Twenty Four Seven Recruitment (Yorkshire) Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We visited the offices on 11 and 12 May 2015 and spoke with people who used the service on 18, 19, 20 and 27 May 2015. The inspection was announced 48 hours prior to our visit to ensure the office was open.

Twenty Four Seven Recruitment (Yorkshire) Limited is a home care provider offering care and support services to people within their own homes and in their local community. The main office is situated in the centre of Ilkley and support is provided to people in and around

Summary of findings

Leeds. The services provided include personal care, assistance with medication, cooking meals, daily activities and shopping. At the time of our inspection 112 people used the service.

The service had a registered manager in post. 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.

We found care records were not always accurate and complete and did not contain effective information to demonstrate that potential risks to people's health and wellbeing were being fully assessed, monitored and managed. Appropriate arrangements were not in place to ensure the proper and safe management of medicines.

Staff were recruited safely and were provided with appropriate training and support to enable them to fulfil their role. However, staff were not deployed in an organised and effective way and there was a high turnover of care staff. This meant people were not always provided with consistent care and some people experienced missed and late calls. We found little evidence to show the service matched care staff to people's needs, so that person centred care could be delivered.

Most people we spoke with told us care staff were nice and good at what they did. All of the people we spoke with told us staff treated them with respect and they felt safe when staff visited them. However, most people told us their experience of the quality of care provided was influenced by the high turnover of staff.

We found the involvement of people and their relatives in making decisions about their care was variable. Where people had made suggestions about how they wanted their care to be delivered, these requests were not always put into practice. Care was not always being planned and delivered to ensure it met the individual needs and preferences of people who used the service. We recommend the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Procedures were in place to help keep people safe, such as in the event of an emergency or to protect people from the risk of abuse. Staff had a good awareness of these procedures and what action they would take to protect people's health and wellbeing.

We found inadequate systems and processes in place to ensure the delivery of high quality care.

Records were not being effectively stored, monitored or maintained. We found a lack of attention to detail in the care records we reviewed. Issues identified within care records had not been identified and addressed through a robust system of audit. The systems in place for managing and allocating calls was disorganised and put people at risk of not receiving support when they needed it.

Management tried to encourage a positive culture amongst care staff and shared learning to try to improve practices and the quality of the service provided. However, most people we spoke with told us they felt many of their concerns with the service were the result of ineffective management.

We found four breaches of legal requirements. You can see what action we told the provider to take in relation to this at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means it has been placed into 'Special measures' by CQC. 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

Summary of findings

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.

Summary of findings

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.

Care records were not always accurate and complete and did not contain sufficient information to demonstrate that potential risks to people's health and wellbeing were being fully assessed, monitored and managed.

Staff were recruited in a safe way however they were not deployed in an organised and effective way. There was also a high turnover of care staff which impacted upon the quality and consistency of care provided.

There were not effective systems in place to ensure medicines were managed safely.

Staff had a good awareness of safeguarding and how to report concerns about people's wellbeing.

Is the service effective?

Requires Improvement

The service was not always effective.

Care records did not always contain detailed and complete information to ensure staff could effectively care for people.

Staff were provided with appropriate training and support to enable them to fulfil their role effectively.

Staff demonstrated understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and had a good knowledge of the people they supported and their capacity to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

The involvement of people and their relatives in making decisions about the care they received was variable.

Care staff were knowledgeable about the people they supported. People spoke positively about care staff and told us they treated them with respect. However, their experience of the quality of care provided was influenced by the high turnover of staff. People told us this meant they did not always receive consistency in the staff who supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always planned and delivered to ensure it met the individual needs and preferences of people who used the service.

Summary of findings

Where people made suggestions and requests about how their care was to be delivered it was not always clear staff had taken appropriate action to respond.

Complaints were investigated and responded to. However, the underlying causes of complaints were not always addressed.

Is the service well-led?

Inadequate

The service was not well-led.

We found inadequate systems and processes in place to ensure the delivery of high quality care.

Records were not being effectively stored, monitored or maintained.

Management tried to encourage a positive culture amongst care staff. However, most people we spoke with told us they felt many of their concerns about the service were the result of ineffective management.

Twenty Four Seven Recruitment (Yorkshire) Limited

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 visited the offices on 11 and 12 May 2015 and spoke with people who used the service on 18, 19, 20 and 27 May 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection team included three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience had experience of services for older people and people living with dementia.

Prior to the inspection we spoke with the local authority commissioners and reviewed the information we held about the service. Before our inspections we usually ask the provider to complete Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the provider to complete a PIR.

As part of the inspection we reviewed 14 people's care records and other records relating to the management of the service. We spoke with two care workers, two care supervisors, the care manager and registered manager. We also spoke with 26 people who used the service or were relatives of people who used the service.

Inadequate

Is the service safe?

Our findings

We found care records were not always accurate and complete and did not always contain information to demonstrate that potential risks to people's health and wellbeing were being fully assessed, monitored and managed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records did not always contain up to date information which meant they did not always reflect people's current needs and provide care staff with up to date information to help them provide safe care. Potential risks to people were not always supported by robust risk assessments and care plans. For example, one person's continence risk assessment detailed they had 'poor and slow mobility'. However, no moving and handling risk assessment was completed for this person.

Where risks were identified we found an absence of appropriate information to demonstrate risks were being appropriately monitored and managed. For example, one person's care assessment identified a risk of behaviour that challenged. There was no specific information about the triggers to this person's behaviour or potential strategies and actions for staff to take to help calm this person if they showed signs of agitation. This meant care staff were not provided with appropriate information to help them manage this person's behaviour to ensure their safety and the safety of staff supporting them.

We found that where risk assessments were in place, these were not being consistently reviewed and updated. For example, one person's moving and handling risk assessment had not been fully completed and the level of risk had not been assessed. There was a separate risk assessment in place for the person's wheelchair. However this had been completed on 25 October 2013 and there was no evidence to show it had been reviewed since. This meant we were unable to establish a complete and accurate picture of this person's current moving and handling needs.

It was not always clear that care staff had taken appropriate action to mitigate risks. For example, one person was identified as being at risk of pressure sores. Their care assessment and summary of care detailed they should have their position changed every four hours to help reduce the risk of developing a pressure ulcer. We spoke with the care manager about how this was being monitored. They told us staff should document all position changes within the daily activity records. This was not documented within the care records to ensure care staff were aware of this procedure. The service were unable to provide us with daily activity records for this person, which meant we were unable to evidence that appropriate action had been taken to ensure the risk of developing pressure sores was reduced.

We found sufficient numbers of staff employed to meet the needs of the people who used the service. However, our discussions with care staff, relatives and people who used the service and our review of records showed us staff were not always deployed in an effective and organised way. This meant the service could not provide people with a consistency of care or respond to unplanned staff absences without detracting from other people's needs. We found this sometimes led to missed or late visits and a shortfall in the number of carers providing care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with expressed concerns that the service had a high turnover of staff which meant they were not provided with a consistency of care. People told us they did not always know which carers were going to turn up and at what time. Some of the comments people provided about this included;

"The carers cannot be faulted they provide a great service and are capable of meeting [my relative's] needs. There is no continuity in the care from staff as the turnover is so high. It's pot luck on who turns up. They are running on a skeleton workforce because they just cannot retain their staff."

"Call times are variable, especially around lunch and tea times. They can vary by up to an hour and a half. This causes me problems because it interferes with our meal times."

"So many different staff attend you don't ever know who is going to turn up."

"There are problems with staffing levels at the service. They have a high turnover of staff and this affects the quality and consistency of care we receive."

Inadequate

Is the service safe?

What people told us was supported by the records we saw. For example, we looked at the allocation of carers to one person over a 24 day period. We found there to be 20 different care staff attending their calls.

Another person's care records showed they required two staff to support them to move because they had to be hoisted. We reviewed this person's daily records and found some occasions where only one carer had attended this person's tea time call. Their daily notes recorded that staff had to be assisted to hoist this person by their relative. We spoke with this person's relative. They told us; "Sometimes, especially in recent months, only one carer has showed up for [my relatives'] tea call. There should always be two. So when only one shows up I either have had to help the carer to hoist, which I find difficult, or the carer doesn't provide what's required on that call."

We looked at the systems and records in place for managing medicines. We found appropriate arrangements were not in place to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed prior to starting to use the service to determine the level of support they required with their medicines. We found this initial assessment was translated into clear instructions to guide care staff about the level of support each person required with their medicines.

The service had procedures in place regarding the management of medicines. However, we found these were not being consistently followed by care staff. For example, the medicines policy stated; 'Staff will not be expected to make judgements on medication e.g. take as required. These are beyond the scope of the training provided.' However, our review of people's daily activity records showed care staff asked people if they were in pain and if so administered prescribed 'take as required' (PRN) painkillers. Thereby going against the service's own medicines policy.

We reviewed a sample of nine people's care plans, daily activity records and medicine administration records (MAR). These records showed us most people received their medicines at the times they needed them and in line with the prescriber's instructions. However, where people received support from more than one domiciliary care provider we found an absence of information and gaps on people's MAR sheets, which meant we were unable to confirm that these people had received their medicines as prescribed.

Everyone we spoke with told us they felt safe when staff visited them and found care staff to be nice and approachable. Care staff had a good awareness of the service's safeguarding procedures and were confident in what action they would take to report any concerns about people's wellbeing. All of the staff we spoke with told us they would report any safeguarding concerns to the management and if they felt appropriate action was not taken to respond, would escalate their concerns to outside agencies such as the local adult protection unit. One staff member described how the registered manager had supported them to whistle blow, they said they felt listened to and that improvements were made as a result of the concerns they had raised.

Staff were aware of the protocols to follow in response to medical emergencies or changes to people's health and well-being. Staff also explained that the service had contingency plans for dealing with extreme weather conditions and provided examples of where this had been applied in the past to manage the risks associated with any potential disruption to the service.

Effective recruitment procedures were in place to ensure staff were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check before staff commenced work and obtaining written references.

Requires Improvement

Is the service effective?

Our findings

We found care records did not always contain detailed and complete information to ensure staff could effectively care for people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's health and medical care plan stated that care staff should check their stoma and catheter on each visit. However, there were limited instructions about how this should be done. The service was unable to provide daily activity records for this person so we were unable to evidence that staff had consistently checked the stoma and catheter sites. The care manager told us this person regularly refused support from staff. The care manager provided evidence they had participated in a multi-disciplinary meeting with other health and social care professionals about this issue. The meeting concluded that the person had the capacity to refuse this support but that this should be monitored. However, this information was not translated into their care records. There were no clear instructions for staff to follow when this person refused support and no information about how the service was monitoring this.

People told us most health care appointments were co-ordinated by themselves or their relatives. However, we saw evidence that care staff made referrals to healthcare services where they felt this was appropriate and worked with other health and social care professionals to ensure joined up care. For example, we saw care staff had noted a decline in one person's skin condition so had contacted their GP to arrange an appointment for them.

People told us they found that care staff had the necessary skills to do their work and felt confident they knew how they should support people. We saw evidence that new employees received a comprehensive induction which took account of the common induction standards published by Skills for Care. We saw the induction also included periods of shadowing experienced staff before new employees began working unsupervised. Care staff told us they also had access to ongoing training which they said was good and provided them with the skills, knowledge and understanding they needed to carry out their job effectively.

We reviewed four staff files. We saw a range of training had been delivered over the past year. This included formal training to teach new skills and refresher training on key subjects such as; medicines administration, end of life care, safeguarding, first aid, moving and handling, dementia awareness and pressure area care. We also saw evidence of staff gaining a Level 2 Diploma in Health and Social Care.

The service used formal supervision meetings to discuss training and personal development needs with individual staff members. Supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern. We also saw evidence supervision meetings were used to share learning and address complaints. This helped ensure improvements were made and performance issues were addressed. We also saw evidence the service had used their disciplinary procedures to take action where appropriate.

We asked care staff what they did to make sure people were in agreement with any care and treatment they provided. They were able to demonstrate a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA). Care staff described how they always asked people for their consent to carry out care on every visit. They were clear they did not rely on the fact people had provided consent in the past to imply consent and ensured they obtained people's consent on each occasion they provided support. The people we spoke with confirmed this. We spoke with care staff about people's capacity to agree to their care arrangements. They had a good knowledge of the people they supported and their capacity to make decisions.

Most people were supported with meals by their family members. However, those people who had a meal prepared for them by care staff said the food was well presented and they were offered a choice of meals and drinks. Our review of daily activity records showed care staff ensured people were left with access to food and drink. The people we spoke with confirmed this. However, one person told us their relative liked to have two drinks left out for them over night and not all care staff ensured this was the case.

Requires Improvement

Is the service caring?

Our findings

We found the involvement of people and their relatives in making decisions about the care they received was variable. Some people told us they felt involved and attended regular reviews of their care. One relative said; "I feel very involved, we have attended care reviews and carers will always ring us if there is a problem or if they are worried about my relative." Another person described how staff had involved them in planning their care and had moved the time they were supported to shower at their request. Some care records showed people and their relatives were involved in developing care plans. However, as care records were not always complete and up to date it was difficult to establish an accurate view of how involved people were. Some people told us they had never attended a review of their care. Whilst others described how they had not attended a care review for some time. One person told us; "I don't feel particularly involved. I have never been to any care reviews and staff have never really asked me about my relative or what they would prefer so I can't say that's something they do well because we haven't experienced it."

All of the people we spoke with told us care staff treated them with respect and gave examples of how care staff helped to maintain their privacy and dignity when providing support. They also told us care staff provided them with choices where possible. Most people we spoke with told us care staff were nice and good at what they did. One person said; "Staff are good and reliable." Most people told us there were carers who would go above what was expected of them because they genuinely cared about the people they supported. For example, one person said; "Our carer came at 7am one morning in her own time to make sure my wife was ready for the ambulance to go to hospital. We thought this was an exceptional commitment from someone."

People's experience of the quality of care they received was influenced by the high turnover of staff at the service. People told us this meant they did not always receive consistency in the staff who supported them and they found it difficult to maintain lasting relationships with the people who supported them. Some people described how their regular carers would often be taken to support others due to staff shortages and that this made them anxious as they did not know who would be coming to support them for each call. One person told us; "The quality of care provided is variable, it depends which staff turn up. Nine out of ten times [my relative] gets really good care. Most carers go above and beyond their call of duty and are fantastic. But others have no attention to detail and don't seem to care about the little things that may seem trivial to them, but they mean a lot to [my relative]."

Care staff demonstrated they were knowledgeable about the people they supported and people's families and relationships. We saw information within people's care records to prompt staff about how they could help people to retain their independence. For example, one person was assessed as being capable of supporting themselves with their medicines. Their care plan highlighted the need to ensure the person's spectacles were available to ensure they could differentiate between different medicines. Risk assessments were also carried out to ensure when the carer departed the person could manage alone. For instance where people used mobility aids it was made clear that they should be left within the person's reach so they could move independently.

We recommend the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

Care was not always being planned and delivered to ensure it met the individual needs and preferences of people who used the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a lack of person centred information within most care records we reviewed. For example, home care assessment forms had not been completed. The home care assessment form included; health assessments, medical history, personal preferences, life history and cultural and religious beliefs. Through not completing this assessment staff were not provided with sufficient information to ensure they could provide people with responsive and person centred care. The care staff we spoke with demonstrated a good understanding of the people they supported. However, the high turnover of staff at the service meant they could not always develop in-depth knowledge of the people they supported. The lack of information within care records risked that care staff would not be able to provide people with care and support which reflected their personal needs and preferences.

Where people made suggestions and requests about how their care was to be delivered it was not always clear staff had taken appropriate action to respond. For example, one person had a review of their care on 23 October 2014. The review documentation stated they had a desire to be able to walk again and a regular visit from a physiotherapist may help them achieve this. It was documented that care staff would speak with the care manager to arrange this. There was no information within this person's care records to show this had been done. We spoke with the care manager and they were unable to show us evidence this had been followed up.

We spoke with the care manager about how they asked for feedback from the people who used the service. They explained that surveys were sent to people who used the service and their relatives every six months. We reviewed the results of the last survey from September 2014. Most comments people made about staff and the support they received was positive. For example, one person said; "The staff are very pleasant and make independent living easier." Another person said; "Very, very pleased with the care received, they never fail to put a smile on [my relative's] face." However, of the 35 surveys 5 people raised concerns about the staff turnover being high and that they would prefer to have more regular carers. We spoke with the care manager about what they had done to address this. They provided a letter which was sent to people informing them of the results of the survey and what actions they would take to address the concerns raised. However, this letter was dated June 2014 and related to the survey conducted in April 2014. The care manager was unable to provide us with more up to date information about what had been done in response the survey completed in September 2014. The concerns people made about the high staff turnover and inconsistency of carers as part of this inspection suggests the service had not taken appropriate action to address this issue.

It was also not always clear that people's preferences were being respected. For example, one person's initial care assessment completed on 6 April 2015 stated this person preferred to be supported by female carers. However, from our review of the call rotas we saw this person had been put on the male call run. We asked the care manager about this and they told us this person had originally been supported by female carers but had recently moved onto the male call rota. They stated this had been discussed with the person and they were now happy to be supported by male carers. However, they were unable to provide evidence that this had been discussed and agreed with the person. We asked to see this person's daily activity records. A care supervisor went to the person's home and could not locate any daily activity records. Care staff said this person had refused all care and support from staff since they had been discharged from hospital on 6 April 2015. One staff member told us; "I am not surprised they are not having support as they would tell male staff to leave if they turned up." From the care records we saw this person had the capacity to refuse support from staff. However, by not sending female carers the service were not showing respect for this person's preferences and had not taken appropriate action to try to encourage this person to accept the support being offered. The service had also not taken action to ensure the local authority were informed that this person had been refusing support.

We found little evidence to show the service matched care staff to people's needs so that person centred care could be delivered. The people we spoke with confirmed this. Most people told us staff turned up when they expected them to and were usually on time. One person said; "The service is fine and staff stay for the required time". However,

Requires Improvement

Is the service responsive?

some people described how staff were often up to an hour and a half late and they had experienced some occasions where staff had not turned up at all. They told us this had become more of a problem in recent months as a lot of staff had left. One person said; “The impact of them not coming is huge as I rely on them as I am not in the best of health myself, and also my wife feels let down.” Another person said; “I was told by the office that they would let me know if a carer was going to be over half an hour late but they never have. It is very frustrating.”

The service had processes in place to manage complaints. Records showed 12 complaints had been made in the last year. We found all complaints had been investigated and responded to in line with the complaints policy. Learning from complaints was taken up with individual staff members in their supervision meetings and the service used its’ disciplinary processes where appropriate. However, we found themes in the complaints people had made. Six of the 12 complaints made in the past year were in relation to missed or late calls and five were with regard to the attitude of care staff. This showed that whilst the service responded to the individual concerns people raised, they did not always taken appropriate action to fully address the underlying cause of complaints. This was confirmed by what people who had made a complaint told us. One person said; “Whenever I have reported concerns the manager says they will put things right but they never do, nothing changes or improves.” Another person told us; “There is little satisfaction contacting the office unless you really forcibly complain and then something is done but this lasts only a short time and it is back to normal problems.” Another person told us; “Sometimes you get a good response and other times you wonder why you bothered”. One relative told us they planned to escalate their complaint to the local authority for review because they felt the service had not appropriately addressed their concerns.

Inadequate

Is the service well-led?

Our findings

We found inadequate systems and processes in place to ensure the delivery of high quality care. We identified concerns with a number of aspects of service delivery including; the management of medicines, the deployment of staff, incomplete and ineffective care records and an absence of a person centred approach to care planning and delivery. These issues had not been identified or addressed prior to our visit, which demonstrated an absence of robust quality assurance systems. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in place on the date of the inspection. However, the service was not well-led. The people we spoke with told us they felt many of their concerns with the service were the result of ineffective management. One person told us; "Supervisors and carers are really good, the problem lays with management. They don't take action to put things right and rather than support their staff they just seem to put pressure on them when they are already trying their best." Another person said; "The organisation seems to be the problem as the carers are really good."

The registered manager told us the care manager was responsible for the day to day management of the service and had recently handed in their notice to leave. They were investigating concerns relating to the effectiveness of the care manager at the time of our inspection. However, the registered manager was not fully aware of the issues identified during our inspection. Where responsibilities for the management of a service are delegated both the registered manager and registered provider should have appropriate systems and processes in place to assure themselves that the service is being well-led.

Records were not being effectively stored, monitored or maintained. We found a lack of attention to detail in the care records we reviewed. Some examples included care records being completed with the wrong person's name, incorrect dates and wrong information. An absence of an effective and robust care plan audit system meant the service had not identified and corrected these issues.

We asked for a sample of daily activity records for the past three months for the 14 people. Staff were unable to provide us with daily notes to cover the full period requested for some people. For four people staff were unable to locate any daily activity records, despite one person having received care from the service since 2012. There was no organised way of storing notes and no consistent procedure for when daily notes should be returned to the office to be archived.

We found some gaps in people's daily activities records which had not been identified and addressed through a robust system of audit. For example, in one person's daily activity records for March 2015 seven calls had not been recorded and four calls had no time recorded. This meant on those occasions the service was unable to demonstrate that appropriate support had been provided to this person. For another person, no daily activities records had been completed since 6 April 2015 because the person had refused all support. Neither of these issues had been identified or addressed because effective systems were not in place to return and review people's daily activities records. This risked that issues or changes were not being identified and people were receiving care that was not appropriate to their needs.

We found the systems in place for managing and allocating calls was disorganised and put people at risk of not receiving support when they needed it. Most people who used the service had their care funded by the local authority. The local authority provided the service with individual service plans which detailed what support people required and when this was needed. The call rotas developed each week by the service did not always match the person's individual service plan. In most cases we were able to establish that people's needs had changed and the service had not included a copy of the most up to date individual service plan within the person's care file. However, in one case staff told us this person had been 'missed off' the rota for one of their three calls for the week of our inspection. In another case one person only had one of their three calls listed on the rota. Care staff told us this person was in respite care so were not being supported by staff from this service. Including them on the rota was confusing and demonstrated that appropriate checks for accuracy were not being completed.

Care supervisors completed unannounced spot checks of care staff. We spoke with two supervisors who explained

Inadequate

Is the service well-led?

these checks included ensuring care staff; arrived promptly, stayed for the allocated time, completed daily activity records accurately and provided people with the care and support they required. They told us care staff should have a spot check every two months. However, this had not been possible in recent months because supervisors were regularly asked to support with care. We found evidence of this in the spot check and observation records we reviewed. For example, one staff member had received a spot check in January and March 2014 but had not received one since. We also found that where concerns and issues were identified as part of a spot check these were not always appropriately followed up. For example, two members of care staff received a spot check in October 2014 which identified they had not completed the daily activities records accurately. It was noted this would be monitored, however no further spot checks had been completed and there was no evidence this had been followed up through supervision meetings. This meant there was not a consistent and effective system in place to monitor the competence of care staff and the quality of care people received.

Staff meetings were held so staff were kept up to date with any changes in policies and procedures and any issues that might affect the running of the service or the care and support people received. We also found that management tried to encourage a positive culture by sharing feedback given by people, their relatives and other health and social care professionals. There was also evidence that information about lessons learned from untoward incidents and complaints was shared with care staff to try to improve practices and the quality of the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (g) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because medicines were not managed safely and where responsibility for care was shared with other providers care planning was not always coordinated to ensure the health, safety and welfare of people.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always planned and delivered in a person centred way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes were not established and operated effectively to ensure the service; Assessed monitored and improved the quality and safety of the service provided. Assessed monitored and mitigated risks relating to the health, safety and welfare of people who used the service and others. Maintained securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided.

The enforcement action we took:
We issued a warning notice to the provider and registered manager to be met by **2 September 2015.**