DCS&D Limited

Heritage Healthcare-Middlesbrough

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 and 22 November 2016. Both days of inspection were announced which meant the registered provider and staff knew that we would be attending. This meant we could be sure someone would be in when we visited the service.

This service was registered on 8 November 2013 and we carried out a previous inspection on 7 May 2014. We found the service was meeting all of the requirements of the Health and Social Care Act 2008 and associated regulations.

Heritage healthcare Middlesbrough provided personal care to 131 people living in their own homes in Stockton-On-Tees. This included people living with a dementia and people with physical and mental health difficulties. At the time of inspection 61 staff provided personal care to people.

Prior to inspection, the registered provider made us aware that the registered manager had left the service in 6 October 2016. 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. At the time of inspection, a registered manager from another service within the registered provider's portfolio had taken over the running of this service.

The manager who took over from the registered manager had made us aware of concerns surrounding the service. We found that the concerns they raised around staff practices were valid.

Staff training in safeguarding was up to date, however staff were not always clear about what aspects of care could constitute a safeguarding concern. We found staff did not always raise safeguarding concerns or when they had raised concerns with the previous registered manager, they told us safeguarding alerts had not always been made to the local authority safeguarding team. There were gaps in safeguarding records.

Staff understood the whistleblowing procedure, but told us they did not feel confident raising concerns with the registered manager in post prior to our inspection. When a staff member did raise concerns with the registered provider, immediate action was taken to address these concerns.

Risk assessments were in place but didn't always reflect people's actual risks. There were gaps in the information in these risk assessments and they had not always been regularly reviewed.

Missed calls had not always been recorded. Missed calls meant people could be left at risk of harm as no one would know if they had become unwell or had an accident . Records did not show what action had been taken to reduce missed calls and the impact of harm to people.

We heard mixed reviews about staffing levels. Staff told us there were missed calls because of staff shortages

and they felt pressured to take on extra calls.

Medicines were not managed safely. People did not always receive their medicines as prescribed. Risk assessments for medicines were not always in place and there were gaps in all medicines records looked at.

Most staff had completed mandatory training; however we identified that staff lacked knowledge in areas such as the Mental Capacity Act and deprivation of liberties safeguards.

All staff were enrolled onto the care certificate. The registered provider told us that observations of staff had been carried out to determine their competency in each of the key areas, however records were not in place to confirm this during inspection.

There was conflicting information in the care records about people's ability to give consent. Staff lacked understanding about the Mental Capacity Act and best interest's decision making.

Staff had not received regular supervision and appraisals. This meant staff had not been supported to carry out their roles

Staff did not know which people had a valid 'Do not attempt cardio-pulmonary resuscitation' (DNAR) certificate in place. There were gaps in the care records for this.

We spoke to people, their relatives and staff about the care provided. We heard mixed reviews about the quality of care.

People told us they were involved in their care when they started using the service. However, some people's records showed that care and support was delivered to them without any care plans in place. This meant staff did not know people's needs, wishes and preferences. Regular reviews of people's care had not been carried out.

We found that people's privacy and dignity was not always respected or maintained. People told us care was not always carried out in the way they expected and they were not always spoken to in a caring and respectful manner.

Care plans for end of life care had not always been put in place. We identified this was because of a lack of communication at the service. Not all staff were aware when people were on the end of life pathway and the care and support people needed.

Care plans were not person-centred and did not reflect people's needs, wishes and preferences. This meant staff did not have the information they needed to provide the care which people wanted and monitoring and reviewing of specific conditions such as epilepsy had not taken place. We also found that recently updated care plans still contained gaps in information.

Care plan reviews did not regularly take place with people. Where actions were identified, they had not been addressed. When people made verbal requests, such as changes to the care they needed or the time they needed it we identified these requests were not met.

People and relatives told us they had made complaints. We found that complaints had not been recorded; some had been recorded as incidents. There were no records in place to show what action was taken to address complaints when they were made.

Audits had not been regularly carried out at the service. Audits by the registered provider had been carried out and actions identified, however they did not highlight the level of concerns which we had during inspection. Action plans had not been addressed and had been signed off as completed when they were still outstanding.

The registered provider had failed to notify the Commission when required to do so when people using the service died in their own home. Where safeguarding alerts had been made to the local authority, the Commission had not been notified. We are dealing with these matters outside of the inspection process.

Staff told us that they had noticed some positive changes at the service since the new manager came into post.

Staff worked with health professionals to support people with their nutrition, hydration and pressure area care.

Staff supported people to seek medical advice when they became unwell

We found eight breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009 during inspection on 8 and 21 November 2016. These breaches related to person centred care, dignity, consent, safe care and treatment, safeguarding, complaints, good governance, staffing and failure to notify the Commission about the death or a service user and safeguarding alerts. You can see what action we told the provider to take at the back of the full version of this report.

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.

Staff had not always raised safeguarding concerns; when they had, safeguarding alerts had not been made.

Care plans and risk assessments did not always clearly identify the risks to people. Staff were not always aware of the risks to people and the action they needed to take.

Missed calls had not always been recorded. This meant the service could not demonstrate the risks to people and take appropriate action.

Medicines were not managed appropriately. People did not always receive their medicines as prescribed and there were gaps in medicine records.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff supervision and appraisal was not up to date. There were gaps in training and competency checks required for the care certificate had not been carried out.

Staff worked with health professionals to make sure people received support with their nutrition, hydration and pressure area care.

Care records contained conflicting information about people's capacity to make their own decisions. Staff lacked knowledge about the Mental Capacity Act and there was very little evidence of best interest decision making in people's care records.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they received care and support which reflected their needs, wishes and preferences when calls were carried out.

People told us they were involved in making decisions about their care when they started at the service; however reviews were not always carried out. When people requested changes they were not always made.

We received mixed reviews about whether people's privacy and dignity was respected and maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always in place when people started using the service or did not contain the information needed. This meant staff were not always aware of important information needed to deliver appropriate and specific care for their health needs..

We questioned the accuracy of some care records.

Complaints were not dealt with appropriately. The service had not followed the registered provider's policy for managing complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider was not aware that the registered manager had not been carrying out the duties expected of them. This meant that people were put at risk of harm. Staff raised concerns, however they told us, the previous registered manager had failed to act. Once staff raised their concerns with the registered provider, some action was taken.

Quality assurance measures had not highlighted the level of concerns which we had during inspection. This meant the registered provider had not been able to take the action needed to improve the quality of the service.

The registered provider had not notified the commission when people had died and had not always notified the commission when safeguarding alerts had been made. Safeguarding incidents and accidents and incidents had not been routinely investigated because they had not been recorded. Quality assurance processes had not flagged this up.

Prior to inspection the registered provider had started to take some action to address concerns at the service. After inspection,

the registered provider responded to our concerns, provided us with an action plan and continued to make changes to improve the service.

Heritage Healthcare-Middlesbrough

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.

One adult social care inspector carried out an announced inspection on 8 November 2016 and one adult social care inspector and one pharmacist inspector carried out inspection on 22 November 2016. This meant the registered provider and staff knew we would be attending on both days of our inspection because we needed to be sure that someone would be in the office.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning officer from the local authority commissioning team about the service. Prior to inspection, the registered provider had made us aware of some concerns relating to the quality of the service, which had been identified following a whistleblowing.

The registered provided completed a provider information return (PIR) when we asked them to. 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.

During this inspection, we spoke with 12 people who used the service and 19 relatives over the telephone. We also visited four people in their own home. We spoke with the registered provider, manager, deputy manager, care coordinator and six care staff.

We reviewed six care records and ten medicine administration records. We looked at the supervision,

appraisal and training summary records for 61 staff; three staff induction records and three supervision and appraisal records. We also looked at five staff recruitment records and records relating to the day to day running of the service at the registered providers office.

Inadequate

Is the service safe?

Our findings

Staff had not accurately documented the level of support that people needed in their care plan. For one person whose care plan we looked at, the medication risk assessment stated that they required their medication to be administered by staff but we saw on the medication administration record (MAR) and the daily records that on some occasions, one medicine was left out for the person to take later. No risk assessment had been completed so that the registered provider could be sure that the individual knew when and how to take this 'left out' medication and that they could manage it safely. The care plan for another person stated that a relative ordered and collected their medicine, however care staff had recently taken over this role but staff had not updated the care plan to reflect this.

One person usually had their medicines administered covertly (hidden) by a relative and had no medicine care plan in place. However on two occasions during August 2016, when the relative was away, staff administered medicines to this person. We saw that a MAR was completed but there was no guidance for staff on how to administer the medicines safely.

Staff did not always ensure that the administration of people's prescribed medicines was accurately recorded. We saw that staff signed medicine administration records (MAR) when people were given their medicines. The MARs we looked at did not always clearly demonstrate which medicines were administered on each occasion. We saw gaps in the records kept for all the people we looked at, these were identified in the audits carried out by the registered provider.

Staff had not always recorded the strengths and dosages of medicines onto the MARs. Some people could take different doses of medicines depending on what they thought they needed at the time for their health condition. When this was the case, staff had not recorded the dosages of medicines which people had taken. We also found that where dosages had been recorded for three people, they did not match the dosage prescribed. This meant we could not tell whether medicines had been given correctly.

Two people whose records we looked at had allergies recorded in their care file however on their MAR allergies were recorded as none known.

Several people were prescribed topical creams and ointments that were applied by staff. There was no guidance for care staff in some care plans looked at which described how these preparations should be applied. In the care plans we looked at, the information was missing, or the guidance referred to several topical creams on the same chart and for other people the frequency or area of application was not specified. This meant there was a risk that staff did not have enough information about which creams were prescribed and how to apply them.

One person was prescribed co-codamol tablets for the relief of pain. To avoid Paracetamol toxicity the interval between doses should be a minimum of four hours. For this person on a number of occasions the time interval between doses recorded on the medicine administration record was less than four hours.

One person was prescribed medicine administered through a transdermal patch. This meant the medicine was applied to their skin and it is absorbed over time. The instructions for care staff was not clear regarding the positioning of the patch or removal of previous patches. The manufacturer's instructions for this medicine clearly stated that the location of the patch should be varied and patches should not be applied to the same area of skin for several days. We found the transdermal patch had been applied to the same area of skin and staff had not followed the manufacturers instructions.

We looked at the guidance information kept about medicines to be administered 'When required'. The registered provider's risk assessment had a space for information on 'When required' medicines but this was not completed for any of the people we looked at.

The manager told us that the audit of MAR charts had just started in the last month because care staff had not returned the charts to the office for audit on a regular basis. Some MARs from January 2016 had only recently been returned. Carers had completed induction training that included information on medicines but that not all staff had been assessed as competent in medicine administration.

Risk assessments did not accurately reflect the risks to people; they did not contain the information needed and some risk assessments contained conflicting information. An environmental risk assessment for one person highlighted that assistance with mobilisation was needed but the risk assessment did not indicate the reason for this. This risk assessment stated that the person did not display any behaviours which could put staff at risk of verbal or physical abuse, however the person's care plan stated that they could become agitated and verbally abusive towards staff. The risk assessment also suggested that the person was at risk of social isolation because they didn't go outside, however the person's care plan stated that they went to bingo twice per week. This meant the risk assessment was inaccurate.

A local authority care and support plan shared with the service when care for one person was agreed outlined risks and assistance with care. The risks identified in this record had not been included into the person's care plans or identified in risk assessments by the service.

A moving and handling risk assessment for one person contained the wrong name. This meant the risk assessment was not related to the person whose care records it was found in. The manager took action to address this after we discussed it with them.

Each of the risk assessments in place stated that spot checks, annual reviews and regular training for staff would be carried out to help to reduce any risks to people. When we checked these staff records to see if the actions the registered provider had put in place to manage the risks to people had been followed, we found that none of these were up to date for any staff member. This meant the service was not proactively managing the risks to people.

We noted that one person ate a pureed diet and staff assisted them to eat. The person's care records said they liked to eat toast but did not provide any information about why a pureed diet was needed. When we spoke with staff, they told us that they had been informed about this from the local authority when they started to provide care and support to this person. When we looked a the care plan provided by the local authority, we could see that some issues with swallowing had been identified, although no referral to speech and language therapy had been made. This meant we did not know if the person was at risk of choking from eating the toast. We asked the manager to take action to determine whether it was safe for the person to eat solid foods.

Staff told us that one person had a history of epileptic seizures; however there was no information in the

care records to support this. We noted that there was a section in the care records for seizures, however this was empty. There was no care plan, risk assessment or epilepsy protocol in place for this person. This meant staff did not know what action they needed to take in the event of an epileptic fit. A staff member informed us about two epileptic seizures in August and September 2016; we found no evidence of these in any records looked at. No care plans or risk assessments had been put in place following these seizures.

One person had a catheter in place. During inspection, we identified that one staff member had been manipulating the person's catheter bag each night to remove the sediment to prevent the catheter bag from overflowing. The staff member did not seek advice about taking this action. The staff member failed to recognise that sediment in a catheter bag could be a sign of infection and the person needed to seek medical advice. This meant the person was at increased risk of harm because they had not been supported to seek medical advice.

Accidents and incidents were not always recorded or had been recorded inappropriately. Staff had failed to report accidents and incidents or they told us they had reported to them to the previous registered manager who had taken no action. Staff told us they did not complete any records when people had fallen and were not aware they needed to. One staff member told us, "I wouldn't complete a record. I have never been told to." We also became aware of two incidents where emergency services were called and accident and incident records had not been completed. The registered provider's accident and incident reporting procedure dated 01 August 2016 stated that all accidents and incidents, no matter how minor should be recorded. It was evident that the registered manager had not logged the information or made the registered provider aware. Care records had not been updated when people had experienced an accident or incident. This meant staff had failed to follow appropriate procedures.

On 28 January 2015, a staff member scalded their arm. No incident report had been completed and records in place did not detail whether medical assistance had been sought or any effects of injury. A death occurring on 30 January 2016 had been recorded on an accident and incident record which is not the appropriate procedure. On 16 March 2016, a staff member sustained an injury whilst delivering care to a person in their wheelchair. Records did not show if the staff member sustained any injury or required medical assistance and if a risk assessment was needed.

One person had experienced two epileptic fits in August and September 2016 and emergency services were called. These two incidents had not been recorded on an accident and incident record and not documented in the person's care records. There were no records in place to show what action was taken by the service at the time of each of these incidents or the action taken to minimise the risk of future harm to this person and staff. Staff involved in this person's care had not received training in epilepsy.

We requested information from the registered provider about the number of missed calls which had occurred at the service since 1 October 2014. Records show only two missed calls had occurred since this time on 7 and 8 October 2016. This did not match with the discussions with people who used the service and staff. We questioned the accuracy of these records.

When we spoke with people over the telephone, they told us missed and late calls were a regular occurrence. From speaking with people, we identified that these missed calls also resulted in missed medicines. We also found that when missed calls occurred, people were not getting the care and support needed. This meant people were at risk of harm. Staff told us they were aware of these missed calls and had been raising them with the registered manager in post prior to our inspection and they failed to take action.

We looked at the missed calls for one person from 7 September to 19 September 2016. The person's care

plan stated they should receive three calls per day; however a local authority care plan provided to the service when the person started receiving care stated they required four calls per day. The deputy manager confirmed that the person should receive four calls per day. From the records, we established over these 13 days, the person only received four calls per day for three days. They also received three calls per day for six days, two calls per day for one day, one call per day for two days and no calls per day for one day. These had gone unnoticed by the service until we identified them during inspection.

There were no effective systems in place to monitor missed calls. We found that a staff member whistle blew [telling someone] to the registered provider after they became concerned about the level of missed calls. We noted that the registered provider had taken to address each of the concerns raised, and the number of missed calls started to reduce. The manager raised safeguarding alerts for missed calls following this. Safeguarding alerts had not been raised following missed calls prior to this. Because missed calls were not recorded before this time, we could not be sure if they went unnoticed. From our conversations with staff, we found that they were only told about missed calls when they turned up to provide care and support to people.

There is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service took on 61 new packages of care during September 2016. They had not informed the registered provider and the new manager told us they did not have the appropriate numbers of staff in place in September 2016 to deliver safe care and support to people. At the time of inspection, they were working with the local authority to seek alternative domiciliary care agencies to provide care to people. Staff told us there were increased rates of staff sickness during September 2016. This meant that pressures to staff and the opportunity for missed calls increased. Staff also told us that travel time was problematic and caused them to be late for people.

We asked people about their experiences of call times, and whether staff turned up on time or were late. People told us that staff could be late and sometimes their calls were missed. They also told us there was a lack of communication about calls; people told us they received a rota to inform them of which staff to expect, but found different staff turned up. One person told us, "I have, on a few occasions had to phone and say it's half an hour over and they do get back to me but it's usually generated from my side. They're not proactive." Another person told us, "One time, a couple of weeks ago, my husband had to help the carer because one carer didn't show up."

People told us that staff could be an hour late and they had not been informed. One person told us, "Once they were about an hour late for a night-time call. There was no phone call, they just showed up. Sometimes you don't know who's coming." Another person told us, "A couple of times we've been waiting for them (staff) to come but we've never been informed if they're (staff) running late. It would be better if you were notified, because sometimes you're hanging about. The last time was about two weeks ago and they were an hour late."

People told us that despite late calls, staff stayed for the allocated amount of time. One person told us, "They (staff) always stay as long as they should and are never massively late. It's not the girls' (staff) fault because they're not given travelling time from one call to the other. It's not fair on the girls, (staff) they're given three minutes to get from Stockton to Billingham." One relative we spoke with told us that staff didn't always staff for the allocated amount of time. They told us, "It does affect [Person using the service] because they never knows when staff are coming. The teatime can be anytime from 15:25 to 18:00. We are lucky if staff stay a quarter of an hour at lunch and same at teatime but it's a 30 minute call. What's stopping them

(staff) sitting for the half an hour and chatting to my Mam?"

There is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of the last five staff. We found that each person had completed an application form and had participated in an interview. We found that interview records had not always been completed. Of the five records looked at there were no interview records completed for two staff. For all five staff, records did not indicate the rating given to staff during interview to determine if they were suitable for their role. The registered provider's policy showed that all candidates for interview should have a completed interview record and interview rating record completed as part of the recruitment procedure.

All five staff had two checked references and a Disclosure and Barring Services (DBS) check. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The new manager in place at the time of inspection told us that they had checked all staff recruitment records when they first started at the service. They found that one member of staff had been taken on and were delivering care without a DBS check. They told us they took immediate action to address this; they removed the staff member from providing care and support to people until a DBS check was carried out. Quality assurance measures failed to highlight that this had happened until the new manager came into post and carried out their own checks.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The service had not always raised safeguarding alerts when needed. From available records during inspection, we found three safeguarding alerts had been raised since January 2014. There was a lack of information in each of these records, for example, we could not always see the action the service had taken to investigate each of the safeguarding concerns and the action taken to minimise the risk of future harm to people. Minutes from the meetings and actions were not available in all of the records and therefore staff had no means to check that the action had been taken.

We spoke to staff about their understanding of safeguarding; we could see that training in safeguarding was up to date. However, from our discussions, we found that staff lacked understanding about safeguarding and the kind of scenarios where abuse could be taking place. When we spoke to staff, we found that they had not raised safeguarding alerts where they should have. When staff did have a concern they told us they discussed it with the previous registered manager who failed to take action. One staff member told us, "We did raise concerns with [Previous registered manager], but they did not take our concerns seriously." Staff did not document any safeguarding concerns. Staff had failed to raise their concerns with the registered provider. We also identified missed opportunities during our inspection, where we felt staff should have considered whether a safeguarding alert may have been appropriate. Staff still failed to recognise and report abuse to the new manager in place at the time of inspection. This meant people continued to be at risk of harm. During inspection, we raised four safeguarding alerts which related to delivery of care, failure to report and take action about a health condition, dignity, financial abuse and staff conduct.

An allegation of theft was recorded as an incident on 30 March 2016 and not as a safeguarding alert. Records failed to show what action was taken and we identified that a safeguarding alert was not made in respect of this. The Commission was notified on 31 March 2016 about one person who had suffered financial abuse; however a safeguarding alert was not made to the local authority. We identified a significant number of missed calls which meant that people had missed prescribed medicines, food and nutrition and care and

support. The service had not considered whether each of the people who had experienced these missed calls had suffered abuse and had not determined whether safeguarding alerts may have been appropriate.

This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Requires Improvement

Is the service effective?

Our findings

All new staff participated in an induction programme over five days which involved training, shadowing more experienced members of staff and becoming familiar with the policies and procedures of the service. During this five day induction, staff were expected to be observed and a decision made to see if they could work independently. There were no records in place for the three staff records which we checked. This meant we did not know if staff were competent to provide care and support to people on their own. From speaking with the manager, we were told these three staff members were providing care and support to people.

All staff were subject to a 12 week appraisal following their induction period. From the records looked at we found ten of the 61 staff employed at the service had received this 12 week appraisal. Staff were also expected to participate in regular reviews during their induction period to monitor their progress. Very few records were in place to show that these reviews had occurred. We looked at the personal development plans for three staff and found two had not been completed. We noted these staff members had been in post for eight weeks.

All 61 staff were enrolled onto the care certificate. This is a set of standards which staff are expected to follow at work. The registered provider told us that observations had been carried out to demonstrate their competency in each of the key areas within the care certificate. However records were not available during inspection to confirm this to be the case.

Staff were required to undertake mandatory training which included safeguarding, first aid, medicines and health and safety. This is training the registered provider thinks is necessary to support people safely. We looked at the training summary records for all 61 staff and found training was up to date for most people; where training was outstanding planned dates were in place. The registered provider told us that training in the Mental Capacity Act 2005 and deprivation of liberty safeguards had been incorporated into induction training. We found that staff lacked knowledge in many areas such as safeguarding, mental capacity and deprivation of liberty safeguards. After inspection, the registered provided informed us that all staff would undertake training in the Mental Capacity Act 2005 and deprivation of liberty safeguards.

Staff had not received supervision and appraisal in line with the registered provider's policy. These are formal methods of support between a staff member and a supervisor. We looked at the supervision and appraisal matrix of 61 staff. We found that five staff had received their annual appraisal and 16 staff had received between one and three supervision sessions during the last year. This meant the majority of staff had not received appropriate support from the registered provider. We looked at supervision and appraisal records of three staff in detail. We found the information in them was repetitive and not individual to each staff member. We also noted gaps in each of the records and there was little evidence of staff voice.

Where actions had been identified, such as training, we found that these had not been addressed. We also identified a number of supervision and appraisal records in the previous registered manager's desk which had not been completed but had a staff signature on each of them. We queried whether these records

contained accurate signatures on them and why they had been signed. The manager was not able to tell us, but told us they would share this with the registered provider. The registered provider confirmed they were investigating these issues.

This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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

When we spoke with staff about MCA and best interest's decision making, we found their knowledge was very limited. We identified that had not received any training in these areas. We also found that each person's care records did not always contain information about whether they had capacity to make decisions about all aspect of their lives. We also found these records contained conflicting information about whether people had capacity. Where people were deemed not to have capacity, there was no evidence of a MCA or any best interest decision making. There was a lack of information in people's care records about what decisions they could make.

We looked at the care records for three people and they stated that these people did not have capacity to make decisions. There was no information in the care records about when a MCA was carried out, what (if any) decisions each person could make and if any best interest decisions had been made. We noted each of these people received regular care and support from staff. We questioned how these people could consent to the care and support which staff were providing to them. Staff told us, that in each case they were acting upon the social worker recommendations.

In another person's care records, they stated that the person had the ability to make, 'Simple life choices' but records didn't specify what these were. We noted that each of this persons care plans and risk assessments had been signed by their relative, however the relative did not have lasting power of attorney for health and welfare which would have allowed them to do this. A lasting power of attorney (LPA) is a legal document that allows a person to appoint someone as an attorney to help you make decisions or to make decisions on your behalf.

One person's recorded stated they had 'Fluctuating capacity' however records did not contain the detail needed. We noted that this person's relatives crushed their medicines and mixed them with a liquid iron supplement; when this relative was away staff carried out this action. There was no best interest decision in place to support this and we did not know if the person could consent to this. Following inspection, we were given a copy of a letter from the person's GP which stated that medicines could be crushed, however there was no best interests decision recorded.

We identified two people where best interest's decision making had taken place. We noted that these had been instigated and carried out by a local hospital and the local authority.

We asked staff about 'Do not attempt cardio-pulmonary resuscitation' certificates. All staff told us about the action they would take in the event of an emergency if a certificate was in place. None of the staff we spoke with could tell us if any of the people they provided care and support to had a current certificate in place. We

noted a lack of information in people's care records about whether a certificate was in place. This meant we could not be sure that staff could take the action needed in the event of an emergency which reflected the person's wishes.

This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

At the time of inspection, the manager and care coordinator told us that no-one required specialist help with their nutrition and hydration. This meant that no monitoring records and risk assessments were needed. When we spoke with staff, we could see they understood the action they needed to take if people became at risk of dehydration and malnutrition. Staff spoken with during inspection all told us that they made sure people had enough to eat and drink when they visited people. Staff also told us that they offered to collect groceries such as bread and milk for people. One person told us, "They (staff) probably do more than they need to, like if I'm short of milk, they'll bring some milk in with them." Another person told us, "Now and again, if they've [staff] cooked something at home, they might bring me a bit of cake and they've made a Sunday dinner and brought that round for me."

People told us staff helped them to prepare and cook food at mealtimes. One person told us, "They always ask me what I want for me lunch and I look at the fridge and freezer and tell them what I'd like." From speaking with people, we could see that people were given choice about their meals. Relatives told us that staff knew people's dietary requirements, likes and dislikes well. One relative told us, "[Person using the service] asks for specific biscuits and [Person using the service] told them they wanted a specific one. The staff gave them a choice of three." Another relative told us, "There's always somebody [staff member] there who knows what they're doing. They [staff] get things done how [person using the service] likes, such as sandwiches cut into triangles, with the crusts off and how they like to have their drinks." Relatives also told us that staff assisted people to eat and made sure people had access to specialist cutlery and crockery. This meant staff supported people with their nutrition and hydration and with their independence."

From speaking with people, their relatives and staff, we could see the service had good links with health professionals. Staff told us they followed the recommendations from health professionals to manage people's pressure area care and to support people during their end of life care. People told us that staff often recognised when they were not feeling well and suggested that they see their GP. Relatives told us they valued the communication from staff when people became unwell. One relative told us, [Staff member] texts me and keeps me in the loop. [Staff member] will say 'I think your mam's got a water infection,' that kind of thing. They just seem to know what to do. It feels like team work. This one carer, she's brilliant. I can't praise her enough. She asked me to speak with the social worker to increase one of the call times. This allows my mam to have the full support she needs." Another relative told us, "[Person using the service] is prone to UTI's [urinary tract infections] and they will go to the Doctors with a water sample; the first sample of the day. The carers have been very good at organising that."

Requires Improvement

Is the service caring?

Our findings

We heard mixed reviews from people and their relatives about whether privacy and dignity was maintain and respected. One person told us, "I have a catheter and they've (Staff) been known to put a [urine] bottle on the sideboard or stuff on the furniture when it's not covered up." A relative told us, "Staff left soiled bed linen on the bedroom floor when they are supposed to put it in the washing machine. Staff are supposed to let [Person using the service] know if they are running out of anything, but half the time they're not doing that. Another relative told us, "[Person using the service] said they were in bed one night and the carer had pulled the covers off them without asking. This made them feel cold. I've found that staff can be a bit abrupt and [Person using the service] doesn't always like the way staff speak to them."

Staff told us that care plans did not contain the information needed and people often needed more support than identified. Staff told us this compromised people's dignity because they hadn't delivered all of the care people needed because it had not been identified. One staff member told us that some staff didn't speak to people appropriately and some people had been shouted at by staff. We asked them if they had raised this with the manager and they told us they had.

This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The service had provided end of life care to people prior to our inspection, however at the time of inspection, there was no-one receiving end of life care. Staff told us that that limited information had been available when they had provided care to people receiving end of life care. One staff member told us, "It's all guess work." Staff told us there were gaps in communication and the information given to them about people's needs during their end of life care. One staff member told us, "It's appalling that we ask about people's needs when they go onto the end of life pathway, when we've been caring for them for months. We should have discussed this with them before this time." The service could not show that they had carried out person-centred assessments with people to ensure their needs, wishes and preferences were met during their end of life care.

Other people and their relatives told us that dignity was maintained and respected. One relative told us, "They're very respectful of [Person using the service]." Another relative told us, "Staff suggest things to make [Person using the service] more comfortable and always make sure the blinds are closed." One person told us, "They (Staff) always pull the curtain round when I'm getting showered." Another person told us, "[Staff member] comes and puts me in the shower and they cover me in towels. As soon as I shout 'I'm finished now', they come in and make sure I'm covered up."

Some people and their relatives spoke positively about staff. People told us, staff looked after their care needs and felt supported by them. One person told us, "I like it when they (Staff) call out my name when they come in." Another person told us, "They (Staff) always ask if we want anything else; they're always obliging when they come." Another person told us, "It's nice when you get to know them (Staff) a bit and they (Staff) get to know you, but some [Staff] are better than others."

One relative told us, "[Person using the service] feels very reassured and happy when they're [Staff] there. They [Staff] look after her really well." Another relative told us, "The girls [Staff] wait in the kitchen with [Person using the service] and put the water out for their medication, then put the plates and bowl away in the dishwasher. They clean her bathroom daily and clean and make the bed and mop her kitchen once a week and they always ask her if they're changing bedding or 'what would you like to eat?'"

Some people and their relatives told us staff were kind and respectful. One relative told us, "It's the friendliness and they're respectful all the time. They speak to [Person using the service], not so much to me, which is how it should be." One person told us, "There's one carer, they would take me out in the wheelchair. They are very caring. They offered to do it and I jumped at the chance." Another person told us, "They ask things in a friendly way. They're always good with me. They do everything because I'm unable to, like putting toothpaste on my brush. They try to help me to do things and try to keep me independent."

Requires Improvement

Is the service responsive?

Our findings

Not all complaints had been recorded. We found that some complaints were raised as incidents and therefore not recorded appropriately. We found that evidence of complaints, such as a record of a verbal conversation or letter was not always in place. Where a complaint was recorded as an incident, there was sometimes evidence of action taken to resolve the complaint; however this was not in line with the registered provider's policy for managing complaints. These records were incomplete and no outcome to show if people had been happy with the response.

Staff told us that the previous registered manager would not deal with complaints. They told us that when people raised verbal concerns or complaints they shared these with the previous registered manager who did not take any action. Staff told us they had not recorded these complaints because they had shared them verbally with the previous registered manager. We noted that quality assurance systems had not flagged up a lack of complaints or a lack of action taken when complaints had been made.

Staff told us that when people rang to speak with the previous registered manager about any concerns, they refused to speak with them. This meant people's complaints went unresolved. People we spoke with during inspection told us they did not have confidence making a complaint because they did not feel listened to. Some people and their relatives told us they had raised concerns and complaints but no action was taken to address these.

This is a breach of regulation 16 (Receiving and acting upon complaints) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The registered provider told us they had not been made aware of all complaints which meant they had not been able to take action inline with their own policy. Where they had been made aware of complaints, the policy had been followed.

Care plans were not always in place when people started using the service. Where care plans were in place, they had not always been signed by the people they related to. This meant that we did not know if people were involved in planning their own care. From speaking with people and from looking at the care records, we could see that personalised information was not always in care plans and regular reviews of care had not taken place. People also told us that they were not given explanations when changes to their care occurred, such as when calls were late or were missed. Some people told us they had requested changes to their call times which had not been addressed.

Care plans lacked the detail needed to provide personalised care and support to people. One person's care plan stated that the person could become agitated when people didn't understand them. There was no information about how staff should communicate with this person and the action they needed to take when they became agitated. The records stated that if the person experienced any difficulties then staff should speak with their relative. This meant staff did not have the information needed to deal with this type of situation.

One person had a care plan for communication, however the outcomes of this care plan stated the person wanted to be treated with dignity and respect, to remain in their own home and this would be achieved with a flexible care package from the service. We questioned the relevance and accuracy of this care plan because the outcomes did not meet the care need. We noted all care plans for the people we looked at had a section for 'Goals and aspirations,' 'Personal outcomes,' and asked 'How they would like to achieve their outcomes.' We found care records looked at, had not been completed or had the exact same statements in them. This meant where information had been recorded, it was not individual to people.

People did not have the care plans which they needed. For example, some people had specific health conditions such as strokes, cellulitis, low heartbeat, high blood pressure and dementia. Care records did not have any information in them about how these conditions affected people, what support they needed with these conditions and the actions staff needed to take if people experienced a deterioration in their health and well-being. We spoke to staff about one person and they told us this person had epilepsy; the care records did not contain any information about this. This meant staff did not have the information they needed to provide the most appropriate care and support to this person.

This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Where care records identified potential risks, we found that care plans were not always in place or had not been included into care plans. For example, the care records for one person stated they required assistance with eating and drinking because they were living with a dementia and were unable to do anything for themselves. We questioned whether this person required nutritional and hydration monitoring records so that staff could make sure they did not become at risk of dehydration or malnutrition. The records stated that the person was unable to do anything for themselves and we questioned the accuracy of this. There was no information in the care records to support this.

We could see one person's relative had been involved in their care plan and the care plan reflected the relative's wishes. The care plan stated that the person could make simple life choices, however there was no evidence of the person's choices, wishes and preferences in their care plans. This meant we could not see evidence that the care and support being delivered was what the person wanted.

Care records contained inaccurate information, for example, in two people's records looked at, some care plans contained names which were different to the person's care records. We questioned the accuracy of one person's care records. The records stated that the person required assistance with personal care, medicines and with preparing hot food and drinks. Staff told us that this person experienced memory loss which is the reason staff assisted them with their medicines; however there was no record of this in the person's care records. We noted that staff did not provide assistance with an evening meal and this person had regularly spent time out of the country over the last six months without the assistance of care staff.

There were gaps in care records. This meant we did not know if they reflected people's needs, wishes and preferences; if they were accurate or who had been involved in developing them. Care plans were not always signed or dated by the people they related to or by the staff member completing them.

We questioned the accuracy of daily records for one person which were completed by staff after each visit. We were aware of an incident which occurred for this person where medical assistance was needed. When we read the daily notes for the day of this incident, there was no mention of this incident. The daily notes for the day prior to and following the incident suggested that the person had been at home and had been assisted with personal care, medicines and with their diet. Given the nature of the incident, we were

confident that all of the care identified could not have been carried out. Further to this, staff had not noted any changes in the person's presentation following the incident, such as confusion, nausea, tiredness and headaches.

The local authority supplied a copy of their own care plan to the service once the service had agreed to deliver care and support to people. We found the care records in place at the service did not reflect the level of detail contained in these local authority care plans. This meant staff did not always have the level of information they needed and we could not be sure if the service was delivering care which the local authority identified that people needed.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We looked at one person's care records and we found there was sufficient detail in them to provide personalised care and support. The care records identified what was important to the person and how staff could support them. The records showed what the person was able to do for themselves; this meant staff could maintain the person's independence by only providing the support the person needed. The care records gave information about the person's health conditions and prompted staff to make sure the person was wearing their hearing aid and dentures.

Another person's care records contained detailed information in place, for example, there was information about portion size for meals and how to cut up food to allow the person to be more independent with their eating and how to assist the person with their hydration.

A small number of care reviews had taken place. We found that records contained minimal information; however people and their relatives were happy with the care and support delivered by the service.

Daily records were completed by staff at each visit. We found that these contained information about the care and support delivered by staff. Staff told us these records were valuable because they helped them, as a team to monitor people's health conditions and their nutritional intake.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had not made notifications to the Commission when required to do so. The service made two safeguarding alerts to the local authority on 30 March 2016 and 30 August 2016 in relation to abuse. The service failed to notify the Commission about either of these incidents.

We have written to the register provider separately about this breach of the Care Quality Commission (Registration) Regulations 2009.

The registered provider had not been accurately recording deaths of people at the service. At the time of inspection 94 people had died since 1 October 2014, of which 19 people died at home and 16 people in hospital. The registered provider could not tell us whether the remaining 59 people died at home or in hospital. The Care Quality Commission (Registration) Regulations 2009 state that the Commission should be notified of all deaths occurring at the service without delay.

We have written to the register provider separately about this breach of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they regularly raised concerns with the previous registered manager about the people they provided care and support to such as complaints which people had made or where staff felt people could be at risk of harm and abuse. Staff told us that this manager dismissed their concerns and did not take action to make sure people were safe. The registered provider had not been aware of the behaviour of the previous registered manager and staff had not followed the whistleblowing policy in place. The registered providers own quality assurance systems failed to highlight that this registered manager had not been carrying out the duties expected of them. Staff told us they became less confident at raising concerns because of their lack of confidence in the management team. Despite a new manager in place, staff initially failed to raise concerns and take the action needed to keep people safe. We noted that staff did not raise concerns when people were at risk of abuse because medicines had been missed or they had not received the care needed. We also noted that staff carried out the practices put in place by relatives for caring for people, without questioning whether it was safe for them to do so. This meant that the new manager was not always aware of things happening at the service.

Quality assurance processes were in place which required the previous registered manager to carry out regular audits which included medicines, care records and staff records. However, they had failed to ensure these audits were carried out regularly. The quality assurance team for the registered provider had identified a number of gaps during their audits; however they appeared to have been signed off without actions being addressed. There was not always evidence of action taken by the registered provider. The registered provider informed us that audits were closed once actions had been addressed. However audit records had not been updated appropriately to reflect this.

The registered manager was expected to complete 'Key performance indicator' reports each month. This meant the registered provider could monitor accidents and incidents, audits, safeguarding and deaths for

example. The quality assurance team had highlighted a lack of reporting of safeguarding incidents, accidents and incidents and complaints. Despite procedures put in place by the quality assurance team, we found these were not followed consistently. This meant incidents in these areas had gone unnoticed.

The registered provider had carried out a survey to look at the quality of the service. This included staff conduct, quality of care and information provision. Forty two people responded to the survey. Two areas of concern had been highlighted which were specific to two individual people. We could see that both areas of concern had been addressed straight away. From the results, we could see people had responded positively about the service they received and had not identified any of the areas of concern which people shared with us during this inspection.

Staff told us they had not been regularly informed about changes occurring at the service. From the records available during inspection, we saw that they had only been four staff meetings during the last two years.

The registered manager had taken on 61 new people in September 2016 and had not informed the registered provider. The service did not have the appropriate resources in place to take on this number of packages and provide safe care and support to people. This put the service under immediate strain.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our inspection, we shared our concerns with the local authority, Clinical Commissioning Group (CCG) and Continuing Health Care (CHC). The local authority met with the registered provider on 17 October 2017 and the registered provider offered to place a voluntary embargo in all areas within Stockton-On-Tees excluding Ingleby Barwick. On 29 October 2017, the local authority placed an embargo on all referrals to the service.
The previous registered manager left the service on 6 October 2016; at this time the registered provider had been made aware of some concerns with the service after a member of staff whistle blew. The registered provider took immediate action to speak with the staff member and put supportive measures in place for the previous registered manager, however they had made the decision to leave the service.

At the time of this inspection, a registered manager from another service within the registered provider's portfolio had taken over as manager of this service. Staff told us changes had already started to take place. From speaking with the new manager, we could see that they had already started to implement correct procedures at the service. Staff told us they had confidence in this new manager and felt they could approach them at any time. One staff member told us, [Manager] and [Deputy manager] have been fantastic. We are learning how to do things properly." Another staff member told us, [Manager] and [Deputy manager] have changed things and put new procedures in for us to follow. They support us and we feel like something is done when we speak to them." A relative told us, "I think with the new Manager, it's going to be a bit more organised. A bit more professionally managed."

During inspection we identified multiple breaches and concerns in most areas looked at, of which the registered provider had already started to identify their own concerns. There were some areas of inspection where our concerns were greater than the registered provider had initially identified. However the registered provider, new manager and deputy manager discussed our concerns with us and proceeded to take immediate action to look at these areas in detail. Since inspection, more robust quality assurance measures have been put in place. The registered provider has kept the Commission informed about the action they have taken to improve the quality of the service. This has included recruitment of experienced care coordinators, training, monitoring of key performance indicators and more frequent auditing by the

manager and auditing team. We are confident that the registered provider will continue to make improvements in all areas of the service and overcome the breaches to the regulation identified during inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Records were not person-centred. They did not contain the information needed to provide the most appropriate care and support to people. .

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always maintained.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care records contained conflicting information about whether people had capacity to consent. There were no best interests decision records available. Relatives had signed care plans where no LPA was in place. Staff did not know which people had a DNAR and information was not available in care records.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care records did not contain accurate information about people's needs and risks. Medicines were not managed safely, there were gaps in medicine records and medicines were not always given as prescribed..

Care plans and risk assessments were not always in place for people who needed them. Accidents and incidents had not always been recorded or investigated. There was evidence of missed and late calls. There were gaps in recruitment records.

People were at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to raised safeguarding alerts which meant people were at risk of harm. Staff lacked understanding of safeguarding and training was not up date. There were gaps in safeguarding records.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not been investigated appropriately. We could see that the service had not dealt with people's complaints when they had been made. There were gaps in complaints records. People told us they did not have confidence in the service to deal with their complaint.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were gaps in all records looked at during inspection. Audits failed to identify the level of concerns found during this inspection. The registered provider had failed to monitor the quality of the service appropriately.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient staff to care for the new of people using the service.

People were not supported appropriately during their induction period. Staff supervision and appraisals were not up to date. There were gaps in training.