Angel Care Tamworth Limited

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Inspection report

Unit 4, Anker Court
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Tamworth
Staffordshire
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Date of inspection visit:
18 July 2018
19 July 2018
24 July 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 18 19 and 24 July 2018 and was announced. This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to adults. At the time of our inspection the provider was supporting approximately 90 people.

At our last inspection the provider was rated as Requires Improvement and were in breach of regulations.

There is 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.

At this inspection people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. We found when needed there were no capacity or best interest decisions in place. Relatives were consenting on behalf of people without the legal power to so. Individual risks to people were not considered or managed in a safe way and when needed action was not always taken to ensure people were safe.

Medicines were not managed in a safe way and an accurate record of medicines administered was not in place. When people had as required medicines there was no guidance in place for staff to follow to ensure people receive their medicines as prescribed.

We found that people did not always receive calls at the allocated time or for the correct amount of time. There were not enough staff available to offer support to people and they had to wait for support. Some people received calls before their times. The provider's recruitment process did not ensure staffs suitability to work within people's homes.

Staffs training and induction did not ensure they had the skills and knowledge to support people.

There were no systems in place to assess and monitor the quality of the service so this information could not be used to drive improvements. Staff did not have access to the guidance they needed to keep people safe. We could not be assured we received all notifications as required as documentation within the service was limited.

As guidance for staff to follow was not available people did not receive support that was individualised. People did not receive a consistent approach to care due to the turnover of staff. People's support needs were not understood and people's cultural needs had not been considered. Information was not made available to people in a format they could always understand. Complaints were not always recorded or responded to in line with the provider's procedure.

There were concerns with the culture of this service and when we asked the provider for reassurances this was not provided to us.

People were happy with the staff that supported them. When people required support with meals they were offered a choice and people were referred to health professionals accordingly. There were infection control procedures in place and people's privacy and dignity were maintained.

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

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

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

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People did not receive their calls as planned or for the assessed amount of time needed. There were not enough staff available to offer support to people. Risk to people were not considered or reviewed and staff did not have the necessary information. Medicines were not managed in a safe way. The provider had not ensured staffs suitability to work with people in their homes. Staff had not always received safeguarding training so people were not always protected from potential harm. There were infection control procedures in place and these were followed.

Is the service effective?

Inadequate

The service was not always effective.
When needed capacity assessments were not in place or decisions made in people's best interests. Staff did not receive the necessary induction or training to support people. There was an inconsistent approach to care and people were unaware who was delivering care to them. People were offered a choice when supported with meals and staff supported people to access health professionals when requested.

Is the service caring?

Requires Improvement

The service is not always caring.
The lack of staff meant care was rushed. There was not always information available detailing the levels of support people needed. People and relatives were happy with the care they received from staff and felt they were respectful.

Is the service responsive?

Inadequate

The service was not responsive.
Staff did not have the information to deliver personalised care to people. There was not always information about people in place and this was sometimes out of date. Complaints were no responded to in line with the providers procedure.

Is the service well-led?

Inadequate

The service was not well led.
There were no systems in place to drive improvements within the

service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed. We could not be sure we were notified of significant events that occurred within the home. There were concerns with the culture of the service. The provider was displaying their rating in line with our requirements.

Angel Care Tamworth 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.

This inspection visit took place on the 18 19 and 24 July 2018 and was announced. We gave the provider five days' notice of the inspection site visits. This was because the manager and staff are often out of the office providing care and we needed to be sure that they would be available. The inspection visit was carried out by two inspectors and an expert by experience. The expert by experience had knowledge of care services including domiciliary services. The Inspection site visit activity started on 18 July and ended on 24 July 2018. It included making telephone calls to people and staff. We visited the office location on 24 July 2018 to see the manager and office staff; and to review care records and policies and procedures.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. A notification is information about events that by law the registered persons should tell us about. We brought forward our planned comprehensive inspection of this service due to the concerns we were receiving. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to formulate our inspection plan.

At the inspection we gave the provider the opportunity to send us further information including risk assessments for people and staff and updated care plans. We asked for this information to be provided on Monday 30 July 2018. We did not receive this information on this date however we did receive some blank copies of documentation.

We used a range of different methods to help us understand people's experiences. We made telephone calls to ten people who used the service and five relatives. We spoke with seven members of care staff, the registered manager and three office staff. During the office visit we looked at the care records for twelve people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including, rotas complaints and policies.

Inadequate

Is the service safe?

Our findings

At our last inspection we found care staff understood how to identify where people may be at risk of harm but action was not always taken to ensure this was suitably reported and investigated. There were sufficient staff available but improvements were needed to ensure people received their calls as agreed. At this inspection we found the provider had not made the necessary improvements and further areas of concern were identified.

Before our inspection we received information of concern that people were not receiving their calls as required from the provider, we also received information of concern that calls were being missed.

At this inspection people and relatives raised concerns about their calls and call times. One person told us, "They can arrive late in the morning. I do prefer an early call. My time should be 07:15 and it can be up to 10.00. I have to ring up sometimes and they just say they are on their way." Another person said, "Their timings could be better." A relative told us, "The times have been a bit muddled up. They can vary. Sometimes they let my relation know. They have missed visits twice over the last 18 months or so." We reviewed records which related to the calls people received. We saw that people did not receive calls as rostered. For one person we saw their evening call was planned for different times between 21:00 and 22:35. There was no evidence stating what this person's preferred call time was. The records we reviewed showed us that staff did not attend this person's calls at the time they had been allocated. For example, on one occasion in July 2018 the call had been planned for 21:05 and the staff member attended at 22:16 and on another occasion the call was planned for 22:40 and the staff member attended at 21:26. We reviewed records for July 2018 for this person we saw that out of the 64 calls that were planned in this month only 31 had been provided within 15 minutes of the time they should have been. We reviewed records for a further three people and found the same concerns. We spoke with the registered manager about this and they were unable to provide us with an explanation. This meant people did not receive calls as planned.

Before our inspection we had received information of concern from staff who had previously worked at the service. They raised concerns with us around the pressures they felt under to deliver unsafe care to people. They told us they had left their employment due to this. At this inspection we found people did not receive their assessed care hours. One staff member told us, "There can't be enough staff; they [management team and office staff] are always putting pressure on to us to do extra shifts and calls. They add calls onto the system without telling us, it's not good." Another staff member said, "There are not enough staff, we always feel pressured its constant. Weekends are bad we are rushing calls." We looked at records and saw people were not always receiving the correct allocated amount of time. For one person we saw they should have received a 30-minute call and it was recorded they had received a one-minute call. We reviewed the information that was recorded for this person for July 2018. We saw out of the 77 calls the person had received, 28 had been cut short by over 10 minutes, we saw calls had been cut short by up to 25 and 29 minutes during this month. We found the same concerns for three other people. We spoke with the registered manager who confirmed to us there were not enough staff. They told us they were recruiting however this had been unsuccessful and office staff were carrying out care to cover the shortfalls. Despite the registered manager recognising this they had continued to take on new care packages. One staff

member told us, "We haven't got the staff, they take on new people knowing full well they can't support the people they already have, and it's unsafe".

Furthermore, we saw there were gaps on the systems which suggested to us calls had been missed. We saw since May 2018 there were 10 gaps for the four people we looked at. The registered manager told us no calls had been missed and that staff had not logged into the system correctly. We did not see any evidence to support this or that the registered manager had taken any action after this had occurred. Records showed calls had been cancelled; there was no evidence to support if the provider or person had cancelled these calls.

Staff raised concerns with us about the rota and the time they had to travel in between calls. One staff member told us, "Sometimes we have to be in the same place at once." Another staff member said, "That is something that needs improving we sometimes get five minutes between a call and it can take you 15 minutes to get there. You are behind before you start." We looked at a rota for one member of staff. There were not always gaps between call times to ensure the staff member could travel between people's homes. Furthermore, the staff member was rostered to be in different homes at the same time. This meant the provider had not ensured that people's call times could be safely met.

There were insufficient staff to provide people's commissioned care. Staff rota's did not provide staff with sufficient time to travel between care calls and staff had developed strategies to manage this which included cutting short people's commissioned care. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Although people told us they felt safe. Risks to people were not always managed in a safe way. We saw an initial risk assessment had been completed for people. However, these were not always dated which meant we could not tell if they had been reviewed. When potential hazards had been identified the control measures section had been left blank and no further information was available. Therefore, we could not see how risks had been mitigated for people.

When people had been individually identified as at risk, there were no individual risk assessments in place or guidance for staff to follow. During our inspection the registered manager told us that one person needed a soft diet as they were at risk of choking. There was no risk assessment, care plan or other information in place to confirm this person was at risk of choking or required a soft diet. The provider had not made a referral to the relevant health professional for advice. We spoke with staff about this. One staff member said, "You have to cut it up into small pieces. They cough when they are eating." Another staff member told us, "No they are not as risk. I'm not sure they choke there is nothing in place about that. They have no special diet and eat whatever they fancy." This meant the lack of recording and inconsistent approach to care placed this person at an increased risk of choking.

Staff also told us another person had developed sore skin. They told us this person had been seen by a health professional who had offered advice. However, there was no risk assessment or care plan in place in relation to this medical concern. Three staff we spoke with unaware of this or the support they needed. This meant this person remains at risk of developing sore skin.

As part of the inspection, we looked at records and spoke with staff in relation to 10 people who were receiving a service from Angel Care Tamworth Limited. From the evidence available we identified risks in relation to all 10 individuals. For example, the registered manager told us that one person had acquired sore skin and that another person was at risk of falls. There were no individual risk assessments in place for these people despite risks having been identified. Staff we spoke with told us that they did not feel they had the

necessary information available to support people in a safe way. This placed people at an increased risk of harm.

After our inspection we issue a letter of intent detailing our areas of concern. We offered the provider the opportunity to evidence to us that risks for people had been considered, reviewed and where possible mitigated. We were not provided with the necessary reassurances from the provider.

Medicines were not managed in a safe way. When service users had 'as required' medicines there was no guidance in place for staff to follow when administering these. For example, information confirming what the medicines were for, when they could receive the medicines and the maximum dose they could receive within 24 hours. We looked at a MAR chart for one person, we saw they were prescribed 'as required' medicines this included paracetamol and co-codamol. It was documented that these medicines had been administered together. We saw documented over a 24-hour period eight co-codomal tablets and four paracetamol tablets had been administered, there were no times documented to show us when these were administered. As paracetamol and co-codomal (which contains paracetamol) had been administered together there was an increased risk this person had exceeded the maximum dose for this medicine, placing them at risk of an overdose and therefore at risk of harm.

Staff and members of the public have raised concerns with us about medicines not being signed for on the MAR as well as concerns with the administration of medicines at people's homes. Staff told us they had raised their concerns with the registered manager and office staff about this. However, there were no records of these concerns. We also saw on three people's MAR there were crossings out and no signatures to show administration with no documentation to provide an explanation. This meant we could not be sure these medicines had been administered as prescribed.

After our inspection we issue a letter of intent detailing our concerns in relation to the management of medicines. We offered the provider the opportunity to evidence that improvements had been made. We were not offered the necessary reassurances.

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

At this inspection we found concerns with the provider's recruitment process. We found when information had been received by the provider about staff's potential lack of suitability to work within people's homes they had not completed the necessary checks and relevant risk assessments. Staff worked with people, in their own homes, therefore this placed people at risk. We also found for some staff that suitable references had not been obtained; this again meant that the provider had not ensured staffs suitability to work with people. This demonstrated the provider did not have a suitable recruitment process in place.

After the inspection we asked the provider to offer us reassurances that the relevant risk assessments had been completed for staff, we were not provided with these reassurances.

This is a breach of Regulation 19 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There were safeguarding procedures in place however, staff were unable to demonstrate an understanding in this area and action to take to keep people safe. One staff member said, "It's keeping an eye on things." Another staff member told us, "I'm unsure on this I haven't had any training." We could not be assured all concerns had been reported to the safeguarding team as required. For example, we could not be assured

that calls had not been missed and these had not been considered as potential safeguarding's by the provider. When calls were late there were no investigations taking place to consider why these had occurred. This meant as information was not always documented or investigated we could not be assured people were protected from potential harm.

Three of the staff members that we spoke with told us they had not received safeguarding training. We looked at records and saw out of the 40 staff employed, nine had up to date safeguarding training. The registered manager told us that a further 12 staff had completed this training as part of their NVQ, however we did not see any recorded evidence of this. An NVQ is a worked based qualification which recognises the skills and knowledge a person may need to do a job.

We asked the registered manager to give us examples of when things went wrong within the service how lessons were learnt and improvements made. We were provided with a written example. This stated that a concern was identified with the administration of creams. The example told us they had added the word 'cream'. It was unclear why this was or the improvements that had been made to the service. There was also no evidence to show how this had been shared with staff.

There were infection control procedures in place and these were followed. People and staff told us there was enough personal protective equipment to use. One person said, "Yes they always wear gloves and aprons." A staff member told us equipment was always available for them to use. Although the provider had a policy in place there was no audit currently being completed by the provider in this area.

Inadequate

Is the service effective?

Our findings

At our last inspection we found where people were unable to make their own decisions, their capacity had not been clearly assessed to ensure decisions made for them were in their best interests. At this inspection we found the provider had not made the necessary improvements and further areas of concern were identified.

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 or 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.

We checked to see if the principles of MCA were followed. When needed there were no capacity assessments or best interest decision in place for people. We saw that relatives were consenting on behalf of people without the legal power to do so. For example, consent to care and administration of medicines. The registered manager told us some relatives had the legal power to consent for people however there was no evidence to support this and they had not requested this information from the families.

The registered manager, the staff trainer and staff did not demonstrate an understanding in this area. Out of 40 staff employed records showed us only three members of staff had received training in this area. The registered manager told us that a further three staff members had completed this as part of their NVQ. However, we were not provided with evidence to support this. This shows that staff had not been adequately trained to ensure they had the knowledge and skills needed to ensure that principles of the MCA were followed to ensure people consented to their care and treatment. This meant the principles of MCA were not understood or followed.

After our inspection we issue a letter of intent detailing our concerns about MCA. We offered the provider the opportunity to offer us reassurances in this area. The information we received did not offer us reassurances that they will be working within the principles of MCA or demonstrate they understand the process that needs to be followed.

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

Before our inspection staff who had previously worked at Angel Care Tamworth Limited told us that they had left their employment as they had not received adequate training, placing people at risk of harm. Staff currently working for the service told us they did not feel adequately trained to carry out their role. Some staff had not received training in key areas such as safeguarding and MCA. We received mixed views about staffs training from relatives. One relative commented, "Yes I think they are well trained." Whereas other relatives said, "I think it can vary from carer to carer, some are better than others and some can be a bit

slow." and "Yes, all except one. They just stand there and I have to ask them to do things."

Staff also told us that they commenced employment without an induction or adequate training. They also us they did not shadow staff and went out independently straight away. On staff member said, "I was told there would be shadowing but there wasn't." There were no records in place to confirm if staff had received an induction or had the opportunity to shadow other staff.

When people needed specialist support staff were not adequately trained. For example, one person had a medical condition. Staff we spoke with told us they had not received training to support this person. One staff member said, "We just watch a video, I think its YouTube." We requested to see this video and the information the staff had provided was accurate.

We reviewed the information that the provider had documented in the PIR that they completed prior to our inspection. This told us, "The induction process which covers the 15 standards of the care certificate, will now be completed before they meet clients rather than working and completing at the same time." The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high-quality care. Although we saw records to suggest staff were undertaking the care certificate as staff worked with people before completing training the provider had not completed the action as set out in their PIR.

This is a breach of Regulation 18 (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People's care was not delivered in line with current legislation. This was evidenced by the lack of care plans or risk assessments in place, which meant we could not determine how care was assessed and delivered to people.

People received an inconsistent approach to care. One person said, "I have different ones [carers] and they don't stick to the rota. I don't know who is coming it is hit and miss." Another person told us, "Yes I usually have the same ones. I don't always know which ones are coming though." A relative said, "My relation does have different ones and I do think it is important for them to have the same ones. They do just turn up they do not know who is coming.". People and relatives also told us new carers would turn up at their homes before being introduced to them. People were not provided with a rota identifying who would be carrying out the care. The registered manager also confirmed this to us. Staff raised concerns with us. One staff member said, "It changes all the time, you can be driving to someone's house and another person is added on to the system without you knowing." Another staff member told us, "As we don't know what we are doing half the time it impacts on the people. Staff just keep walking out and it's not fair, they get use to one staff member and they leave then the next day its someone different turning up". We reviewed the PIR, the provider had documented that 187 staff had left the service in the last 12 months. This demonstrated that there was high turnover of staff and that people did not receive a consistent approach to care.

People who were supported with eating and drinking told us staff offered them choices. One person said, "They get my breakfast and a cup of tea in the morning." A relative told us, "They will do a microwave meal at lunch time for my relation. They choose what they want." We saw that staff had recorded people's food intake when they had supported people with this. However, people did not always receive a diet in accordance with their assessed needs. For example, when one person required a soft diet. As the information in relations to people's diets was not always accurately documented we could not be assured staff had the relevant information to offer the correct support.

People were responsible for managing their own healthcare needs however staff told us they would offer support to people if they requested it. For example, a staff member told us if a person was unwell they would contact their GP for them if they requested them to. Staff also told us they worked alongside the district nurses. One member of staff told us, "If I am at someone's home with the district nurses come I let them know how the persons been doing and what we have done." This showed us staff shared information with other organisations.

Requires Improvement

Is the service caring?

Our findings

The lack of staff meant people's care was rushed. One person said, "If I ask them to do something they are very obliging. They don't get time to sit and chat though." Another person said, "They chat all the time but rarely have time to sit down." All the staff we spoke with raised concerns. One staff member said, "We are told to be quick, so we can move onto the next person." Another staff member said, "We don't stay there anywhere near the times we should. We must get to everybody so we have to cut times short, the manager and office staff are aware." As staff were not always at people's homes for the allocated times, [see safe] care was rushed. As staff often left early we did not see that they used the reminder of people's time to sit and talk with people or offer them emotional support.

Staff told us they encouraged people to be independent, people confirmed this to us. One person said, "I do try to be as independent as possible and they do encourage me as much as possible." However, the levels of support people needed were not detailed in people's records. For example, when people needed support with transferring there was no guidance in place stating what people could do for themselves.

People and relatives spoke positively about the care staff and the support they received from them. One person said, "They are kind, they always ask me if I am okay." Another person told us, "Lovely girls, very kind nothing is too much trouble for them." Relatives told us, "They have all been marvellous. They will jolly my relation along and have a bit of banter. Also, they are very kind to me when I have a wobble." This meant that people and relatives were happy with the care staff and felt they were supported in a kind and caring way.

People dignity was considered and staff were respectful. One person told us, "They are all very respectful and treat me very well." Another person said, "They help me wash and dress and are very kind and respectful. I feel at ease with them. "A relative said, "My relation can get very agitated and they are very patient and understanding with them." Staff gave examples how they promoted people's dignity. One staff member said, "We knock the door before we go in and give them a little shout to know we are here. We also make sure door and curtains are closed. I try to give them some time alone, so when they are using the toilet or washing if it's safe to do so I wait in another room till they are ready."

Inadequate

Is the service responsive?

Our findings

At our last inspection people felt able to raise any concerns and complaints although some people said these were not always satisfactorily resolved. This was a breach of Regulation 16 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We also found people received the agreed level of support and confirmed their needs were met but this wasn't always provided by a consistent staff team. At this inspection we found the provider had not made the necessary improvements and further areas of concern were identified.

At the last inspection we found some people that had raised concerns felt that they had not been resolved to their satisfaction. At this inspection we found the same concerns. Although we saw a complaint policy was in place, when complaints had been made these had not always been responded to in line with this procedure. For example we saw an complaint had been made to the provider via email raising concerns about care a person received. The provider had printed a copy of this complaint, we saw no evidence the provider had responded to the complainant, the complaint had been investigated or action had been taken following this. We also saw when some other complaints had been made there was no evidence action had been taken or they had been responded to at all. There was no evidence what action had been taken and if the complainant was happy with the outcome. This meant the provider was unable to demonstrate that complaints were responded to or were investigated thoroughly and actions and improvements taken when required.

We reviewed the PIR that was completed by the provider. This told us in the last 12 months, 18 formal complaints had been made. During our inspection we did not see a record of 18 complaints being made.

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

At this inspection the information staff needed to deliver individualised care for people was not in place. For example, people had one care plan in place that was a breakdown of what support they received during their call. Information included, 'personal care and medicines. For some people there was no further detail provided. There was also no evidence in place as to how this information was reviewed. We also requested to see pre- assessments that had been completed prior to the person receiving support from Angle Care Tamworth Limited as there were none in place. We were told that information relating to this was held in members of the management team's heads and not recorded. As the information staff needed was not in place we could not be sure people received the support they required, therefore staff did not have the information available to deliver the individual care people required.

Staff also told us they would offer care to people without any information being in place. One staff member said, "If it's the first call we just turn up, it's put on our system and we don't really know anything about them. There won't be a care plan in place so we just ask the person. I have always been to people who can tell me what to do."

Information that was in place for people was out of date. For example, for one person we saw documented they "May need a hoist or I may use my rotunda". There was no further information about this. Furthermore, when we discussed this with the registered manager they told us this person now mobilised independently. This meant staff did not have the most up to date information to offer safe care and treatment to people placing them at risk of harm.

When people were being supported with end of life care there were no care plans or guidance in place to support staff to care for this person during this time. This meant people were at risk of not having their individual care needs met.

People's cultural needs had not been considered. The provider had not considered people's needs in relation to the protected characteristics. The Equality Act 2010 covers the same groups that were protected by existing equality legislation, including age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. The provider confirmed this was not something they assessed or considered for people they supported. We did not see that an equality and diversity policy was in place. When asked about this, the registered manager did not understand or appreciate why these would need to be considered. After our inspection we asked the provider to offer us reassurances in relation this, the provider's response demonstrated they did not have an understanding of the importance of this.

The registered manager confirmed they were unaware of accessible information standards (AIS) they were not implementing this to support people. AIS were introduced by the government in 2016 to make sure that people with a disability of sensory loss are given information in a way they can understand. We did not see any communications plans in place for people or evidence that information shared with people was available in different formats to help them make informed choices.

This is a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found systems to assess and monitor the quality of support provided had not been developed to ensure areas for improvement were identified and action taken as needed to drive improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. The provider had also not notified us of important incidents as required. This was a breach of Regulation 18 of the care quality commission (Registration) regulations 2009. At this inspection we found the provider had not made the necessary improvements and further areas of concern were identified.

Following our inspection, we issued the provider with a letter of intent highlighting the high levels of concerns we found during our inspection. We asked the provider to offer us reassurances in the form of an action plan. The provider did not offer us with the necessary reassurances or an action plan. Following receipt of this response we offered the provider a further opportunity to send us supporting documentary evidence. They failed to offer us the necessary information, sending blank copies of templates of only some of the documents requested.

During the inspection we found no evidence that audits were in place. We were shown a spreadsheet which collated information including the number of late calls people received during a given month. It was documented that 553 calls were late in January 2018, 714 in February 2018, 347 in March 2018, and 198 in April 2018. There was no action plan in place or action taken in relation to this. There was no further information recorded since April 2018. We saw from records relating to the care planner system that people continued to receive late calls. [See safe] This meant the system the provider had in place were not effective in identifying areas of concern or driving improvement within the service.

There were no audits taking place to ensure medicines were managed in a safe way, which meant people were at risk as none of the concerns we have reported upon in safe had been identified or acted upon.

We saw satisfaction surveys had been completed by people and their relatives, and concerns and suggested improvements had been raised. For example, one person had rated the service as adequate and stated improvements with call times could be made. However, this information had not been collated or used to make changes or improvements to the service. This meant the provider had not acted on feedback that they had received.

Records were not always accurate and up to date. For example, we asked to review the incidents and accidents that had occurred since the last inspection. Other than one incident that had occurred with a staff member nothing was recorded. We checked people's daily notes to see if any information had been documented. The information that was documented in people's daily notes was limited. For example, "Fine today" and "Hasn't eaten much". As staff were not recording in detail what had happened to people we could not be sure that all incidents and accidents had been identified and recorded as needed. As we could not be assured all information was documented as needed we could not be sure the provider was notifying us of significant events that occurred within the service. During our inspection we did not see anything

documented that we consider should have been referred to us.

Medicines administration records (MAR) were hand written and illegible. We saw the MAR included the name of the medicine but no further information was documented, such as the dose. Furthermore, the name of the prescribed medicines had not been documented; the MAR simply stated 'dosset box'. This meant that an accurate record was not being kept of what medicines you were administering to people.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There was a registered manager in place. Although they felt staff who worked in the office were helpful, staff, people and relatives raised concerns with how the service was managed. One person said, "Overall yes I think it is, just wish they would sort their rotas out. I sometimes have to lie in bed until they get here." A relative said, "We are satisfied with the care. I just think they could be better organised. It's a shame they have lost some good carers recently." During our inspection staff told us they felt pressured by the management team to carry out extra hours. This was echoed by information of concern we had received from staff who had previously worked at the service. They raised concerns with us around the pressures they felt under to deliver unsafe care to people and confirmed that this was the reason they had left their employment.

During our inspection staff raised concerns with the culture of the service. Prior to our inspection, we made telephone calls to people who used the service. When we spoke with staff they told us that people who used the service did not feel they could be open and honest with us as they were concerned about the consequences of raising their concerns. They also gave us example of when complaints had been retracted by family members following visits by the registered manager and office staff. Staff knew how to whistle blow however they did not feel they would be protected if they did. Staff who contacted us after our inspection wished to remain anonymous as they were concerned about the outcome if the registered manger and office staff were made aware. One staff member said, "Nothing is confidential, you can go in the office and they are talking about people and staff. I know how to whistle blow but I would not be confident that everyone else would find out it was me, I think pressure would also be put on me to retract what I had said". During and after our inspection we found that the registered manager was not approachable and did not demonstrate an understanding of the requirements or action we were considering.

Staff did not always receive the support they needed from the management team. We saw that some staff received supervision from the management team, however we could not be sure how effective this process was. For example, we saw concerns had been raised by one person about a staff members attitude. We saw a conversation had been documented. The management team had failed to offer support to the staff member or any training to help rectify the concern that had been raised.

The registered manager and staff told us that no staff meetings were taking place. This meant staff did not have the opportunity to raise concerns which could place at risk of harm.

We saw that the rating from the last inspection was displayed in the office and on the providers website in line with our requirements.

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 Staff did not have the information to deliver personalised care to people. There was not always information about people in place and this was sometimes out of date.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When needed capacity assessments were not in place or decisions made in people's best interests

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people were not considered or reviewed and staff did not have the necessary information. Medicines were not managed in a safe way.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were no responded to in line with the providers procedure.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place to drive improvements within the service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured staffs suitability to work with people in their homes.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive their calls as planned or for the assessed amount of time needed. There were not enough staff available to offer support to people. Staff did not receive the necessary induction or training to support people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff did not have the information to deliver personalised care to people. There was not always information about people in place and this was sometimes out of date.

The enforcement action we took:

NOD to restrict admissions into the service and impose a positive condition.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When needed capacity assessments were not in place or decisions made in people's best interests

The enforcement action we took:

NOD to restrict admissions into the service and impose a positive condition.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people were not considered or reviewed and staff did not have the necessary information. Medicines were not managed in a safe way.

The enforcement action we took:

NOD to restrict admissions into the service and impose a positive condition.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were no responded to in line with the providers procedure.

The enforcement action we took:

NOD to restrict admissions into the service and impose a positive condition.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place to drive improvements within the service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed.

The enforcement action we took:

NOD to restrict admissions into the service and impose a positive condition.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured staffs suitability to work with people in their homes.

The enforcement action we took:

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Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive their calls as planned or for the assessed amount of time needed. There were not enough staff available to offer support to people. Staff did not receive the necessary induction or training to support people.

The enforcement action we took:

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