Psalmist Community Health Care Service Ltd

PCHCS

Inspection report

56 Oakley Road
Luton
Bedfordshire
LU4 9PU

Tel: 01582591672
Website: www.psalmistchcs.org

Date of inspection visit:
18 September 2018
19 September 2018
24 September 2018
02 October 2018
10 October 2018
16 October 2018
23 October 2018
25 October 2018

Date of publication:
17 September 2020

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 between 18 September and 25 October 2018. We visited the provider's office on 18 September and between 19 September and 16 October, we carried out telephone interviews with people who used the service, their relatives and staff. On 23 October, we received further information of concern about the service, so carried out a second visit to the provider's office. The was an announced inspection, although the second visit to the office on 25 October was unannounced.

We last carried out an inspection at this service in April 2016 and the service was rated 'Good' overall, with a rating of 'Requires Improvement' in the 'Well Led' domain. This was because we identified concerns in relation to late care calls and how the provider monitored the quality of the service provided. At this inspection we found that these issues continued to be a significant concern. In addition, we identified concerns in relation to how the provider identified and managed risks to people, poor quality care planning and delivery, poor quality training, poor record keeping and complaints management. Much of the feedback from people and staff regarding the quality of the care and support was poor, and showed that changes were not being implemented or embedded within acceptable timescales. As a result, the service has been rated inadequate.

PCHCS is a domiciliary care service providing personal care and support to people in their own homes. At the time of our inspection, the service was providing care to 18 people.

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.

People did not receive their care visits on time, and care visits were frequently cut shorter than the allocated time. This meant that people were placed at risk of neglect, medicines not being administered at the correct intervals and not having their care needs attended to within a reasonable time. The service had a system for monitoring their calls and identifying persistent issues that required improvement but it had not been used effectively.

People had care plans and risk assessments in place but these were poor in quality and lacked sufficiently up-to-date, relevant and personalised information to enable staff to carry out their care effectively. There were concerns in relation to people having consented to the care provided and the provider's understanding of the Mental Capacity Act 2005 was poor. People were asked for their views through surveys and quality monitoring calls but issues identified were not resolved. People had mixed views as to whether they felt cared for and were treated with dignity and respect.

Staff recruited to the service did not always have suitable references in place, and there were gaps in employment histories which had not been accounted for.

Staff training was inadequate and left staff to provide care to people for which they had not been fully trained. Their competency was not assessed to ensure they were able to provide this care safely to people.

Understanding of how to protect people from harm and how to report incidents of concern was insufficient throughout all levels of staffing. This had led to a significant increase in investigations into incidents by the local authority.

People did not always feel confident that complaints would be resolved, and expressed concerns that the management were not always responsive. Records, including those in relation to complaints were chaotic and frequently incomplete and there were no effective systems in place to monitor these.
The provider oversight of the service was poor and they had little understanding of their regulatory responsibilities.

Feedback from people was not used to make improvements to the service and little meaningful monitoring of quality was carried out by the management team.

The service was slow to make improvements following prompting by the local authority and the Care Quality Commission, and did not take a proactive approach to developing the service.

Notifications of reportable incidents were not made as required by law.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

This inspection identified multiple breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. Following this inspection we took action to cancel the Provider's and Registered Manager's registration. This means that they are no longer legally permitted to provide this domicilliary care service.

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 did not always receive care on time, and calls were frequently late or shortened.

Risk assessments were not always completed and appropriate action taken to mitigate people's exposure to the risk of harm was not recorded.

People's medicines were not managed safely.

The provider did not use information from when things went wrong to make lasting improvements to the service.

Recruitment checks were not always fully completed to ensure a robust recruitment process was in place.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive training of a sufficient quality to meet the needs of people they supported.

Understanding of the Mental Capacity Act 2005 was insufficient.

People were not always supported to have enough to eat and drink of an acceptable quality, when this was part of their planned care.

The service did not ensure that people's healthcare needs were met.

Is the service caring?

Inadequate

The service was not caring.

Some individual staff were kind, but others were not.

The service was not organised around the needs of people and they were often left waiting for care or receiving care that was

hurried and late.

People did not have sufficient choice about how their care was delivered.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans contained insufficient information in relation to people's individual needs

People did not always receive their funded amount of care hours or care at the time it was needed.

Care Plans did not include information about people's wishes for their end of their life.

Complaints were not handled effectively and the provider did not keep accurate logs of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was insufficient provider oversight of all aspects of the service.

Action was not taken to address shortfalls in care provided, or to manage care visits effectively.

Staff Practice was not monitored effectively.

Action was not taken to resolve concerns raised by people and their relatives.

Records were insufficient, inaccurate or contradictory.

People were not always confident that they would always receive a response from the office when they raised concerns.

The provider did not work proactively with other agencies to ensure a good quality service was provided.

Notifications of reportable incidents were not made as required by law.

PCHCS

Detailed findings

Background to this inspection

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

This inspection took place between 18 September 2018 and 25 October 2018 and was announced, although the second visit to the provider's office on 25 October was unannounced. The provider was given 24 hours' notice of our inspection because we needed to ensure that they would be available in their offices to meet with us, and that all the necessary documentation would be made available to us. The inspection team was made up of one inspector and a second inspector who was shadowing as part of their induction into the role. The second visit to the office was carried out by one inspector and one inspection manager.

This inspection was prompted by an increase in concerning information about the service being shared with us by the local authority and members of the public. These concerns included allegations of neglect and omission, poor quality care, poor nutrition and hydration support, late and shortened calls, insufficiently trained staff and poor record keeping. We considered these issues during the inspection. We returned for a second visit to the provider's office on 25 October because we received new information that suggested that people may be at ongoing risk of serious harm.

Before the inspection we reviewed information available to us about the service, including information provided to us by the provider such as notifications. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with four members of the care staff, and six office staff including the Registered manager and the deputy manager. We contacted eight people who were using the service and their relatives by telephone to ask for their views on the care they received. We also spoke with the relative of one person who had recently chosen to stop receiving support from the service. The local authority shared feedback received by them from people who used the service, their relatives and other involved professionals. We reviewed the care records and risk assessments of six people who used the service, checked medicines administration records, call monitoring logs, daily records and reviewed how complaints

were managed. We also looked at five staff records and the training for all the staff employed by the service. We reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

We received mixed responses when we asked if people felt safe. One person using the service said, "I don't always feel safe, no. Staff don't know how to move me safely, or at least, some of them don't." Another person said, "They don't always remember to secure the door after themselves. That worries me." However, another person said, "Yes, they are good. I feel safe with the Carers."

Although there were enough staff employed to meet the needs of people, the way in which care visits were organised meant that people did not always receive the care they required. Care visits were organised for the benefit of the service rather than for the needs of the people. The timings of visits did not reflect the needs of the individuals with some starting too early or too late. Drivers employed by the provider took care staff to people's homes where care was delivered. Because of the way care visits were organised, rosters showed that staff were sometimes picked up by a driver for early visits at 6am and still scheduled to be carrying out visits the same night, as late as 10 or 11pm. The provider told us that staff were only considered to be working when they were directly providing care. This meant that they were not considered to be working during travel time, despite being away from home for up to around 16 hours at a time.

Some people using the service had received their final night care visit at 11pm when they had expected it much earlier in the evening. For other people the call times were close together and they would receive a breakfast and lunch call mid-morning and within half an hour of each other. One person told us that they were unable to get up without staff support and had been left in bed for 17 hours on one occasion. This put them at risk of pressure ulcers and skin breakdown, as well as leaving them inconvenienced and uncomfortable. The local authority shared that one person had reported receiving a care visit at one o clock in the morning that should have taken place at 9pm.

Care visits were frequently cut short, and records showed that staff rarely stayed for the correct amount of time with people. This had a significant impact on people. For example, visits which were supposed to last half an hour were frequently cut to ten minutes or less. We noted that one person was assessed as needing two 30 minute visits a day. During a period in October, where they should have received 10.5 hours of care, the visit logs showed that they had received 49 minutes. Although incomplete records could account for some of the shortfall, of those calls recorded none of them were longer than 10 minutes, and one was as short as 4 minutes. A second person, who required four calls a day, should have received a total of 113.5 hours care but the actual hours of care logged was 60.5 hours. Again, there were unlogged calls, but logged entries showed significant shortening of calls. For example, a half hour tea time call on 24 October was completed in 11 minutes and a half hour lunchtime call on 17 October was completed in 13 minutes. We were also made aware of an occasion where one person did not take their medicine for 48 hours because staff failed to attend care visits for two days. This put them at risk of ill health.

The failure to deploy staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely. Although medicine administration records reviewed at the inspection

showed no errors, we received information about a significant number of concerns relating to medicines that had been reported to the local authority by people using the service or their relatives. Upon investigation, these concerns were upheld and included issues such as; mixing up tablets for different days leading to confusion as to whether the person had taken their tablets; records for another person's medicines left in one person's folder; failure to follow administration instructions from the manufacturer of a medicine resulting in one person becoming immediately unwell. One relative told us, "My[relative] has [medical condition] and can't manage to take tablets without staff helping, and ensuring they have got them into their mouth. I frequently found tablets on [relative's] clothes and on the floor because staff had not waited to make sure [relative] had swallowed them."

Risk assessments in relation to people's care and support needs were not adequate because specific risks to people were not clearly identified and guidance to staff on how to reduce risks was not detailed. For example, the risk assessment for each person showed a generic list of hazards. Where a risk was identified there was a single sentence statement, such as, "[Name] needs support for meal preparation." Under a section for how to control the risk, staff were guided to choose to 'remove the risk completely', 'try a less risky option', 'prevent access to the risk' or 'organise work to help reduce the hazard.' There was no further guidance on how to achieve any of these options.

Similarly, care plans provided little guidance to staff about how to provide safe care. One person's care plan stated they were supported by staff to complete standing exercises. There were no instructions for staff on how to do this safely. We spoke with the person, who confirmed these exercises were ones they had made up for themselves, with no physiotherapy input. They were very happy that staff provided this support. However, there was a risk to this person that they may be injured by staff supporting them in this way with no guidance.

There was no evidence that the provider took learning to make improvements to the service from when things went wrong. Incidents and accidents recording was erratic and many issues identified by third parties had not been identified or acted on by the provider. This resulted in a high number of sustained safeguarding allegations, many of which concerned repeated examples of poor care, such as medicines mismanagement, and neglectful care practice. Action taken to address shortfalls was only taken when the provider was prompted to do so by a third party, and then the action taken was often not sufficient. For example, the provider only took action to address shortfalls in care visit monitoring after the local authority identified that manual logging in was not accurate. The provider moved to an electronic monitoring system, but still failed to use it effectively, so little improvement to the service provided to people was made.

The failure to manage risks to people to manage their medicines safely and to identify improvements that needed to be made to provide safe care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the 12 months leading up to this inspection there was an increase in the number of safeguarding concerns raised with the local authority by third parties in relation the care people received from PCHCS. These concerns included allegations of poor care, neglect and omission. None of these had been identified and reported to the local authority by the provider or the registered manager. This indicated that the registered manager and the provider did not monitor the care provided to people effectively and did not identify or report concerns that arose. This put people at risk of harm because signs that indicated harm may have occurred were not acted on.

Staff understanding was varied about what types of abuse were or the signs to look for that a person might be at risk of harm. Most staff were not clear about how to report concerns beyond their own organisation

although one member of staff was aware of how to do this.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Recruitment processes used by the provider were not robust and some of the necessary pre- employment checks were either not completed effectively or the outcome of them was not recorded fully. Records of staff member's employment history were not complete and there was no evidence that gaps in their employment had been explored. Some employees had only one reference, rather than two as required. Most employee records showed a Declaration and Barring Scheme (DBS) application number, but did not show the date that the DBS was issued. Records also did not indicate the employee's start date, so it was not possible to confirm that checks took place before they took up their post.

The failure of the provider to ensure that staff recruitment processes were robust was a breach of Regulation 19 of the Health and Social Care Act.

Staff were able to tell us about the measures they took to reduce the risk of infection, such as the use of gloves and aprons when providing personal care. However, feedback from some people raised a question as to whether staff always followed good practice. One person raised in feedback to the service that staff did not always wear gloves when supporting them. Another person commented that staff did not always wash their hands before and after providing care. A relative told us that food hygiene practice was sometimes in doubt as staff reheated food or did not cook food fully before serving it. This indicated that people were not always protected from the risk of infection.

Inadequate

Is the service effective?

Our findings

We received mixed feedback about whether people felt staff had the right level of training to carry out their duties effectively. One person said, "Some are better than others, but mostly they seem okay." Another person said, "Some staff know how to hoist me safely, but others not so much. I have felt like I could fall before." A relative told us, "Some staff don't have the skills to support [relative]. They come to help [relative] get up, but sometimes they don't know how to use a sling."

It was clear from our discussions with staff the training provided was not sufficient to support them to meet people's needs with confidence. One member of staff said they only felt confident because they had completed training in previous jobs, but had concerns about less experienced colleagues. They explained that that new colleagues frequently struggled to carry out tasks such as using a hoist safely when they first took up their role. This was despite having completed training and shadowing as part of their induction.

Another member of staff told us that training was not thorough enough to support staff to know how to carry out some aspects of care. Training records showed that staff frequently completed training in several different subjects in one day. For example, records for one member of staff showed that, on one day, they had completed training in: Equality and Diversity, Pressure Care, Safeguarding Adults and Children, Medicines, Health and Safety, First Aid, and the Mental Capacity Act and Deprivation of Liberties safeguards. When we later asked the Registered manager how long each of these training courses should take to complete, he initially said that each one would take three weeks, but then changed this to one week. This indicated that the multiple courses completed on one day had not been completed effectively.

Office staff told us that the registered manager facilitated some face to face training for staff, which was evident from displays in the office. However, it was brought to our attention that the registered manager had not competed train the trainer training to ensure they had the skills to provide effective training. The registered manager confirmed this, but stated that they no longer provided face to face training since this had been pointed out to them.

The service had accepted care packages for people with a variety of complex needs including specific medical conditions, such as multiple sclerosis, but did not provide any specialised training to enable staff to develop a better understanding of these conditions or how to support people living with them.

We discussed our concerns about training with the registered manager during our return visit to the office. During this discussion and a subsequent second review of records, we identified further concerns. One person required catheter care, but none of the staff providing this care had received training on how to provide this safely. A second person required Stoma Care but again, none of the staff providing this care had received training on how to provide this safely. The provider trained staff in moving and handling theory through the use of video and online training materials. However, the provider confirmed staff did not receive practical training in the use of equipment such as hoists, and learned how to use equipment through shadowing colleagues on care visits.

Although assurances were given by the registered manager that staff competency was checked through spot checks, we found this was not the case. For example, there had been no spot checks carried out on staff providing support to one person who had recently changed the hoist they used. Care Plans and risk assessments for the person contained no information on how staff were to support them safely. There was no record of input from physiotherapy or other relevant healthcare professionals, other than one diary entry in the office. The Registered manager was not able to reassure us that they understood the serious risk this put people under and could not demonstrate how they intended to keep people safe with immediate effect.

Failing to provide adequate training to enable staff to provide effective support was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Staff, including office staff did not have a good understanding of the MCA. As a result, every person who used the service went through a generic, non-decision specific capacity assessment every year, whether or not it was thought they may lack capacity. This was not necessary and showed a lack of understanding of this legislation that requires assessments to be completed only if a person's capacity to make a particular decision is in doubt or known to be lacking. Office staff with responsibility for completing these assessments did not understand this. One member of staff said, "We always review capacity assessments annually for everyone." We saw from records that this was the case. Even where it may have been appropriate to complete an assessment, they were not carried out in relation to specific decisions. They did not contain useful information to support decisions to be made in people's best interests when they lacked capacity to make the decision for themselves.

Some people told us, and we saw from records that they had consented to various aspects of their planned care. However, we noted there were occasions where family members had signed consent on people's behalf without evidence to why this was or whether they had the authority to do so, such as the lasting power of attorney for health and welfare status. There was no evidence that a best interests process had been followed when making decisions on people's behalf. We were also made aware of an occasion whereby the signatures of a person and their relative had been falsified to indicate their agreement to changes in the care plan, when they had not actually given this agreement.

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

In the months leading up to this inspection, two incidents occurred that indicated people did not always have their nutritional needs met. When visited by an external care professional, a person presented as unwell and explained they were hungry but had only one egg left to eat. The professional looked in the kitchen cupboards and found that the person indeed had nothing else to eat. They immediately took action to ensure the person had food. This person received daily support from PCHCS, yet no staff had recognised or acted upon the lack of food available to this person.

Staff provided meal preparation support to a second person. A relative was present on one occasion to witness a member of staff boiling an egg in the kettle and serving it almost raw as it had only been cooked for as long as it took the kettle to boil. The member of staff then made the person a cup of tea using the

same water they had used to boil the egg. The person had told their relative that this was how the member of staff always did it.

A relative also raised concerns about the food hygiene practice of staff who supported their family member. They said, "I'm not saying it's definitely the cause, but my [relative] had several upset stomachs and they were always reheating left over food, such as chicken. It was after this that [relative] got sick.

These issues were a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the months leading up to the inspection there had been incidents where communication between the service and other health care professionals had not been effective. This had led to people not receiving care visits when they came out of hospital, and issues in relation to skin breaking down. During this inspection a further incident of failure to provide care visits following discharge from hospital occurred. In this instance a person went without care for two days.

Daily records for one person identified that there were four occasions on 11, 19 and 25 August and 9 September where they had opened the door to staff in a state of undress. The registered manager confirmed this was not usual behaviour for this person but failed to take any action to explore the possible causes of this. They said they contacted the person's social worker about this but there was no record of this conversation taking place. They then said that, as a registered nurse themselves, they considered the person may have had a urine infection (which is a known cause of increased confusion), but did not take action to seek medical attention for the person. This put the person's health at risk because the provider did not ensure care between different health and social care providers was organised and joined up.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care packages for people using the service had mostly been arranged by a local authority, who had provided an overview of the person's needs to the service before they started to provide care. For many people, records indicated that this document was used to develop a care plan, and little additional assessment by the provider took place. This was not in line with current guidance and good practice.

The staff we spoke with told us they received supervisions and appraisals although some said this was not frequent. We saw records to demonstrate that supervision did take place but because records were not kept in order, it was not possible to establish the frequency of these.

Inadequate

Is the service caring?

Our findings

We received mixed responses from people and their relatives about whether staff were kind, compassionate and treated them with respect. One person said, "They are all lovely. I like their smiling faces when they come to see me." A relative said, "They are just how a care service should be." However, another person said, "Some of them are ok, but others are shouters. They shout at me and always know what's best."

Some people told us that the provider and the office staff were kind and friendly, providing a personal touch by keeping regularly in contact with them. However, other people said this was true when they first started to receive a service but had tailed off, and contact from the provider was rare. One relative spoke about how this had an impact on their relative because they had limited contact with people outside of their family and valued regular chats. When this stopped with no explanation, they were left wondering why they no longer spoke with someone they thought of as a friend.

We found that, although some people felt that individual care staff were kind and respectful, there was significant evidence that the care to people was not organised or delivered in a compassionate or respectful manner. This was shown by the failure to organise care so that it was provided at the times people needed it and for the agreed duration, as well as by the high level of incidents amounting to neglect and very poor care. Leaving people waiting for their care, sometimes for hours, hurrying care so that calls can be shortened, not reporting health concerns to medical professionals, providing raw, inedible food to people, and leaving people in bed for very long periods is not compassionate care.

People did not have enough choice about how their service was delivered, and many described a sense of having to take what they were given. For example, one person told us that they received lunch visits at 11 in the morning when this was not their choice. A relative told us that a night time call to support their relative to bed was made at 6pm when the person did not wish to go to bed until 8.30pm. Two relatives told us, despite it being very clearly said that each of their relatives preferred female staff, male staff had been sent to support them on many occasions. This sometimes meant they went without care unless they accepted care from the male staff.

People commented that they never knew which member of staff was coming to provide support to them. Sometimes they did not know the member of staff who came, which made them feel uncomfortable. One person commented that they, 'Rarely see the same person twice and it can be a while before I see a familiar face." However, one person did tell us that the provider had listened when they said they did not want to receive care from one member of staff they did not feel comfortable with.

We also received mixed responses when we asked whether people felt they were treated with dignity. A relative said, "On the whole, yes. You get the odd one, you know, but generally they are nice." However, others raised concerns about the approach and attitude of staff. A relative said, "Some carers just come in and do the job; they don't speak and they leave as soon as they are done." Staff also told us that colleagues varied in their approach to people. One member of staff told us they had to remind colleagues to talk to people and to, "Treat them as a human being." Another member of staff told us, "I like to get to know

people. I really enjoy finding out about them. Others that I work with are not so much like that – it's a job to get done."

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff could describe how they respected people's dignity and privacy while providing care, such as keeping them as covered as possible and closing curtains and doors.

Inadequate

Is the service responsive?

Our findings

Care plans were not detailed or personalised enough to enable staff to provide consistent, person-centred care. The plans included sections such as mobility, personal care and medicines. A brief description of tasks to be completed on each visit was included to enable staff to understand what care to provide the person. However, there was little information available to staff to show them how to provide this support taking into consideration the individual person's needs and preferences. For example, a care plan for one person showed that they needed a full body hoist, but gave no detail about the person's individual needs, sling size or how staff should approach this aspect of the persons care to help them feel comfortable. A second person needed support with Electronic Stimulation exercises, but there was no information provided to staff on how to do this.

Where more information was provided, it was generic in nature and often repeated across multiple care plans. The care plans for both men and women described supporting them to choose which dress to wear. Whilst this may be relevant for a man in some circumstances, it is unlikely to be relevant for all men using the service. Therefore, we could not be certain, that the information within the plans related to the person whose file it was in. This could have led to inappropriate and unsafe care being provided.

There was little correlation between the times people were due to receive care listed in their care plans, the times given on rotas and those recorded in visit logs. This showed that the service had not been organised in response to people's needs, but rather, in the way which most suited the service.

We received mixed responses when we asked if people were involved with the development and ongoing review of their care plan. One person told us they had been involved in making any necessary changes. However, others did not feel this and said they had little to do with their plans. One relative explained, "They write up about the visit before they go, but we never read what they write."

Care Plans did not contain any information in relation to the care people wanted to receive at the end of their life. This meant that the service had no information to guide them to provide the most appropriate care if someone became seriously unwell. This information might include issues such as, the person's religious beliefs, funeral arrangements, where they wanted to be cared for, and family or friends they wanted to be informed and any special requirements they wanted to make them as comfortable as possible.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not managed effectively. Some of the people and relatives we spoke with told us that they were able to raise concerns or complaints with the registered manager or the provider. They told us that the provider was always happy to speak with them on the phone, and some people said they were confident that action would be taken to address concerns. However, other people and relatives told us that, although the provider and registered manager were easy to talk to, and always made assurances that action would be taken to address any issues raised, this was rarely the case. One person gave an example that they had

raised concerns about medicines errors. The provider assured them that this was to be addressed with staff, but errors continued to occur. A relative said, "You never know what happens as a result of your comments. It's never followed up."

We looked at the complaints received since our previous inspection, but found that they were not recorded in a way that enabled the provider to analyse information and use it to make improvements to the service. We found five different files containing partially completed complaints records that were not in date order and contained little detail about each complaint, how it had been managed and resolved. None of the office staff asked were able to tell us which, if any, of these files was actively in use.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who was also one of the two directors and the provider's nominated individual. They were supported by a team of office based management staff. The registered manager was not present for the first day of the inspection, so we spoke with various members of the management team in their absence. The registered manager was present on the final day of inspection. During this inspection we identified that the provider was unable to oversee the safe operation of the business or to ensure that people received safe, effective, compassionate care of a good quality. They did not have a good knowledge of the needs of the people they provided a service to, and were unable to answer straight forward questions about their care packages. We also established from discussions with the registered manager and records confirmed that they had additional employment working as a nurse for a local nursing home. They confirmed they routinely worked two night shifts a week at this home.

There was a lack of clarity about each person's role in the office and some staff, when asked, were unable to explain what their role and responsibilities were. This resulted in some work being duplicated and some being overlooked. People who used the service and staff commented that communication from the office was not always effective and staff told us, "Everyone does all jobs, but no-one is responsible for any of them."

This also had an impact on how the inspection was supported by the service. Some information we requested was not provided until several prompts had been given over the two weeks following the first office visit. This resulted in delays to the inspection being completed. Other information requested was provided several times but by different staff. One piece of information was provided four times and was slightly different on each occasion.

The management oversight of the service was poor and their approach to making improvements was not proactive. The service was in breach of many of the Health and Social Care Act (Regulated Activities) Regulations 2014 and the provider was unable to demonstrate they had a cohesive and robust plan in place to address these issues. Little to no progress towards making improvements was made between the first and second visits to the office. Their understanding of the seriousness of these shortfalls was in doubt due to this lack of action, despite recent input from the local authority, who had raised similar concerns at a recent monitoring visit.

We found that records relating to the management and monitoring of the service were not kept in an organised and effective manner. Essential records, such as those relating to complaints, safeguarding incidents, and incidents and accidents, were poorly maintained and stored in a haphazard manner, frequently in a number of different files. This left records difficult to audit, and to gain an overview of this information across the service was near to impossible.

We found confidential, sensitive information was not kept securely. For example, safeguarding meeting minutes were pinned to a noticeboard in a room used for training. We found the key codes to people's homes were noted in the margins of care documents giving access to any person who looked at these

documents. We were also informed by the local authority that, on one occasion, documentation containing confidential personal information was left in a public house by one of the provider's management team. This put people at risk of their private information, and potentially their homes, being accessed by unauthorised persons.

Systems in place to monitor the service provision were not used effectively to ensure people received the care they needed at the time they wanted it. In the months leading up to the inspection, the service had made some changes to how care visits were logged. Concerns had been raised in July 2018 by the local authority, that call times on daily logs and manual visit logs were not consistent. This led to allegations that the visit logs were being falsified to indicate staff had been on time and stayed for the duration of the visit, when they had not. This led to a change in practice, and management told staff they must sign in electronically to the system used by the provider.

On the first day of the inspection, the deputy manager told us that a further change had been implemented that week, to bring the service in line with the system preferred by the local authority. However, although this new system had gone live one day prior to the inspection, the deputy manager told us that full training on using it would not be completed for another two weeks. This left the office staff unable to monitor care visits using the new system over this period, although staff had already been told they must log in using it. When asked how they would oversee the service delivery in this time, a member of the office team said they would continue to monitor using the old system until the new system was up and running properly. However, because they had told the staff to swap over to the new system, they would not have accurate information to analyse as it was on a system they could not access.

Although some people told us they received their care visits within an acceptable time frame, and that care staff stayed for the duration of the call, other people told us this was not the case. One person said, "They are very late sometimes, and at other times they might arrive on time but they can't wait to get away." A relative told us " There have been times when the timing of calls is way out, very late. One time they were an hour and a half late and did not tell us. They have also sometimes put two calls together if one call is very late." Another relative said, "They are usually here by nine, sometimes ten, and sometimes morning and lunchtime calls are almost joined together. I'm not too worried about it, but it puts you on edge from nine, wondering when they will turn up. They stay 15 to 20 minutes and spend quite a bit of that writing up their notes."

We found that people were not consistently given the care the provider was commissioned to provide to them. We identified numerous occasions when care visits were cut short or provided much later or earlier than planned. Staff confirmed that visit times were not always followed and said that they were sometimes so late or early that two visits would be merged with each other, for example a breakfast and lunch visit were merged and took place at 11 am, instead of a breakfast call at 6am and a lunch call at 12.

On the final day of the inspection when we visited the office for a second time, we found that no improvements had been made to the way care visits were monitored and the provider was no further forward in using the new electronic monitoring system effectively. Although they told us that the logs were reviewed every day, they were unable to provide us with evidence of this. They had taken no action to address the continuing shortening and poor timing of care visits and did not appear to recognise that this was the purpose of undertaking these audits.

Following prompting from the local authority, the management team had started to complete spot checks of staff practice, but some staff we spoke with had not experienced this yet. The spot checks we reviewed

were not carried out effectively and did not include evidence of how staff competency was checked. Instead blanket statements such as, 'all staff are well trained', were used. There was no evidence to show how any issues, if identified, were acted on, or how any feedback provided by people was used to develop the service. For example, feedback from one person raised issues about punctuality, hurried care, and staff conduct, but the conclusion from the manager carrying out the spot check was "We are satisfied with the standard of care delivered." In another spot check, a statement was made that 'Staff are always on time.", even though it was then noted that "Unfortunately [staff] was late this morning. There was no record of action taken to address this.

We looked at a report giving the overview of a recent satisfaction survey carried out by the provider. This report stated that the results showed people were happy with the service and gave three examples of positive feedback. However, despite making this claim, it then went on to list thirteen issues that people raised as requiring improvement but clear actions to make improvements were not identified or followed up.

Staff were not able to tell us what the provider's values were. Members of the management team told us that the provider aimed to promote a person - centred culture within the service. However, we found that their understanding of what this entailed was not strong, and this resulted in people not receiving a service based on their individual needs. There was a lack of planning to ensure people received their planned support, a failure to provide consistent staff who knew people well, or to let people know in good time who was going to be providing their care, a failure to respect people's choice to have care provided by staff of a particular gender, ineffective and standardised wording used in care plans, and risk assessments that did not identify how to mitigate specific risks in relation to the individual person. The provider had not taken sufficient steps to ensure their values were clearly identified, understood and shared by all staff. As a consequence, people did not receive kind, compassionate and personalised care.

People and relatives we spoke with knew the managers and most felt they were approachable. They felt able to raise concerns with the manager but not all people believed that action was taken to address them. One person said " [Name] is very friendly and always happy to talk to me. I'm not sure that anything gets done though." A relative said " I spoke with [Name] about my concerns about [relative] not being supported properly to take [their] tablets, and [they] assured me it would be dealt with, but within days it had happened again. " However, other people gave positive feedback, saying," [Name] is great. I can talk to [them] and I know [they] will listen. ".

Staff had mixed views about whether they felt the management team were responsive to concerns they raised. One member of staff said, "Of course they are; they are good to work for." However, other staff members did not feel concerns they raised would be listened to or acted on and one member of staff told us they had observed a member of the management team becoming agitated when a colleague raised a concern, which put them off doing so.

Staff also gave mixed views about whether the management team provided them with effective support to carry out their roles. The provider had not ensured that training and competency assessments were completed as necessary and this left staff to provide care tasks that they were not trained to carry out safely.

Staff expressed concerns about management support outside of office hours and gave examples of when the on-call system failed because managers either did not answer the phone, or left it without charge. When we requested sight of the on - call log, the deputy manager was unable to show evidence of how management support offered to staff outside office hours was recorded. On the final day of the inspection, a member of the office staff showed us that an on call log had now been created. However, it had not been

completed when an incident known to us had occurred resulting in disruption to one person's service over the previous weekend.

The provider did not work proactively with other key agencies, such as the local authority and the care quality commission to ensure care provided to people was of a sufficient quality. Prompts to make improvements from both agencies have not resulted in timely and effective changes to improve the service and there is little recognition of the potentially serious risk to people using the service.

All of these issues were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had failed to send us notifications of incidents in a timely manner as required by legislation. When a reportable incident has taken place, providers are required to notify us without delay. The provider failed to notify us at all of some reportable incidents, and others were reported to us several months after the event.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 Notifications of safeguarding incidents were not received as required.

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care provided to people was not compassionate and respectful way

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not compliant with the MCA and consent was not always sought

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk Assessments were ineffective , medicines were not managed safely, incidents were not identified and acted on to make improvements

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment safeguarding incidents were not identified or reported appropriately

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs people's nutrition and hydration needs were not met

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints complaints were not handled effectively

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring was ineffective, record keeping was poor, oversight of service delivery was inadequate, staff support was poor, multiple breaches identified at inspection

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment checks were incomplete

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively to meet people's needs safely. Staff did not receive effective training.

The enforcement action we took:

We took urgent action to put a condition on the provider's registration to prevent them from taking on new business without written consent from the Care Quality Commission. We then took action to cancel the provider's registration and the Manager's registration.