Direct Health (UK) Limited

Direct Health (Crewe)

Inspection report

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Date of inspection visit:
04 December 2015
07 December 2015
09 December 2015
17 December 2015
14 January 2016
15 January 2016

Date of publication:
03 May 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 4,9,15 and 17 December 2015 and the 14 and 15 January 2016. The inspection was announced in that we gave the manager 48 hours prior notice of our intention to carry out an inspection in accordance with our inspection methodology.

At the time of our inspection Direct Health (Crewe) provided a home care service to people in Crewe, Sandbach, Alsager, and Congleton areas. It is part of the Direct Health Group, which operate a number of agencies around the country. The service is registered with the Care Quality Commission (Commission) to provide the regulated activity personal care. Information provided by the manager indicated that the service was providing personal care for 59 people in total.

The service has a registered manager. A registered manager is a person who has registered with the Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager became registered with the commission on the 25 September 2015.

This is the second comprehensive inspection of this service we have undertaken in 2015. Our last inspection of the service February and March 2015 was a follow up to a previous comprehensive inspection in July 2014 where we found that the provider was not meeting all the requirements for a service of this type and was awarded an overall rating of inadequate. We took enforcement action following our inspection in July 2014 and served warning notices on assessing and monitoring the quality of service provided, care and welfare of people who use service, safeguarding people who use services from abuse and staffing. On our follow up inspection in February and March 2015 we found that the provider had made some improvements but the people who used the service were still not receiving safe and appropriate care. We again awarded the service an overall rating of inadequate and extended the date by which the regulations must be met in respect of person centred care, good governance and safeguarding service users from abuse and improper treatment to 1 September 2015. We also told the provider that the services recruitment processes needed to be improved to ensure that fit and proper persons were employed.

On this inspection we found that the provider had taken effective action to improve recruitment processes. However, the warning notices we had served on person centred care, good governance and safeguarding service users from abuse and improper treatment were not met because people who used the service were still at risk of receiving unsafe and ineffective care.

Whilst some people told us that their needs were met and they were happy with the care they received, we found evidence that others had not received safe and effective care and continued to be at risk of their needs not being met.

The service was not well led. Since our last inspection a new manager had been appointed and registered

with the Commission but although they were caring in approach they presented with insufficient knowledge, skill and aptitude to ensure the wellbeing of the people who used the service.

We found that an allegation of abuse highlighted at our last inspection had still not been investigated; and concerns raised by staff and visiting professionals had not always been responded to effectively. This meant that managers and staff were not learning from past events, or taking effective corrective action to improve the service.

Although some people told us they felt safe, we found that management and staff had not always taken effective action to protect vulnerable people from neglect.

We identified further breaches of the relevant regulations in respect of person-centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, receiving and acting on complaints, good governance, and duty of candour. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Commission. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 because the manager and staff failed to respond effectively when people who used the service were found to be at risk of severe and imminent harm and failed repeatedly to do all that was reasonably practicable to mitigate risks.

Medicines were not managed safely and the manager failed to ensure that effective arrangements were in place to ensure vulnerable people received their medicines as their doctor had prescribed it.

Managers and staff failed to implement effective adult safeguarding procedures when people were found to be at risk of neglect.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were involved in planning their care to a certain extent but the provider did not always act in accordance with the Mental Capacity Act 2005 to ensure people received the right level of support with their decision making.

Some people told us that they were well cared for by staff who were knowledgeable and skilled. However, we found that key staff including the registered manager lacked the required skills and knowledge to provide safe and effective care and had not always received appropriate training.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people were receiving appropriate levels of care and support and told us about their positive experiences. Others had either experienced poor and inadequate care or were at risk of receiving poor and inadequate care.

Whilst the manager and staff were evidently caring in approach their lack of knowledge about their obligations and

responsibilities had meant that they had not always shown adequate concern or responded effectively when people were found to be at risk of harm.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst some people praised the staff and some reported receiving good standards of care we found examples where care had not always been provided in a person centred way.

Deficiencies in assessment and care planning and key staff who lacked the required skills and knowledge to put things right meant that some people were at risk of receiving unsafe and ineffective care a lack of skill and

Complaints had not always been investigated or responded to, or effective action taken to eradicate problems and prevent recurrence.

Is the service well-led?

Inadequate

The registered manager did not present with the required knowledge, skill or aptitude necessary to manage the service and ensure the safety and well-being of the people receiving personal care.

The service has been rated as inadequate by the Commission on three consecutive inspections dating back to July 2014.

We found that the registered persons had failed to make the required improvements and therefore the service has been placed in special measures.

Direct Health (Crewe)

Detailed findings

Background to this inspection

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

We carried out an announced inspection of Direct Health (Crewe) on the 4, 9, 15 and 17 December 2015 and 14 and 15 January 2016. The inspection was announced in that we gave the registered manager 48 hours prior notice of our intention to carry out an inspection in accordance with our inspection methodology. The inspection team comprised three adult social care inspectors.

Before the inspection we reviewed the information the Care Quality Commission already held about the service. We contacted the local authority commissioning teams before and after the inspection and they shared their current knowledge about the home. During the inspection we visited the offices of the service on the 4, 9, 15 and 17 of December and simultaneously carried out visits to the homes of 12 people who used the services to seek their views on the quality of care provided. Telephone calls were made to a further 16 people who used the services to gather their views and where appropriate the views of their relatives regarding the quality of care provided. As part of this inspection we spoke with 14 members of staff including 10 members of the care staff team, the registered manager, two care coordinators, the provider's representative known as the nominated individual, the human resource manager, and the staff trainer. We looked at the care and support records for 10 of the people who used the service as well as other records associated with carrying on the regulated activity of personal care.

Inadequate

Is the service safe?

Our findings

Most of the people spoken with during the inspection told us that they felt safe and many made positive comments about the care staff and the quality of care they received. For example one person said: I have "no complaints whatsoever, they have all been very good with me. The carers come every day and see that I have got everything that I need. They can't be any kinder". Another person said they are "really, really good, they are always kind and considerate" and a relative of one of the people we said we "couldn't live without them".

Some people told us that there had been times when care provided had not met their expectations and we found evidence of unsatisfactory assessment, risk assessment, care planning and review which put some of the people who used the service at risk of their needs not being met and potential harm. We also found that the manager and staff had not learned from past experience so opportunities to take corrective action and protect people from harm had been missed.

At our last inspection of the service in February and March 2015 we found that the provider had not responded appropriately when it was suspected that abuse had occurred including notifying the local safeguarding authority and the Care Quality Commission. This was in continued breach of the regulations which we had previously identified in July 2014. We took enforcement action and extended the date by which a warning notice we served following the previous inspection in must be met.

Providers and registered managers must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. This action should be in line with the procedures agreed by local Safeguarding Adults Boards.

We were aware that the inspector who carried out the previous inspection had highlighted an allegation of abuse which had not then been reported to the local safeguarding authority and we asked the registered manager for confirmation of action taken in respect of this allegation. The provider was responsible for reporting this allegation to the local authority and had failed to do so.

We spoke with the registered manager and a number of staff about locally agreed adult safeguarding procedures and it was clear that there were gaps in their knowledge as to what constituted abuse including neglect, and how abuse, neglect or suspected abuse should be reported to the local safeguarding authority.

We looked at the service's safeguarding records and found that an issue that had required immediate action to protect a vulnerable person from neglect had been reported to the local authority as a "care concern". This resulted in an unnecessary delay with the person remaining at risk for a period in excess of seven weeks. Care concerns are part of the local safeguarding authority's "Threshold procedures". They are designed to help managers and staff to understand when an adult safeguarding referral must be made without delay and when the matter can be addressed and rectified by the manager and then followed up with a care concern report.

The manager told us that they did not get a response from the local authority from the care concern form submitted 12 July and records showed that they did not take any other effective action at the time to ensure the risks presented to this person were mitigated and their needs met. It was only when the district nurse reported the matter to the local authority that the person's needs were met. Records showed that the district nurse told the service to report the matter as a safeguarding alert to the local authority on the 25 August 2015. Whilst we could see that there was a copy of a care concern form in the service's safeguarding records, when we contacted the local authority they told us that that they had not received it.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment. The registered persons were not operating an established system effectively to protect services users from abuse.

During the inspection we identified a significant number of uncontrolled hazards presented to the people who used the service. Records indicated that the relevant person's care files and risk assessments had not been updated when new or increased hazards were identified. Risk assessments that were in place were inadequate in that they did not always provide control measures that would effectively mitigate the risk of harm to the individual and therefore these people remained at risk.

For example we spoke with the relatives of one person who was in hospital at the time of the inspection because they had been injured after suffering a fall in their own home. This person lived alone, had been living with a diagnosis of mixed dementia for over two years, they did not have capacity to make decisions about their care and were known to be prone to falls. Information provided by their relatives indicated that they had suffered a number of falls before and after they started to receive a package of care from the agency in October 2015. We could see from the service's records that staff and been informed of these falls but there was no indication that any further action had been taken to explore why the person had fallen or whether any action could be taken to protect them from further harm. There was no record of these falls in the agency's accident book even though records showed that a member of care staff had found the person on one occasion lying on the floor. The person's risk assessment and care plans had not been reviewed or evaluated in respect of the falls.

We asked the manager what action had been taken in respect of this person's falls. In answer to our question the manager told us that they had taken no action.

Incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

Further inspection of this person's care records showed that they had not been written up until six days after staff had started to visit the service user, which put them at risk of harm and their needs not being met. Furthermore the records that were completed showed inadequate and ineffective assessment, lack of hazard analysis and risk assessment and poor communication with social services. We spoke to the staff member who had carried out the initial assessment and found that they had not identified the person's needs. We found that they had not paid due regard to the person's lack of capacity to make decisions about their care and welfare. This staff member was unfamiliar with hazard analysis and lacked basic knowledge of the Mental Capacity Act including how to complete a mental capacity assessment. They told us that the person was unable to answer any of their questions but despite this assessed them as having capacity. The care arranger's form from the local authority which had been sent to the agency prior to the start of the care package clearly stated that the purpose of the package included "carer to administer and observe

medication". However, this vital piece of information was ignored and contrary to the person's needs they were assessed as being able to self-medicate only needing prompting. Despite their evident history of falls the assessor recorded no history of falls, and no medical health condition that may make them unsteady. This was despite the fact the most of their medication was prescribed for a condition that could affect their balance.

We found other examples of ineffective risk assessment and review of people that used the service that placed them at significant risk. These included a service user at risk of fire from a gas cooker and a service user that had not been adequately assessed for the safe use of bed rails.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons were not doing all that is reasonably practicable to assess and mitigate risks to the health and welfare of the people who lived at the home.

Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. Risk assessments should include plans for managing risks and should balance the needs and safety of people using the service with their rights and preferences, include arrangements to respond appropriately and in good time to people's changing needs.

We checked the medicines records for a number of people who used the service and found that the service had not always made proper arrangements for the safe management, storage and administration of medicines.

A care concern form in the service's safeguarding records indicated that one of the people had been wrongly assessed as being able to self-medicate. The social worker alerted the manager and asked for the matter to be investigated. We could see from records that the matter had been investigated and the person's assessment had been revised indicating that they needed there medication to be administered by staff. However, the requirements for safe storage, administration and recording were not entered on the person's personal service plan or person centred summary. This meant that staff did not have access to sufficient instructions and guidance they would need to manage the person's medication safely.

A week later the care coordinator visited the person and carried out a review but did not identify that staff were still not managing this person medication properly. We could see that the medication administration and record sheet (MAR) had not been entered on the previous three days. The care coordinator did not see that the arrangements for managing this person's medication were inadequate or that the care and support plans did not provide staff with the guidance they needed.

Three days after the care coordinator carried out the review records showed that the social worker contacted the manager to advise that the MAR sheets were not being completed and the manager gave assurances that the matter would be addressed. However, the care and support plans were still not revised and therefore staff did not have access to the guidance they would need to manage this person's medication safely.

Failure to ensure that this person received their medicine as their doctor had prescribed it put them at high risk of ill health and potential physical injury.. A record made on the 1 December 2015 in the morning recorded that the person had taken their medication but when the social worker and family members arrived later that day they found the medication still on the table.

We visited another person who lived alone and had a diagnosis of dementia. Their assessment indicated that they needed prompting to take their medication. However, observations recorded by care staff two weeks prior to our visit indicated that the person's needs had changed since their assessment had been reviewed in December 2014 and it was clear that they were not always taking their medicines as their doctor had prescribed. Care staff had not reported these concerns to the manager and the person's assessments including risk assessments had not been reviewed or revised to ensure the person received the appropriate level of support to take their medicines. Staff had been recording that the person had taken their medicines but the MAR sheet had not been completed on the three days prior to our visit.

The above comprises a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons did not make proper arrangements for the safe storage and administration of peoples medicine.

Requires Improvement

Is the service effective?

Our findings

A number of people, particularly those people who had a long experience of receiving care and support from the agency, told us that they had seen improvements in the continuity of care since our last inspection in March 2015. The relatives of one person told us that manager's and staff had made a concerted effort to ensure that where possible care was provided by a consistent team of staff who were familiar with the person's needs and requirements. They told us that this was crucial because their relative had dementia and although they were fiercely independent they relied on staff knowing precisely what they could do themselves and what they needed help with. Another person told us that there had been difficulties at first because assessment and care planning had not been thorough and staff had not been clear about how to meet their needs and requirements. However, information provided later in the inspection indicated that they were more content with the service provided. Their relative told us that care was being provided by a small team of competent staff who had developed a good understanding of the person's needs and personal preferences.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. We checked whether the service was working within the principles of the MCA. We found that the managers and staff lacked knowledge and understanding about this fundamental aspect of care. This meant people who used the service were at risk of not getting appropriate levels of support to assist with their decision making when required.

We looked at the records of one person who was diagnosed with dementia. Their initial assessment which had been completed by a care coordinator recorded that the person had no mental impairment and had capacity to consent to care. This did not appear correct. We spoke with the staff member who completed the person's initial assessment and they told us that they and the person's social worker had doubts about the person's capacity to make decisions. The staff member explained that whilst they had training on mental capacity the training did not included completing a mental capacity assessment and they had never been shown how to do one. They told us that they had recorded that the person had no mental impairment because the question was beyond their ability to answer.

When we visited this person we found that care staff had identified that they were at risk from a series of uncontrolled hazards but records showed that nothing had been done to ensure the person was protected from these identified risks. When we discussed the matter with the registered manager they told us that they believed that nothing could be done to protect this person from the identified hazards. This was clearly incorrect and it transpired that the manager's poor judgment arose out of their lack of knowledge and understanding of the Mental Capacity Act.

We spoke with another staff member who had responsibility for carrying out assessment and reviews of the people who used the service. We found that this staff member had also wrongly assessed another person who had a diagnosis of dementia as having capacity to give consent to care. This resulted in the person not getting the care they needed and being put at risk of severe harm. When we spoke to this staff member they

too told us that although they had completed training on mental capacity it had not included doing a mental capacity assessment.

The above comprises a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered person's and staff did not act in accordance with the Mental Capacity Act 2005.

Training records showed that almost all the staff had received training on the Mental Capacity Act as part of their induction training. However we could see that there were gaps in their knowledge and as a consequence they had not always acted in accordance with the MCA code of practice when helping people with their decision making. Key staff told us that they did not know and had not been shown how to carry out a mental capacity assessment or how to construct and record a best interest decision process. They were unaware of the MCA 2015 code of practice. We spoke with the providers designated trainer and looked at the content of the training which staff had been given on the MCA and could see that staff had not been introduced to the code of practice and had not been shown how to carry out a mental capacity assessment or make and record a best interest decision process.

We also found that whilst all staff had received training on safeguarding vulnerable people from abuse some of them including senior staff lacked awareness of what constituted abuse, the role of the local safeguarding authority and the protection afforded whistle blowers under the provisions of the Public Interest Disclosure Act 1998. They told us that this had not been covered in their training. The registered manager told us that they had identified that they needed further development in MCA and safeguarding vulnerable adults as far back as July 2015 but these vital training needs had not been addressed. We could see that a lack of effective training in skills and knowledge vital to the safe management of the service was having an adverse effect of the quality of care provided.

The above comprises a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Persons employed by the service in the provision of personal care had not received appropriate training to enable them to carry out the duties they were employed to perform.

All staff spoken with told us that they had received training in a range of relevant topics before they started to provide care and support. The provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. We looked at the induction records for the most recently appointed staff members and we spoke with three new staff who were engaged in induction training at the time of the inspection. These newly recruited staff told us that they found the training interesting but intensive. They said there was a lot to learn in a relatively short period of time. Discussion with the trainer and records showed that each training session culminated with completion of a work book. The trainer told us that the completed work books were retained at the end of each session so as to provide an audit trail and record of the learning which had taken place. These work books contained a lot of useful information and we asked the trainer to consider whether new recruits would benefit more from the training if they were allowed to retain their induvial work books to help them reflect on and consolidate learning.

All staff spoken with during the inspection told us that they were well supported and received regular supervision from the manager, spot checks on their competency and staff meetings. They told us that they had completed training on a range of relevant topics including safeguarding vulnerable adults, moving and handling, food and nutrition/hydration, basic food hygiene, emergency first aid, and medication. Staff told us that they were offered a personal development appraisal at the end of the year. Records showed that these had been postponed in December 2015 and had been rearranged for January 2016.

Following the inspection we received an action plan from the registered manager which indicated that action was being taken to address staff training needs on safeguarding vulnerable people from abuse and the Mental Capacity Act.

Requires Improvement

Is the service caring?

Our findings

We asked the people who used the service and where appropriate their relatives about the quality of care provided. Their views differed but most people told us that they were content and some made positive comments about the quality of care they received. For example one person said "the care is brilliant, I could not ask for better" and another said "I'm so impressed with the carers, in general I feel they are excellent". The relatives of another person told us that their relative had experienced poor care and inadequate care due to poor assessment and a lack of knowledge and understanding of the person's needs.

When we carried out our last inspection in February and March 2015 we found that the service was not always caring because the provider had not made all the required improvements to its care planning and review processes that had been identified at the previous inspection in July 2014.

Whilst we found that some people were receiving satisfactory levels of care from staff who were informed and knowledgeable about their needs there were still significant gaps in the service's assessment and care planning processes which had resulted in some people remaining at risk of their needs not being met.

Staff tasked with carrying out assessments had variable ability and some had little or no understanding of hazard analysis and risk assessment or mental capacity and how this would impact on a person's ability to answer questions and provide information regarding their needs. This resulted in serious omissions which put people at risk of their needs not being met.

Whilst the manager and staff were evidently caring in approach their lack of knowledge about their obligations and responsibilities had meant that they had not always shown adequate concern or responded effectively when people were found to be at risk of harm. For example the manager told us that they had been told by a senior person in the organisation that they did not need to do anything in respect of a person suffering a fall if the fall had occurred when the agency's staff were not present. This demonstrated a neglectful approach to caring for people and showed a marked lack of care and concern for the well-being of the person, which brought the managers fitness to manage the agency into question.

We visited another person and noted that they had access to large bag of medicines many of which were out of date. We raised this with the manager as a matter of concern. The manager told us that because they did not support this person with their medication this would be something the agency would not address. This again showed a marked lack of care and concern for a vulnerable person who was receiving care from the service.

The provider had developed a range of information, including a service user guide for the people using the service. This gave people information on such topics as medicine arrangements, complaints and the services provided.

We saw that personal information about people was stored securely which meant that they could be sure that information about them was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

We asked all the people we spoke with on the telephone and visited for their views on the service's reliability, punctuality and continuity of care. Most people told us that they had seen improvements in that staff were generally turning up on time and staying the correct amount of time within acceptable margins. One person said "it can be annoying because some people come too early, like 3pm to cook my evening meal I don't like to eat so early and I have told them but they keep on coming at that time." Most people told us that they were benefiting from receiving care from a group of staff who knew them well and knew the way they wanted their care to be provided. Whilst another person said that their regular carer " is great but it all goes to pot when she is on a day off. Some of them don't know me very well, my regular carer knows how I like my care to be done".

Some people told us that they had participated in the assessment of their needs and the development of care plans whilst others were unable to recall being involved in the process. One person told us that their needs were not being met because the service had not carried out an effective assessment of their needs or engaged them in developing adequate arrangements for their care.

At our last inspection of the service in February and March 2015 we found that the provider had not taken adequate steps to plan care so as to ensure the welfare and safety of people who used the service. This was a continued breach of the regulations which we had previously identified in July 2014. We took enforcement action and extended the date by which a warning notice we served following the previous inspection must be met. On this inspection we found that the service's assessment, monitoring and review processes were not consistently adequate to ensure the well-being of the people who used the service and therefore the warning notice was not met.

Registered persons are required to ensure that a clear care plan is in place, which includes agreed goals, and is made available to all staff and others involved in providing the care. Where relevant, the plan should include ways in which the person can maintain their independence.

In some instances the care plans seen were task orientated and did not reflect the needs of the people who used the service. This had left some people at risk of their needs not being met. For example the person centred summary for one person was reviewed and revised following concerns identified by the person's social worker who indicated the person was not receiving adequate assistance with their medication. The revised person centred summary was detailed in some respects but did not provide adequate information as to the safe storage, administration and recording of the person's medicines. These omissions contributed to person's needs not being met on subsequent occasions.

We visited another person who lived alone and had a diagnosis of dementia. Their assessment indicated that they needed prompting to take their medication. However, observations recorded by care staff two weeks prior to our visit indicated that the person's needs had changed since their assessment had been last reviewed in December 2014. It was clear that they were not always taking their medicines as their doctor had prescribed them. Care staff had not reported these concerns to the manager and the person's assessments

including risk assessments had not been reviewed or revised to ensure the person received the appropriate level of support to take their medicines. Staff had been recording consistently that the person had taken their medicines but the MAR sheet had not been completed on the three days prior to our visit.

This person told us that they were fiercely independent but this important factor of their character was not recorded in their care and support plans. The review that was undertaken 12 December 2014 indicated that no action was needed. Their relatives told us that the person's care and support plans were inaccurate because it was recorded that they needed assistance with dressing when they were and had always been independent in that regard. Their risk assessment referred to a range cooker which was actually removed over two years ago. Prescribed medicines had changed but the changes were not recorded. Other people using the service had a person centred summary which set out what staff needed to do and what the person was able to do for themselves. There was no person centred summary at this person's home address so any new staff attending would not have the guidance they need to ensure the person's needs were met.

We visited a further person who lived alone and had diagnosis of dementia. Records made by care staff indicated that there had been times when carers had arrived and found the person was not at home. The service commissioner had identified that this person would be at risk if they went out alone in the information they had provided the agency before the package of care had started. The risk assessment which had been completed by a senior member of staff on the same day the information was received from the service commissioner did not mention the hazards presented to this person going out alone. There was no guidance for staff on action to take should they find the person had started to go out alone and although the manager and care coordinator were aware of the concerns they had not taken any action to mitigate them.

Records showed that staff were responsible for administering this person's medication. Their person centred summary did not provide clear guidance for staff on the safe storage, administration and recording of this person's medication and we could see from the MAR charts that there had been occasions when they had not been given their medicine as their doctor had prescribed it. Records showed that on one occasion the staff had not given the person their medication because they feared that they had taken alcohol and did not know whether it was safe. There was no guidance in the care records as to what the medicines were prescribed for and no indication of its potential side effects or consequences of it being taken with alcohol. We raised this with the care coordinator to enquire as to how the service had responded to such concerns. We found that the care coordinator was aware of the issue but had not taken any action to mitigate the risks presented to the person by not having their medication. There had been no contact with the person's doctor to check whether it was safe to given them their medicines and the risks of the person consuming alcohol had not been explored or mitigated. Care plans and risk assessments had not been reviewed and revised to ensure that staff would know what to do if there was a recurrence of the same problem.

The above comprises a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. The registered had not taken adequate steps to plan care so as to ensure that the care provided was appropriate and met their needs.

The registered provider had a complaints policy and procedure to record and respond to any complaints, ensure that concerns were addressed within given timescales and ensure that effective action was taken to improve the service, where necessary. However, we could see that registered persons had not always acted in accordance with the complaints procedure. Two of the people who used the service gave examples where they had raised concerns with the manager and staff but said they had not been listened to and action had not been taken to resolve their issues. There was no record of these people raising concerns even though one person told us they had spoken directly with the registered manager.

The relatives of another person told us that their relative had received a catalogue of poor care and although they had made a number of complaints the quality of care had not improved. They told us that they had put their complaints in writing but received an unsatisfactory response. We could see that they received a written response from an area manager just three days after they had lodged their complaint. The area manager's response was dismissive of their concerns, did not take the issues seriously and demonstrated a lack of knowledge about the care of the person. For example the area manager claimed that "appropriate paper work and procedures were now in place", unbeknown that the person had been in hospital for over three weeks since the incident and in fact all documents had been removed from the person's home. We raised concerns with the provider's representative about the way this complaint had been investigated. Subsequently the area manager acknowledged that they had not carried out the investigation effectively and the people who had made the complaint received an apology.

The above comprises a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always fully investigated complaints or taken necessary and proportionate action in response to a complaint.

Inadequate

Is the service well-led?

Our findings

The service was not well led. There had been a change of registered manager since our last inspection. The registered manager did not present with the required knowledge, skill or aptitude necessary to manage the service and ensure the safety and well-being of the people receiving personal care. The service has been rated as inadequate by the commission on three consecutive inspections dating back to July 2014. We found that the registered persons had failed to make the required improvements and therefore the service has been placed in special measures.

Given that the registered manager lacked basic knowledge about their duties, responsibilities and obligations regarding the carrying on of the regulated activity we enquired whether they were familiar with the requirements of the regulations. The manager told us that they were aware there were regulations but did not know what they were. The registered manager explained that from being appointed as branch manager in December 2014 and becoming registered manager in September 2015 they had been set up to fail. They told us that they had been promised direct supervision and support from a senior person in the company but this did not materialise. They told us that they had identified that they required training in safeguarding vulnerable people and the MCA as far back as June 2015 but their training needs were ignored and were not met. They said "I was given this job role and left without any support and advice on how to carry out this role. I have been set to fail in this role due to the lack of support given to me, as was promised to me in taking on the role as branch manager".

At our last inspection of the service in February and March 2015 we found that the registered provider did not have an effective quality assurance system in place so that they could check on the quality of service being provided. This was a continued breach of the regulations which we had previously identified in July 2014. We took enforcement action and extended the date by which a warning notice we served flowing the previous inspection must be met.

On this inspection we found that the provider did not have an effective quality assurance system in place so the people who used the service were not adequately protected from receiving unsafe and ineffective care.

The service had a quality assurance system but this was not being operated effectively. The manager was missing opportunities to learn from incidents, accidents and complaints. For example the manager had conducted an investigation when a social worker and family members raised concerns about the care and welfare of a person who used the service. The investigation upheld the concerns raised but the manager did not take effective action to ensure the vulnerable person was thereafter protected from poor assessment, care planning and inadequate care. Records vital to the monitoring of this person care were not made despite this matter being brought to the registered manager's attention on more than one occasion. The manager's investigation found that one staff member was culpable and took disciplinary action but the failings of another staff member involved were overlooked. The second staff member involved had failed to carry out an effective assessment of a vulnerable person who had subsequently been exposed to uncontrolled and unidentified hazards. There could be no doubt that this second person had significant training needs in carrying out an assessment of a vulnerable person but these were overlooked until

inspectors pointed them out.

We identified throughout this inspection that accidents and other incidents that presented vulnerable people with uncontrolled hazards and risks had been overlooked and opportunities to take corrective action and ensure the welfare of the people who used the service were routinely missed.

Given that following our previous we had extended the date by which three warning notices were to be met we asked the manager to show us how improvements were being made to ensure compliance with the regulations. The manager told us that they had not been made aware of any such action plans and if there were any the previous registered manager had not shared them. We asked the area manager the same question and were told that the only action plan they were aware of and could be located on the provider's computer was one that addressed a requirement regarding the recruitment of staff. We could see that this action plan had been put into practice with positive results. However, there was little or no evidence that the registered person's had taken effective action to address the shortfalls identified at the last inspection regarding person centred care, safeguarding services users from abuse and improper treatment and good governance.

This above comprises a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider failed to operate effective systems to monitor the quality of care and ensure compliance with the regulations.

When things go wrong registered persons have a duty under the regulations to be open and transparent regarding why things went wrong and what they have done or will do to put things right. They are required provide the person with account, which to the best of their knowledge it true of all the facts and includes an apology. This is called duty of candour. We spoke with the relatives of a person who had received poor and ineffective care which had culminated in a hospital admission that may have been avoided if proper arrangements for their care had been made. We asked them if they had received an account of what went wrong, what would be done to put things right and an apology. They told us that they had not.

We asked the registered manager if they had acted in accordance with the requirements of this regulation when things had gone wrong for this person and they had received unsafe and unsatisfactory care. The manager told us that they did not know why this person was in hospital they had not enquired about the extent of their injuries. They said they had heard about duty of candour but did not understand it. The provider's representative printed a policy on duty of candour from the provider's website and told us that this policy was only in draft and it had not as yet been implemented.

Duty of candour requires services registered with the Commission to display the ratings which has been awarded them following a comprehensive inspection. This became a requirement of the regulations on the 1st of April 2015. Ratings were not displayed in the office or anywhere in public view and when we checked the providers website there was still no ratings displayed. The provider's representatives acknowledge this failure and gave assurances that it would be addressed.
This above comprises a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Duty of candour. The registered persons failed to operate in an open and transparent way with people who used the service.

During the inspection the commission received a notification from the service dated 3 December 2015 which informed us, amongst other concerns, that a care worker had made a recording omission in respect of a person being administered their medication. We were unable to speak with the person to clarify what had occurred however, when we spoke with the person's family members who raised the concern they told us

that they had actually alleged something far more serious. They advised that they had alleged that their relative had not been administered their medication in accordance with their assessed needs and that the staff member had falsified records to indicate that the medication had been administered.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. In making a false declaration and incomplete notification the registered persons had not notified the Commission of an incident of alleged neglect. We are corresponding with the provider to address this issue.