provider sent us their action plan informing us they would be compliant with this Regulation by 5 October 2016. At this inspection we found the provider had not made the required improvements because people were still being put at risk and identified safeguarding concerns were not followed up or investigated appropriately.

Following the previous inspection in June 2016 the service was being monitored by the local authority quality and monitoring teams due to the high volume of safeguarding concerns about the service. Between June 2016 and this inspection safeguarding concerns continued to be raised to the Commission and the Local Authority safeguarding teams from people, relatives, staff and external professionals. Records of these safeguarding concerns were not present at the time of the inspection and the nominated individual said they would send this information electronically. We received this information. The information received showed five safeguarding concerns had been received between July 2016 and 1 January 2017; this information was not up to date as we were aware more than five safeguarding concerns had been raised against the service. The service's safeguarding spreadsheet identified the nature of the concern but there were no actions of outcomes with regards to how the safeguarding concerns were investigated or followed

up. A number of safeguarding concerns had continued to be raised to the service by external professionals, people and relatives after the 1 January 2017 and these were not included in the safeguarding spreadsheet received.

The overall feedback from external professionals was that people were not safe from abuse or harm from this service due to the number of missed visits, unsafe manual handling practices and failure of the service to address staff shortcomings which meant that mistakes were being made in providing care and people were at risk of coming to harm.

The failure to have effective systems and processes in place to prevent abuse of service users and effectively investigate any allegation of evidence of abuse was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We received a mixed response from people and their relatives when we asked them if they felt staff were skilled and had the knowledge to provide good effective care. People and their relatives felt regular care staff were well trained and had the skills to meet their needs but were not so positive about staff who had recently been employed, particularly with regards to manual handling practices.

We received the following comments from people. "Newbies sometimes appear to have no training." "New staff appear to have no hoist training. Main carer has to explain to them what to do all the time." "I don't think training is as adequate as it should be. Some appear a bit nervous not sure which area to start helping me with first." "Regular carer certainly trained." "Absolutely top class carers they appear to have had good training."

We received the following comment from one relative. "Some very good carers and experienced, confident when moving relative using the hoist. Some probably could do with some more training especially the new ones (carers). I usually hover about when new staff come to make sure that they are managing and they tend to come with an experienced carer"

Another relative said, "Some do not know my [the persons] restrictions and I have to tell them, they should know before they come. New staff don't know, so I have to go over everything every time. I think they need more information and more training."

Comments from other relatives received were, "Some of the carers lack ability and knowledge." "It worries me if people have no-one to communicate for them how would they get the care they needed then."

At the inspection in June 2016 we found staff did not always have the training they needed to meet people's needs. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice and told the provider they were required to become compliant with this Regulation by 16 December 2016. At this inspection we found the provider had not made the required improvements because new staff had not received the required induction training and regular staff had not always received training or updated training in required subjects.

Records showed the three new staff who had been employed since the 16 December 2016 had not completed an induction programme. There was no evidence to demonstrate they had completed required training or been enrolled onto the Care Certificate. The Care Certificate is the new minimum standards that should be covered as part of the induction training of new care workers. Staff confirmed they had not received an induction programme.

Following the last inspection in June 2016 the nominated individual confirmed all staff would receive updated medicines training and competency assessments by 16 December 2016. At this inspection not all staff had completed this training and none of the staff who had completed this training had their competencies checked. As a result medicines were still being missed and mismanaged.

The nominated individual sent us a training spreadsheet which they used to monitor the training which staff were required to undertake. The training spreadsheet showed three out of 75 staff had not received manual handling training, 29 staff had not received updated manual handling training for periods ranging from 2 to 7 years. Four staff had received training from a previous care provider but there was no record on how up to date their manual handling training had been.

Staff who had received manual handling training had done so by completing work books, there was no practical training on the use of hoists or other manual handling equipment. These work books were not checked or reviewed by the provider or registered manager at the time of completion. People experienced unsafe care when being supported with manual handling tasks because staff did not receive the appropriate manual handling training.

At our last inspection in June 2016 we found no evidence that plans had been put in place for care staff to do refresher training on the Mental Capacity Act 2005 in particular those staff that had been identified through safeguarding investigations as needing such training. We found at this inspection only 27 of the 75 staff had received updated training on the Mental Capacity Act.

The training matrix showed less than half of the staff had received training in safeguarding adults and other required training such as infection control, food hygiene and first aid were out of date or not completed for most of the staff. Staff confirmed they did not always complete training and felt training courses had reduced since the absence of the registered manager. One staff member said, "Not much training, not hands on, we used to go to the office – now it's done by booklet at home."

We looked at eight staff supervision records and found all eight staff had received either a recent spot check or supervision but had not received an appraisal. Staff confirmed they received supervisions, although not regularly and not always appropriately. One said the last supervision they had was over a year ago. Another staff member said, "Haven't had a supervision for months, but I went to get gloves and [the manager] said while you're here we'll do your supervision; but you can't really say anything because all the office staff are there." All staff confirmed they had not received an appraisal.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they meet the needs of people and ensure staff receive effective induction, training, supervision and appraisal was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 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 Act.

We looked at the files of nine people. On eight people's care plans we saw people's names had been printed electronically apparently to indicate they had seen, agreed with and signed their care plans. However we could not be assured this meant these eight people had seen or provided consent to their care plan. There was no evidence that their care plan had been explained to them. This also meant the service may not have sought each person's consent before they completed the care plan and provided care or support to them. We talked with staff and they told us that they only provided support to people who had given their consent for them to do so. People who used the service confirmed this.

People's care plans provided information about what support people needed with eating and drinking and people confirmed they were always offered a choice of what they wanted to eat or drink. However due to a lack of insufficient staffing levels people would often miss meals or have them too close together. One relative told us that due to a health condition their relative required four visits a day for help with their meals and other personal care needs. They informed us that when the person's regular carer was away from work they had lunch and breakfast visits within an hour of each other and the person only received a hot drink at the lunch time visit. Due to the person's health condition they were unable to get themselves a sufficient meal prior to the visit.

People and their relatives said they organised health care appointments themselves or for their relatives. However people confirmed that when the care worker felt concerned about people's health they advised them to seek advice from the appropriate professionals. One said, "In November my carer commented that I was more puffed out than normal and suggested I contact the doctor." Another said, "Definitely notice if something is wrong, noticed a redness [on an area of my body] and advised I needed to see follow it up with my podiatrist."
People felt their regular care workers were vigilant and supported them in identifying when they may need to seek advice from a health care professional. One said, "I have no feeling in my body and when my regular [carer] was giving me a wash down below noticed that I had the early signs of a condition. I was able to start treatment straight away." Staff confirmed they would always support people to seek the advice from health care professionals when needed.

Inadequate

Is the service caring?

Our findings

Whilst people and their relatives felt care workers were kind and caring, particularly their regular care workers; people told us carers did not always stay for the full amount of time and were rushed. One relative told us they felt most of the care workers were nice but the majority were rushed and seemed to not be concerned for the welfare of people. One person said, "The regular ones are pleasant, like angels, they deserve a rise." I have carers twice a day every day. They are quite nice now but I had one who I had to complain about, I forbid them to come again." People told us they did not feel the office were so kind one said they felt the office were "abrupt" when they contacted them, so they no longer called the office and would ask the care worker to sort out their concerns. People also told us they did not always know who was coming to visit them and a number of missed and late visits without informing people meant that sometimes people's needs were not responded to quickly enough.

We received some concerning information prior to the inspection that due to insufficient staffing levels people would not always receive a visit or their visit would be late or reduced. As a result people would not have their care needs met, be left in the same clothes for a number of days and would either go without a wash, shower or bath on several occasions or be left in unsafe compromising positions because staff were rushing their visits to get to the next person and finish on time. During the inspection we found these concerns to be substantiated as staff members confirmed people would be repositioned in bed without using the appropriate equipment. One person had developed a sore on their skin as a result of a friction burn because they were being moved up their bed by the care workers using their bed sheet instead of the appropriate slide sheet which was in place. An external professional and staff members raised concerns about two people who had developed pressure areas as a result of poor manual handling practices and skin care. These concerns of neglect were raised to the local safeguarding team and were found to be substantiated.

People and their relatives felt staff respected their privacy and dignity, particularly when they received care from their regular staff and on the occasion's people received a visit. One relative said, "We have regular carers and they have got to know my [relative] really well. They are caring, dignified and respectful." One person said "Carer always makes sure that my towel covers where necessary." However external professionals told us they had observed and been informed by people they had visited prior to and during the inspection that staff did not always respect people's dignity. People told external professionals and they observed staff talking over people when they were completing their care. Staff did not engage with the person and would discuss what was happening in the office between them. People told external professionals and the Commission that staff would taunt them and one person stated that a staff member had applied cream to them in an intrusive way without the use of the appropriate equipment. This concern had been raised as a safeguarding concern.

People's dignity was not always respected when they did not receive a visit or their visit was later than planned because they would have to rely on their relative to help them with their support. People and their relatives did not always feel this was appropriate and raised concerns about the privacy and dignity of the person being supported. Whilst staff gave good examples of how to respect people's privacy and dignity

when providing personal care, there was an expectation that it was acceptable for relatives to provide care to people when the service was experiencing insufficient staffing levels.

A failure to ensure the privacy and dignity of service users at all time was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were not personalised and were task orientated. People's care plans lacked sufficient detail about how they would like to receive their care and did not include information on what people would like to do for themselves. One person's care needs assessment stated they wanted to do as much for themselves as possible and would like to be, "As independent as possible." However when we looked at this person's care plan it did not provide any details on what the person was able to do for themselves.

People told us they were involved with their care plan and were encouraged to make decisions about their care. One person said, "I am very much in control of what is in my care plan, I wouldn't have it any other way."

People confirmed they felt listened to and were always asked what support they would like, although people expressed concern when they did not receive care visits. One person said, "Always extremely polite, always asks 'do you want to do wash yourself or shall I help you?'" One relative told us how care workers showed interest in their relative's history and what they had done in their life. They said the care workers would chat with their relative about the work they used to do and what their hobbies and interests were.

The service had received compliments from four people and five relatives since the last inspection. The compliments came in the form of cards, letters and emails. Comments received were, "Carer is a very professional lady, polite and knows [their] job well. [They] are always aware of the things that have to be done." "Much appreciation for your friendly help." "Thank you for all the kindness and care given to our [relative]."

Inadequate

Is the service responsive?

Our findings

At the inspection in June 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not have an up to date care plan in place prior to the commencement of care. We asked the provider to send us an action plan informing us of how and when they would be compliant with this Regulation. The provider sent us their action plan informing us they would be compliant with this Regulation by 5 October 2016. At this inspection we found the provider had made some improvements in ensuring care plans were in place, however they did not always contain the most accurate and sufficient detail to support staff to care for people responsively.

The nominated individual confirmed that following the outcome of the previous inspection in June 2016 they had decided not to accept new care packages into the service. The local authority had also suspended purchasing from the service. Therefore it was difficult for the Commission to assess whether the service would have followed their action plan to assess whether people would have an assessment of need and care plan in place prior to the commencement of service provision. The nominated individual confirmed that reviews of all existing care packages had been completed.

At this inspection people and their relatives confirmed they had a care plan in place, were involved in the care planning and their care plans had recently been reviewed. We received comments such as, "My care plan reviewed with deputy manager last year sometime. Any updating they checked with me making sure I agreed. I have to sign the plan in agreement." "Assessor came in and updated my plan recently asked me how I managed and what help I needed. The carer came along as well." My care plan was reviewed recently my daughter was asked to be here when I had my last review. I felt I was listened to, there have been no changes." One relative told us they had recently asked for a care plan review for their relative as the person was not able to get around their home as well as they used to. The relative confirmed one of the office staff visited the person along with an occupational therapist. The relative said, "It was a very good meeting; going through the whole plan thoroughly."

We looked at nine people's care records and observed that a date was present on all people's care plans and assessments indicating they had been updated since the last inspection in June 2016. However the information contained within the initial assessments were insufficiently detailed, contradictory and unclear and were not always included in people's care plans.

For example, one person's assessment stated they could not communicate their needs effectively. However there was no information provided on the assessment or in the person's care plan for staff to know how the person should be supported to communicate their needs and whether there were any systems or equipment in place to support this person to communicate effectively. This person's assessment also stated they did not need support with food and fluids, however in the additional comments section it stated, "Drinks to be left out at night if required." There was no information in the person's care plan regarding this support.

Another person's assessment stated they did not require support with medicines because they were able to

self-medicate. However, the person's care plan stated they required support with the administration of prescribed creams. Another person's initial assessment said they were at risk of pressure sores; however there was no information contained within this person care plan to indicate they were at risk of pressure sores and what staff should do to prevent pressure sores from occurring.

Staff said that although people had care plans in their homes the information contained within them were incorrect. One staff member said, "Some are correct, some are wrong. One person needs more care now but half the stuff isn't in the care plan. If you are a new person you would not know." Another staff member said, "If I go to a new client I look through the care plan and see what's wrong. Sometimes they're (care plan) wrong." Staff confirmed they did ensure they asked people what they needed prior to starting their care.

External professionals had visited a number of people following concerns raised by the Commission, people, staff and relatives prior to and during the inspection. They confirmed that people did have assessments and care plans in their home; but they were incomplete, incorrect and did not contain sufficient information to care for people responsively.

This meant although people had an assessment and care plan in place they did not provide accurate and sufficient detail for care workers to care for people to meet their needs responsively.

A failure to design care with a view to achieving service user's preferences and ensuring their needs are met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The service operated an out of hour's service when the office was closed. The out of hour's service was for the use of staff and people or relatives. This service operated in the evenings during the week and on weekends until the office reopened on a Monday morning. The nominated individual stated that when staff sickness was high the out of hour's staff member would have to visit people and complete their care calls whilst still covering the out of hours phone service.

We received feedback from one relative who had tried to contact out of hours staff and did not receive an appropriate response at the time support was needed. They told us, "At weekends the office is closed, someone has a mobile phone. I have had to ring sometimes at the weekend which goes to voicemail. The person who had the mobile didn't get back for several hours, so I was left in the dark. I think this is a weak link in the chain because the mobile holder is also giving care so can't answer the phone. They ought to have someone who is just there to take calls and who can sort them out promptly." Staff confirmed this practice took place and that the out of hour's staff member would have to answer the phone whilst supporting people with their care. This meant people may not receive a personalised service that was responsive to their needs because the person completing the care may be required to address other concerns at the same time as providing people with their care.

We received information of concern during the inspection that the out of hour's service was often turned off after 10pm which resulted in no response to emergencies until the morning. We received confirmation from people and staff that this happened often and as a result visits would be missed or late or information would not be passed on that people were unwell or in hospital or that staff were unable to work and the care visit would need covering.

At our last inspection in June 2016 we found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to take appropriate action in response to complaints. We asked the provider to send us an action plan informing us of how and when they would be compliant with this Regulation. The provider sent us their action plan informing us they would be

compliant with this Regulation by 5 October 2016. At this inspection we found the provider had not made the required improvements because complaints received were not investigated appropriately, dealt with in line with the providers policy and there were no actions or outcomes identified from the complaints.

Many people and relatives complained to us about missed and or late calls, poor quality of care and unsafe practice. Comments from relatives and people included, "I have complained but they [office] don't act on it."; "I had an incident that I had to complain about when a carer did not turn up. They did apologise and sent someone, they explained they would investigate but if they did I did not get feedback on it, so I am not reassured that it will not happen again."

Complaints and concerns were not used as an opportunity to learn and make improvements in the service. We saw four complaints had been documented as received into the service since the last inspection. However, complaints were being made on the lead up to the inspection and during the inspection about missed, late visits and unsafe care practice. These complaints had not been documented or included within the complaints folder with the other four complaints.

Three of the four complaints recorded had been acknowledged but no investigation had been completed for all four complaints. The complaint which had not been acknowledged to the complainant had been placed to one side because the nominated individual told us they did not know what to do about it and had misunderstood the complaint. This complaint had been made more than 28 days prior to the inspection and therefore the nominated individual had not responded within the timescales of the provider's complaints policy.

There was no learning from complaints as the issues being complained about were still occurring at the time of the inspection.

The failure to investigate complaints and take the necessary proportionate action in response to any failure identified was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they had no regular contact with the registered manager or office staff. People commented that there had been many changes to staff early last year and there was a lack of communication about staffing and scheduled visits when staff were absent from work. People felt there was a real concern regarding the management of staff sickness.

When we asked people and relatives for feedback on how the service was managed and the leadership of the service we received comments such as, "What leadership?."; "Generally all right could do better."; "Don't feel the management tell us everything, I saw something on the news that Grove was in trouble a couple of months ago, we shouldn't have to find out on the news, it's very worrying."; "There should be more communication from the office, when I have had to leave a message which says they will ring back, they don't."; "No, I don't think the management of the service is good. They make excuses."; "Communication is poor."; "They are never proactive."; "One way street I accommodate them, not them accommodating me."; "It is not as adequate as I think it should be." ;"They should contact the client to let them know what is going on rather than us having to call."

Staff sickness levels were high and the provider did not have a sickness policy in place. There was no evidence that the nominated individual had been managing sickness levels effectively in the absence of the registered manager. This was a concern as sickness levels were the major reason for the continued missed and late visits and visits being rushed. This staff member and other staff members felt due to the lack of management care staff could "do what they wanted" and "ran the show." There was no evidence and a lack of documentation to demonstrate staff sickness was managed or that those staff who persistently went absent were performance managed.

People and staff did not feel that management were open and transparent. Staff confirmed they did not have confidence in the management team to deal with any concerns or issues and felt compromised if they informed the management team of concerns relating to other staff. Staff had not benefitted from any team meetings being convened and did not feel they were part of the service.

At the last inspection we found the provider had breached Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because they failed to notify the Commission of safeguarding concerns. We asked the provider to send us an action plan informing us of how and when they would be compliant with this Regulation. The provider sent us their action plan informing us they would be compliant with this regulation by 5 October 2016. At this inspection we found the provider had not made the required improvements because the Commission had received several safeguarding concerns about the service and the provider had not notified us about all of these.

The nominated individual advised they did not know that the Commission needed to be notified of all of the safeguarding concerns because they were mostly a result of missed visits which did not need to be notified to the Commission in their view. There is no requirement to notify the Commission about missed or late visits, but a notification would be required if the cause or effect of a missed visit met the criteria for one of

the following to be notified; A death, an injury, abuse, or an allegation or suspicion of abuse and/or neglect, or an incident reported to or investigated by the police. Where relevant, services are asked to make it clear that a missed visit was a known or possible cause or effect of these incidents or events when notifying the Commission.

A number of missed visits had resulted in people not receiving their meals or medicines and unsafe manual handling practice was being carried out in part due to staff being rushed. For example one person was left hanging out of the bed. Therefore as people were at risk of harm due to late or missed visits this suggested a potential allegation of suspected neglect and therefore the Commission should have been notified of these concerns.
A failure to notify the Commission of any allegation of abuse or suspected abuse was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

At our last inspection in July 2015, we found that the service did not have an effective system to monitor the quality of service they provided. Auditing systems were not effective and did not identify where improvements were needed. The provider sent us an action plan in July 2015 telling us they would be implementing an 'improved auditing system'. At the inspection in June 2016, we did not find any improvement in this area. We served a warning notice and told the provider they needed to be compliant with this Regulation by 16 December 2016. At this inspection we found the warning notice had not been met because there were no systems in place to assess the overall quality of the service and the systems which had been implemented to assess the quality and safety of the service were lacking and not fit for purpose.

The nominated individual told us that systems were not in place to assess the quality of the service. The nominated individual said they had a plan to send out a questionnaire to people, which would mirror the questionnaire which was used in another of the provider's services. However they stated they had not had time to complete this due to dealing with other concerns about the service. Most people could not recall receiving a questionnaire or being asked for feedback about the service they received.

Audits developed to review the overall safety of the service were not accurate and did not improve the overall safety of the service. Following the concerns raised at the last inspection in June 2016 regarding medicines not being signed for, the nominated individual developed an auditing tool to review all MARs from November 2016 onwards. The nominated individual had completed an audit for November 2016 and identified eight medicines errors had occurred. This outcome was incorrect as in fact when we checked the audit it showed more than 41 medicines errors where staff had failed to sign eight people's MARs. We spoke with the nominated individual about this and they did not comment.

MARs audits had not been completed for December 2016 and January 2017 at the time of this inspection. The nominated individual confirmed they were currently working on the audit for December 2016 and that it was almost complete. However, when we looked at people's care records we found MARs for December 2016 which had not been included in the audit. The nominated individual said they did not realise these MARs had been sent back to the office and placed in people's care plan records. The nominated individual confirmed they did not have a system in place to ensure they captured the results of all MARs where people were in receipt of support with their medicines. We reviewed MARs for December 2016 and January 2017 and found that a number of gaps still existed where signatures should be. This meant the audits developed to ensure the completeness of people's MARs in place were ineffective and unfit for purpose because signatures were still absent from MARs and they were not completed in a timely fashion.

The continued failure of the service to implement the changes as specified in their action plan in relation to the breaches of regulation found at the July 2015 and June 2016 inspection, demonstrated that the

management of the service was lacking. Alongside this, we identified further breaches in regulations that have placed people at risk of harm.

The nominated individual had auditing tools in place to assess incidents and accidents, however there was no evidence to demonstrate whether incidents or accidents had occurred and what action had been taken as a result.

Records relating to the care people received were not personalised, accurate or fit for purpose.

The continued failure to ensure that there were accurate, complete and contemporaneous records in respect of each service user and effective quality assurance and auditing systems or processes in place to assess the overall quality and safety of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.